MASS CONFLICT AND CARE IN WAR AFFECTED AREAS

IN SEARCH OF ASSESSMENT AND PSYCHOSOCIAL INTERVENTION

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MASS CONFLICT AND CARE IN WAR AFFECTED AREAS

IN SEARCH OF ASSESSMENT
AND PSYCHOSOCIAL INTERVENTION

ZORG BIJ GROOTSCHALIG GEWELD IN OORLOGSGEBIEDEN

ZOEKTOCHT NAAR METHODEN
VAN METEN EN PSYCHOSOCIALE INTERVENTIES

(met een samenvatting in het Nederlands)

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Section I

Introduction

Photo: Francesco Zizola

Chapter 1

Introduction

Introduction

Genocides in 1993 and 1994 in the neighbouring African countries of Burundi and Rwanda displaced hundreds of thousands of people, many of who were subjected to further brutality as they fled their place of origin. The refugees, who eventually numbered around 400,000, settled in make-shift camps and tried to survive in their new, unknown social environment. Having left behind most of their belongings and with no source of income, the refugees were dependent on humanitarian organisations to meet such basic needs as those for food and water. This dependence, in addition to the constant threat of being sent back, made them an extremely vulnerable population, and their experiences of violence and terror were compounded by on-going survival stress.

The primary health care clinics in the camps were flooded with patients, one-third of who attended with somatised psychosocial problems. Patients described to the medical staff what they had experienced and lost. Exit interviews revealed that many attended the clinic three or even four times a week, most with unclear physical signs. Individuals probably not in need of physical medical attention received drugs such as antibiotics, as physicians were afraid of overlooking a serious disorder. This misuse of limited resources frustrated the medical staff, but the patients continued to return, requesting treatment.

Only a small number presented psychiatric disturbances. These patients were experiencing a medical emergency and were treated as such, but the day-to-day management of these refugees was time consuming. In addition, follow-up of instructed caregivers was difficult, because of a lack of mental health professionals and trained supervision staff.

The medical staff requested an intervention that would address the emotional origin of the patients' physical signs and thus increase medical effectiveness. There was an evident need to supplement the physical medical services, and to address the pervasive destruction of other aspects of human health - mental, social, spiritual and moral [1].

Problem definition

In the early 1990s the medical humanitarian world was challenged to solve the problems encountered in caring for large groups of people affected by extreme violence. At that time, knowledge of the incidence of psychological suffering among populations subjected to mass man-made violence was derived mostly from research among refugees in Western settings, coupled with general insights from the after-effects of World War II and other military conflicts. No specific theoretical framework

existed for interventions to address psychosocial suffering in areas of mass violence, such as Rwanda in 1994. How to establish the effectiveness of such interventions was terra incognita.

This thesis reviews psychosocial humanitarian research carried out from 1999 until the present (2014). It follows the scientific endeavour to answer questions (operational in origin) about how to assess needs in terms of psychosocial mental health, how to address those needs, and the likely effectiveness of interventions. Substantial improvements have been made; current studies, conducted worldwide in a variety of areas of armed conflict or its direct aftermath, demonstrate how research can help find ways to address psychosocial needs related to mass violence. In contrast to the lack of knowledge on these issues during the Rwandan crisis, now (2014) during the Syrian, Sudanese and Central African Republic crisis it is known much better what to do and what not.

The research in this thesis focuses on the psychological consequences of large-scale armed conflict. Armed conflict is defined in International Humanitarian Law as: 'international armed conflicts, opposing two or more States, or non-international armed conflicts, between governmental forces and non-governmental, armed groups, or between such groups only' (page 1 [2]). Single or multiple (but geographically confined) violent incidents (such as terrorists attacks) in high-resource countries are not part of the research focus. The impact of violence on special groups such as children, elderly people, etc. was not a topic of research either.

To introduce the research questions this chapter describes the understanding of the psychosocial consequences of war that have dominated the field of psychosocial support programmes and research for the past two decades.

Understanding the psychosocial consequences of war: The dominance of PTSD

Post-traumatic stress disorder as the basis of a theoretical framework

Humans have experienced adverse psychological consequences from war throughout history. The first scientific study on the psychological effects of war was published in the late 19th century [3]. However, it was not until 1980 that a specific type of war- and violence-related psychological suffering received official recognition. The third edition of the internationally accepted *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) ascribed a unique diagnostic label to the phenomenon of called post-traumatic stress disorder (PTSD) [4]. The PTSD diagnosis was the outcome of the scientific and clinical discourse in the 20th century [5], but this formulation of a specific war- and violence-related diagnosis also had a socio-political dimension. In the seventies US veterans of the Vietnam-war lobbied for formal medical recognition

of their (psychological) suffering during and after this violent conflict. PTSD became and remains the sole mental health diagnosis to qualify an individual for financial allowances and treatment from the US Veteran Administration Medical System. The PTSD diagnostic label implied that psychological suffering following traumatic experiences should no longer be explained by an individual's weakness or malingering [6], but is in fact a series of predictable and measurable mental health and psychosocial effects.

Since its introduction, PTSD has become a popular area of mental health research. PTSD has a special interest of researchers because it is considered one of the few mental disorders whose unique cause is an external event [7]. In the decades following its first definition, research into PTSD contributed significantly to Western researchers' understanding of the relationship between external stimuli of violence and internal psychological processes [8].

Generally speaking there is consensus on PTSD signs and symptoms, but on-going discussion on the definition of a 'traumatic event' [4]. Initially, a traumatic event was defined from the symptomatic perspective: if a person exhibited a specific set of (distress) symptoms it was assumed that they had experienced a traumatic event. The underlying assumption in DSM-III was twofold: traumatic events will cause signs of severe maladjustment in any individual (the relationship is causal) and the specific set of distress symptoms is similar in all those affected, i.e. they are universal.

In the manual's next revision, DSM-III-R [9], the focus shifted from distress symptoms to specifying the type of event, now defined as being 'outside the range of normal experience'. An implicit assumption of a universal reaction to the event remained. The definition of 'outside the range of normal' met with severe criticism that centred mostly around the question: what is normal? DSM-IV and its revision (DSM-IV-R) [10, 11] dealt with this lack of clarity in a two-fold definition that added distress symptoms to the specification of the event [9]: i.e., actual, or threat of death or serious injury and a reaction to this of fear, helplessness, and horror. In the latest version of the DSM (DSM 5) [12], the definition of a traumatic event is further modified by the addition of sexual violence to death and injury, while subjective distress reactions are no longer included. The modifications of the definition of PTSD over time reflect developments in research and the enduring difficulties in defining a traumatic event (for an overview see Table 1).

In the slipstream of Western research on individual consequences of conflict and violence, non-governmental organisations (NGOs) became interested in using the PTSD concept to model psychosocial support programmes in areas of mass violence. As most mass violence conflicts occur in non-Western areas the (assumed) universality of the symptomatology was appealing. Estimation of psychosocial need was based on the (assumed) causal relationship [9] between exposure to violence and the specific syndrome of PTSD. Among humanitarian workers, adoption of this

concept created the widely held belief that whole populations were to be affected by PTSD.

Table 1 Evolving definitions of a 'traumatic event' in successive revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

Version	Definition of traumatic event	Year
DSM-III	Evokes significant symptoms of distress in almost everyone	1980
DSM-III-R	Event outside the range of normal experience and distressing to everyone	1987
DSM-IV (DSM-IV-TR)	I Event that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others II Provoking intense fear, helplessness or horror	1994 (2001)
DSM 5	Exposure to actual or threatened a) death, b) serious injury, or c) sexual violation, either directly experiencing, witnessing, learning that the traumatic event(s) occurred to a close family member or close friend; (cases of actual or threatened death must have been violent or accidental), or experiencing repeated or extreme exposure to aversive details of the traumatic event(s); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.	2013

Alternative criticism: The limitations of the PTSD framework

A universal concept as a point of departure for those organising research and support programmes has an intuitive appeal. However, the assumptions underlying the PTSD concept, most notably its universality and the 'causal' relationship between event and symptoms, have been disputed from the mid-1990s [13],[14] until today [15], [16]. A first consideration is the 'post'-criterion (at least 4 weeks after the event) in the PTSD diagnosis. Though various signs of PTSD may be useful indicators for psychosocial, mental health suffering in areas of *on-going* conflict, the occurrence of PTSD cannot be formally established. A second issue is the risk of pathologising normal reactions to extreme events such as being upset, having nightmares, shock reactions, fears, feeling lonely, feeling lost, and despair. Many people confronted with war experiences have these negative responses, but only 10–40% go on to develop diagnosable mental disorders [17]. The general psychological and physical processes that emerge in the wake of trauma can help an individual to integrate traumatic experiences, and should not be regarded as pathological responses [18]. An exclusive emphasis on the signs of PTSD overlooks the normal and healthy ways in which many victims adapt to extreme stress. This may lead to invalid generalisations [19], such as the prevailing thought among humanitarian workers in

the 1990s that in areas of mass violence, where nearly everybody is confronted with death, loss and other highly traumatising events, most of the population will be traumatised and suffering from PTSD.

The listing of PTSD in the DSM suggests the existence of a universal reaction to traumatic events, and Western explanatory (medical) models tend to focus on the individual as the cause and origin of the phenomena. However, Bracken et al. [13] and Summerfield et al. [14] strongly disagree with this assumption that these individualistic models are applicable in non-Western settings, where often other (collective) approaches are used. They point at a category fallacy[1] [20] that prevails in the trauma literature as well as in the psychosocial and mental health programs in conflict areas. The syndrome of PTSD is used as justification for psychosocial, mental health interventions. Even if the phenomena of PTSD are observed worldwide, it does not imply that the understanding and meaning of them is the same everywhere [19]. Whether the individual's signs are perceived as suffering or even as disorders is subject to cultural and historical collective understanding. The focus on individual bio-psycho-social disorders or symptomatology reduces the impact of mass violence, as a collective experience, to the field of individual mental health, ignoring other elements of the social ecology such as the destroyed context in which the trauma was experienced and the impact it has on relationships, family and community functioning [13], [19]. Hence, the exclusive focus on internal mental processes is not meaningful. Instead the emphasis of intervention and research should be on the shattered social collective context [19]. Social rehabilitation is therefore considered to be the appropriate approach.

At the end of the 20th century nearly all research on trauma and PTSD came from the West, and studies often dealt with individuals in stable recovery environments after experiencing (single) traumatic events. On-going traumatisation, referred to as type II trauma [21], has been associated only with contexts of early child abuse or soldiers with war-related experiences. Whether either of these concepts of trauma and PTSD fit a civilian context of on-going violence, mass violence and destroyed recovery environments is a valid question in itself.

Unfortunately, those who criticised the trauma and post-traumatic stress disorder framework focussed on the theoretical elements mainly. This does not undermine the validity of the concerns raised, but limits the development of different models to be tested and compared. An alternative approach to address psychosocial needs in areas of mass conflict became more prominent in the first decade of the next century. Social rehabilitation as an approach to assessment and intervention in relation to mass conflict has only relatively recently received scientific attention.

1 Category fallacy: one infers that something is true of the *whole* from the fact that it is true of some *part* of the whole [20]. F.i. this fragment of metal cannot be broken with a hammer, therefore the machine of which it is a part cannot be broken with a hammer.

Thesis questions

Carrying out research presents medical and humanitarian NGOs working in conflict areas with an ethical dilemma, as the priority of these NGOs is to provide support to as many beneficiaries as possible and as quickly as possible. Research combined with this primary objective of service delivery, can be characterized as 'Operational Research'. 'Operational Research' is prompted by questions generated from field programming, and often deals with topics that other parties cannot (e.g. specific tropical diseases) or will not (e.g. specific drugs for specific tropical diseases) investigate - or not in a timely way. 'Operational Research' should benefit primarily the populations in which it is carried out and ideally should adhere to existing scientific standards, so far as field conditions allow.

The field research in this thesis on assessment and effectiveness benefit the population directly. Assessment studies on needs lead to resource allocation, research on effectiveness resulted in programme continuation. After all, resources for psychosocial programmes in emergencies are justifiable only if the magnitude of the problem is substantial and the proposed intervention is possible and effective. Knowledge that was not available at the onset of our research.

This thesis, first of all describes these operational studies; however, it goes beyond the concept of operational research by integrating and combining findings of these different studies. Research in areas of mass conflict is dangerous, and therefore few institutions and individuals are able to conduct these studies. To date no other studies have been published from some of the areas where we have conducted research (e.g. Somalia, Chechnya).

Question 1 What is the best methodology to assess violence and the related psychosocial needs in populations affected by on-going mass violence?

The assessment of psychosocial and mental health needs in areas of on-going violence is challenging for reasons such as the limitations set by the fast-changing environment, cross-culturally validity aspects of measurement and the safety risks for the researchers.

To assess psychosocial needs on a population level we initially followed the perspective that the psychological impact of violence results from an external, traumatic event that is a unique cause for psychological signs and symptoms. To measure exposure to potentially traumatic events we initially used the DSM-IV TR definition of a traumatic experience [10] (see Table 1). This definition of violence- and war- related experiences allows for detailed description of local prevailing types of violent events. Besides, to specify forms of violence is important for advocacy on human rights and when asking for international attention to beneficiaries' suffering.

We used mental health symptoms as a second indicator for psychosocial suffering, referring to them as psychological problems rather than disorders. This approach has been formalised later in official guidelines [22]. In the absence of viable alternatives, and despite the limitations of a symptomatic approach, it seemed to be the most efficient method to establish and evaluate the emotional and psychological suffering of populations in resource-poor areas of mass conflict. The data collected would allow us to clarify the prevalence of suffering and possibly also identify alternative indicators for psychological distress.

This inclusive, non-labelling approach was justifiable because, according to the DSM-IV [11], extreme distress after traumatic events may manifest as other problems than PTSD alone [23]. For instance, co-morbidities such as depression, substance abuse, dissociative disturbances, etc. have been found to be much more prominent in trauma patients than was originally assumed [24]. The Somalia assessment [25] has been a pragmatic exception to this rule; the sole validated instrument in that context used PTSD as indicator.

Instruments and methods for assessing psychosocial and mental health needs in contexts of on-going violence were scarce at the start of the 21st century. We carried out our first needs assessment at the end of 1999 [26], at which time 33 refugee/displaced/conflict-related survey studies had been completed [27]. Most of these surveys were conducted in Western countries and focussed on specific groups. Seven survey studies were carried out in communities exposed to active conflict [28] [29]. Only one was carried out in Africa [28]. Table 2 shows these assessments in active conflict contexts from before 2000. All these surveys used Western-designed instruments, mostly with the PTSD (medical pathology) perspective, to assess needs. The outcomes varied widely, with the prevalence of psychosocial and mental health needs ranging from 10% to 71%, which gave raise to doubt such as: have the mental health needs in areas of on-going violence been overrated in certain assessments? And are the majority of those exposed to on-going violence indeed in need of psychosocial help?

Question 2 What are the key components of a framework to address the psychosocial consequences of mass conflict?

Currently, there seems consensus on how to conduct psychosocial support programmes to address the consequences of mass violence, and this consensus is expressed in several international guidelines [30].

Two initial publications put the mental health of refugees on the international health agenda and indicated to medical and humanitarian organisations what psychological support could consist of. The Harvard Program in Refugee Trauma reported on the psychosocial support provided to refugees of the Khmer Rouge regime in Thailand [31], while the World Health Organisation and the office of the

Table 2 Overview of population surveys carried out in areas of on-going violence before 2000

Study	Sample characteristics	Sample size
Dahl et al., 1998 (1994)	31 Consecutive Bosnian women attending a non-governmental humanitarian organization in Bosnia over 3 days who had experienced a high number of traumatic events	55
Karam et al., 1997, 1998	Multi-stage probability cluster sample of selected residential areas in the Bejjeh region of Lebanon (a low-conflict zone). Interviews were conducted with all available residents	221
Mangoud 1996 (1992)	A two-stage sampling procedure of Bosnian refugees who arrived within 6 months of the invasion and were resident in refugee camps in Split or Zagreb	578
Mollica et al., 1993 (1990)	Multi-stage area probability sampling of Cambodian refugees in the Site 2 refugee camp on the Thai-Cambodian border	993
Peltzer 1999 (1994–96)	Sudanese refugee community residents in Northern Ugandan camps. No information on sampling frame	100
Reppesgaard 1997 (1993)	Random sample of Tamil villagers in refugee camps in Jaffna, a high-conflict war-zone in Sri Lanka	356
Somasundaram et al., 1994 (1991)	Random sample from a pool of 1322 families living in the northern area of Sri Lanka. One member of each household selected at random for interview	98

(Year in brackets)= year in which survey is conducted. PTSS/D: post-traumatic stress syndrome/disorder; DIS: Dissociation questionnaire; SRQ= Self-reporting Questionnaire; HTQ: Harvard Trauma Questionnaire; HSCL: Hopkins Symptom Check List; SIQ: Stress Impact Questionnaire

United Nations High Commissioner for Refugees launched publications on how to support the mental health of refugees [32].

However, these reports did not explain how to intervene in situations of mass violence, how to prioritize services, nor what practical steps to take to organize an intervention in (often) low-resource settings. Furthermore, most of these publications focused on refugees, leaving it unclear what to do in on-going conflict situations where populations did not become displaced and did not leave their country.

Efforts were made in nearly 200 (185) psychosocial projects during the war in the former Republic of Yugoslavia (1991-1995) to gain empirical knowledge and learn lessons [33]. However, the diversity of approaches hindered the formulation of an

	Tools	Country	Prevalence
	PTSS-10	Bosnia	- 41–71% PTSD
	DIS Lebanon	Lebanon	- 29% Depression - 10% PTSD - 16–41% Depression
	SRQ-20	Croatia Bosnia	Elevated levels of stress-related mental health disorders
	HTQ, HSCL-25	Thailand Cambodia	- 55% Depression - 15% PTSD
	HTQ	Uganda, Sudan	- 32% PTSD
	DSM checklist	Sri Lanka	Elevated levels of serious MH problems in 10% of males, 25% of females
	Clinical interview, SIQ	Sri Lanka	- Somatisation (41%) - PTSD (27%) - 26% Anxiety disorder - 25% Major depression - 19% Hostility - 13% Relationship problems - 15% Alcohol and drug misuse - 18% Functional disability

overall intervention framework for psychosocial programmes in contexts of mass violence. The lack of practical knowledge on how to implement an emergency psychosocial mental health programme in an area of mass violence became evident during the Kosovo crisis (1999) [34]. The already mentioned dilemma faced by NGOs in Rwanda (1994), of how to help the population affected by mass violence, remained unaddressed, and it was unclear what operational elements constituted a psychosocial program.

At the time of the research the question, for those organising psychosocial field programmes, emerged on which perspective would serve an intervention program best: the expert or the local view. These different perspectives were a practical

consequence of the previously described emphasis on PTSD and the critical response. Mental health experts use Western-defined bio-psycho-social models (such as PTSD) to look at suffering and interventions, seeing the beneficiary as the patient; for those taking the local perspective, the population is the most important element, and it should guide the design of what they need. The underlying criticism of the expert perspective by those favouring the local perspective was that the consequences of violence became the domain of experts that provided services using (Western) mental health focussed interventions. Those advocating the local perspective stated that not experts but beneficiaries know best: the recipients of aid should decide what their priorities are [14]. Advocates of the expert perspective stated that mental health needs cannot be addressed through local beneficiary action but require targeted professional interventions. Each perspective has its credibility. Nevertheless, what is viable in the execution of psychosocial programmes is addressed in our research on the question: What are the key components of a framework for addressing the psychosocial consequences of mass conflict?

Question 3 In areas of on-going conflict, how effective are interventions to address psychosocial consequences of mass violence?

Taking an evidence-based approach to mental health care has become increasingly important in the past decade, 'effectiveness' being the justification for psychosocial interventions in the Western world [35]. In Western settings, successful evidence-based treatment for survivors of violence is fairly well established (e.g. [36]). However, until recently there has been a lack of conclusive scientific outcome studies in conflict areas, which has undermined the confidence of donors and medical as well as psychological professionals in the relevance of psychosocial interventions. Hence, evaluation research has become an essential element to justify resource allocation for psychosocial, mental health interventions in areas affected by war and violence. What is an effective intervention? Effectiveness is being defined as the actual achievement of the intervention in a clinical trial. What indicators for effectiveness can be used, and how best can one deal with cultural differences?

Our research aims to contribute to the development of knowledge. Are psychosocial programmes in non-Western settings successful in addressing violence-related psychosocial needs, and what interventions are effective or ineffective?

Thesis and general design

The research in this thesis addresses these three questions in a number of empirical studies conducted in areas (outside Western Europe and North America) of mass conflict. To exemplify the context in which each study was conducted the chapters are preceded by a brief description of the humanitarian background of the study-area. The last chapter is an integration of the previous study findings and recommendations are given for the way forward to develop further the quality of psychosocial mental health field interventions in areas of mass conflict.

The terms 'psychosocial health' and 'mental health' are interchangeable in this thesis. In most parts of the world, mental illness is associated with much prejudice (stigma), and the term is considered to refer to severe psychiatric illness such as schizophrenia. The term 'mental health' has a medical (disorder) component. The term 'psychosocial health', covering the whole spectrum of mental wellbeing, including psychiatric illness, was introduced to avoid stigma and to ensure a better understanding of support being offered. The term 'mental health' has remained in use among societies where mental health is understood not to be limited to severe psychiatric illness and the user wishes to emphasize the medical component. Important guidelines such as the Inter-Agency Standing Committee (IASC) guidelines on mental health and psychosocial support in emergency settings [37] continue to use both terms to avoid confusion.

Question 1 What is the best methodology to assess violence and the related psychosocial needs in populations affected by on-going mass violence?

Data on needs assessment have been gathered in several conflict contexts. Findings based on the study in Russia – Chechnya/Ingushetia (2005) are being described in Chapter 2; on the study in India – Kashmir (2005) in Chapters 3 and 4. The last chapter of the section on assessments (Section II, chapter 5) the findings of an assessment in Mogadishu - and Somalia (2011) are described.

Question 2 What are the key components of a framework to address the psychosocial consequences of mass conflict?

Section III (chapter 6, 7 and 8) deals with the principles of, and the approach to, implementing psychological programmes in areas of mass violence. Experiences of mental health, psychosocial programming in more than twenty different countries over a period of ten years and the lessons learned are presented.

Question 3 In areas of on-going conflict, how effective are interventions to address psychosocial consequences of mass violence?

Section IV (chapters 9, 10 and 11) starts with a discussion on the effects of psychosocial, mental health interventions by looking at the outcomes of an evaluation study of programmes implemented in Bosnia (1994–98). The next chapter (10) reviews the effect of all empirical evaluation studies in areas of on-going violence (till January 2013). The final chapter of this section describes an alternative evaluation method implemented in eight-teen different humanitarian contexts.

In the epilogue (12, Section V), implications from the overall findings of this dissertation are discussed: how did the research of this thesis contribute to the understanding and improvement of the support to those suffering from psychosocial, mental health problems in areas of mass conflict?

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Section II

Question 1

What is the best methodology to assess violence and the related psychosocial needs in populations affected by on-going mass violence?

Background on the Chechnen/ Ingushetian survey (July 2004)

The relationship between Russia and the States of the Northern Caucasus, most notably Chechnya and Ingushetia, has been strained for centuries. Stalin expelled the entire Ingush and Chechen populations to Central Asia in 1944 as punishment for the Chechen uprising during the World War II. Many died before and during the deportation, and in 2004 the European Parliament classified the expulsion as genocide. A substantial minority of the half million deportees returned in 1957. As the Soviet Union disintegrated, the Chechen separatists declared independence in 1991, and an intense and violent conflict between Russia and Chechnya/Ingushetia razed the Northern Caucasus. Two episodes of outright war (1994–1996 and 1999–2002) led to the destruction of many houses (the capital Grozny was totally destroyed), other buildings and vital infrastructure. All local resources and productive capacity collapsed. The two decades of violence, human rights abuses, and criminality led to the breakdown of social networks, poverty and the broken morale of many.

After the second Chechen war international attention lessened, despite regular reports by international and Russian human rights organisations of human rights abuses such as torture, rape, murder and disappearances, looting and restrictions on freedom of movement and expression. The Chechen battle became a 'forgotten conflict'. Few international NGOs continued their presence, in part because of Russian obstruction but mostly in response to high risk of kidnap by Chechen freedom fighters and criminal networks.

Many civilians deprived of their livelihood and tired of the violence escaped to neighbouring countries. Around 260,000 Chechens were displaced in Ingushetia, finding shelter in tent camps and in collective squats ('spontaneous settlements') in farms, sheds, train wagons and disused or still operational factories. Living conditions in the tent camps and spontaneous settlements (Kompakniki) were poor, and most of these IDPs (internally displaced persons) lacked food, medical care and clothing. For most, a return to Chechnya was no option.

The Russian authorities implemented a policy of forced repatriation of IDPs displaced from Ingushetia, to give the outside world the impression the Caucasus conflict had ended. The few international NGOs that continued to work were asked to leave. Médecins Sans Frontières has been present in the North Caucasus since 1992. Following the war in Chechnya, MSF began programmes in Ingushetia, Chechnya and later in Dagestan. A mental health survey was organised for several reasons. First, objective data were needed to verify existing needs and to target our intervention. Second, the survey could be used to bring the world's attention to this largely forgotten conflict.

Photo: German Avagyan

Chapter 2

The trauma of on-going conflict and displacement in Chechnya

Quantitative assessment of living conditions, psychosocial and general health status among war displaced in Chechnya and Ingushetia

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Abstract

Background: Conflict in Chechnya has resulted in over a decade of violence, human rights abuses, criminality and poverty, and a steady flow of displaced seeking refuge throughout the region. At the beginning of 2004 MSF undertook quantitative surveys among the displaced populations in Chechnya and neighbouring Ingushetia.

Methods: Surveys were carried out in Ingushetia (January 2004) and Chechnya (February 2004) through systematic sampling. Various conflict-related factors contributing to ill health were researched to obtain information on displacement history, living conditions, and psychosocial and general health status.

Results: The average length of displacement was five years. Conditions in both locations were poor, and people in both locations indicated food shortages (Chechnya (*C*): 13.3%, Ingushetia (*I*): 11.3%), and there was a high degree of dependency on outside help (*C*: 95.4%, *I*: 94.3%). Most people (*C*: 94%, *I*: 98%) were confronted with violence in the past. Many respondents had witnessed the killing of people (*C*: 22.7%, *I*: 24.1%) and nearly half of people interviewed witnessed arrests (*C*: 53.1%, *I*: 48.4%) and maltreatment (*C*: 56.2%, *I*: 44.5%). Approximately one third of those interviewed had directly experienced war-related violence. A substantial number of people interviewed – one third in Ingushetia (37.5%) and two-thirds in Chechnya (66.8%) – rarely felt safe. The violence was on-going, with respondents reporting violence in the month before the survey (*C*: 12.5%, *I*: 4.6%). Results of the general health questionnaire (GHQ 28) showed that nearly all internally displaced persons interviewed were suffering from health complaints such as somatic complaints, anxiety/insomnia, depressive feelings or social dysfunction (*C*: 201, 78.5%, CI: 73.0% – 83.4%; *I*: 230, 81.3%, CI: 76.2% – 85.6%). Poor health status was reflected in other survey questions, but health services were difficult to access for around half the population (*C*: 54.3%, *I*: 46.6%).

Discussion: The study demonstrates that the health needs of internally displaced in both locations are similarly high and equally unaddressed. The high levels of past confrontation with violence and on-going exposure in both locations is likely to contribute to a further deterioration of the health status of internally displaced. As of March 2007, concerns remain about how the return process is being managed by the authorities.

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Background

The conflict in Chechnya has resulted in over a decade of violence, human rights abuses, criminality and poverty. Since the start of the second war between Chechnya and Russia in 1999, thousands of civilians have been killed or have disappeared, all in a climate of impunity.

Years of conflict have resulted in severe destruction of health infrastructure. Many doctors have left the country, while those who remain in Chechnya often fear for their personal safety. Lack of experienced medical personnel, especially in remote rural districts, is one of the biggest problems facing Chechnya's health system today.

The last decade of conflict in Chechnya resulted in around 260,000 Chechens being displaced to neighbouring Ingushetia, most finding shelter in tent camps and collective squats (*Kompakniki*) or spontaneous settlements – farms, sheds, train wagons, and factories. Living conditions in tent camps and spontaneous settlements have been poor. In a 2003 survey carried out by Médecins Sans Frontières (MSF) [1], 54% of the families interviewed in tent camps in Ingushetia stated that their tents leaked, did not have protection from the cold, or had no flooring in conditions where temperatures regularly fall bellow - 20°C.

The Ingushetian and Russian governments have increased pressure on the Chechen displaced population to repatriate. Physical, psychological and administrative harassment, the cutting-off of basic services such as gas, water and electricity, and intense propaganda about imminent camp closures, were all used to compel people to return to Chechnya [2]. 'Repatriation' was pushed forward despite the fact that people did not want to return to Chechnya due to the continuation of the conflict and insecurity, and the lack of proper shelter and adequate health services in Chechnya.

To inform the future direction of assistance programmes MSF undertook quantitative surveys among the displaced populations on both sides of the border – both in the spontaneous settlements in Ingushetia and temporary accommodation centres (TACs) housing returned internally displaced within Chechnya. As a consequence of poor health infrastructure and limited external assistance, the health status of internally displaced in Chechnya and Ingushetia is poorly documented; to our knowledge no systematic data on the general and psychosocial health status of this population have been previously published.

Assessment of violence and related health needs

Methods

Two surveys were executed: one in Ingushetia (January 2004) and one in Chechnya (February 2004). A systematic sampling method was applied in both locations [3]. Sample size was based on an estimated prevalence of trauma-related psychological

problems of 20% [4], a precision of 5% (confidence interval 95%), and an assumed dropout rate (including refusal) of 5%. This gives a samples size of 257 households in each location.

Official demographic data were used to calculate the sampling interval. In Ingushetia, the population to be surveyed was divided over 143 spontaneous settlements (tent-like arrangements within empty buildings). The official population was 21,901 with an average household size of 5.3 persons distributed over 4107 households. In order to arrive at a sample size of 257, a sampling interval of 15.9 was required (rounded to 16).

In Chechnya, the target population was those living in 20 TACs. According to the authorities approximately 3,520 households were permanently present in the TACs. Given the average household size of 5.7, the population was estimated at 20,064. In order to arrive at a sample size of 257, a sampling interval of 13.7 was used (rounded to 14).

In both places the number of interviews per settlement (or TAC) was proportionally related to the number of inhabitants (a logical result of a systematic sampling). The first household was randomly chosen to start the survey in each location. The first household for the systematic sample in the TACs (Chechnya) was chosen randomly by taking a random number from the sampling interval and choosing the house with that number. The next households were chosen according to the fixed sampling interval (14) following a specific direction. Households in the spontaneous settlements in Ingushetia were not systematically ordered, so the starting household was randomly chosen by spinning a pen in the centre of the settlement and the survey started with the first household in that direction. The next household was chosen in a predefined circular direction (systematic) according to the sampling interval (16).

Only people aged 18 or above were interviewed. To avoid selection bias a coin was tossed before knocking on the door to determine whether a male or female respondent would be requested. If the person answering the door was the opposite gender to that determined for selection, the interviewer asked whether there was a respondent of opposite gender and the same age in the household. If no one of the desired gender was present the person answering the door was interviewed. If nobody answered the door the adjacent household was selected.

All interviews were done during the day, with an average of four interviews conducted daily by each team member. Interviews lasted a maximum of 60 minutes and for those participants that needed follow-up support, referral to professional counsellors was offered.

All participants gave written permission for their participation. Interviewers respected confidentiality at all times; guarantees of anonymity were given to each participant, together with a clear explanation of the purpose of the survey and the fact that the general findings would be released publicly. It was made clear to participants that they would not receive any compensation for participating in the survey, and that they could decide at any moment to stop the interview without giving a reason. Forms

were registered anonymously and data were analysed by EXCEL and EPIINFO-6 using descriptive and univariate analyses.

Instruments

The survey questionnaire was translated from English into both Russian and Chechen, and then back translated to English, and differences discussed and agreed on. The design of the questionnaire was informed by experiences from other assessments done in acute conflict settings [5] [6]. Triangulation (the use of different sources and/ or methods to verify validity when information is potentially conflicting or inconsistent [7] of several conflict and health-related variables and methods (open-ended questions, semi-structured questionnaires) were used to get insight in the suffering and needs of the Chechnen IDPs in both Ingushetia and Chechnya.

Demographics

General demographic data (age, gender etc.) were obtained.

Displacement history

Questions on displacement history were asked in order to seek insight into the collective experience of being displaced and their wishes to leave the settlements and preferred locations of return.

Living circumstances

Several questions on the availability of water and sanitation, food and physical shelter were posed.

Confrontation with violence

People are confronted with traumatic events in several ways, including exposure to an event (being in the area but not witnessing or self-experiencing an event), witnessing of an event (seeing the event happen) and self-experience. All are established risk factors for developing health (including mental health) problems [8] [9] [10]. Generally speaking the proximity to the event [11] [12] [13], the severity of the incident [14], and the extent of the physical injury increases the risk of developing health problems. A list of violent events was developed in close consultation with the national counselling staff. Both the composition of the list and the outcomes provide an important testimony of the collective experience of violence. A distinction was made between recent (i.e. the previous month) and past (since the start of the conflict in 1994) experiences for two reasons. First, it gives insight in the current security situation. Secondly, it gives an indication of the number of potentially traumatic events experienced over time (accumulation) as long-term exposure to violence is a risk factor for developing health problems [15].

Loss

In addition to questions relating to violence, questions on the consequences of the conflict such as human and material loss were included.

General health

The General Health Questionnaire 28 [16] (GHQ 28) is a tool that has been widely used for many years to screen general health in community settings including those affected by violence [17]. Four subjective indicators of health are assessed: somatic complaints, anxiety and insomnia, social dysfunction, and depressive feelings. These subscales are not designed to make a specific diagnosis for an individual, and are not mutually independent [18]. However, for assessment of general health of a community it is helpful to identify subscales that are proportionally higher than others. For each of the 28 items, one of four answers is proposed: less than usual; usual; more than usual; and much more than usual (Likert scale). People suffering from chronic or traumatic stress often report non-specific complaints such as headaches, stomach problems, general body pain, dizziness or palpitations [19] [20]. Open questions were used in this survey to find out the type and order of importance of the subjective health complaints over the past 6 months (maximum of four) in order of priority. All answers on these open questions were then grouped in categories based on prevalence. Closed questions were used to gain information about the availability and accessibility of medical services and drugs. Answers to these questions were registered using a Likert scale.

Coping mechanisms

Questions were included that were designed to obtain qualitative information regarding how the respondents coped with their problems.

General items

The last section of the questionnaire was used to find out whether respondents were able to distinguish between psychiatric disorders and psychological complaints caused by violence. We included open questions in which respondents were asked to indicate a maximum of four signs of each. At the end of the survey, we asked respondents what additional support they needed.

Results

In the following reporting of findings, the Chechen Temporary Accommodation Centres (TACs) and the Ingushetian spontaneous settlements (*Kompakniki*) are shown in the text by using: '*C*' for Chechnya and '*I*' for Ingushetia.

Demographics

256 people in Chechnya and 283 people in Ingushetia were interviewed (see Table 1). None of those approached for interviewing refused and no interviews were interrupted (i.e. 100% completion). The vast majority of interviewees were Chechen; despite randomisation more females were interviewed then men (*C*: 70.3%, 180; *I: 65.4%*, 185). To a lesser extent females were also over-represented in the general population (*C*: 52.5%, *I: 55.4%*).

Table 1 Overview of demographic and socio-economic findings

	Chechnya		Ingushetia	
	n	%	n	%
Population				
Total population number in TACs, Spontaneous Settlements (official figures)	20,064		21,901	
Interviewees (one per household)	256		283	
Female interviewees	180	70.3	185	65.4
Total number of family members in surveyed households	1107		1668	
Average number of family members in surveyed households (official average in population in brackets)	4.3 (5.7)		5.8 (5.3)	
Displacement history				
Displaced >4 years	249	98.0	272	96.1
- During first Chechnen War (1994-1995)	*122*	*48.0*	*104*	*36.8*
- During second Chechnen War (1999/2000)	*118*	*46.5*	*154*	*54.4*
- Others	*9*	*3.5*	*25*	*8.8*
Displaced <4 (missing data)	5 (2)	2.0	11	3.9
Displaced more than once (2-5 times)	212	83.1	160	56.6
Wish to return home	220	86.3	243	85.9
Origin				
Chechnya	250	97.7	253	89.4
Other	6	2.3	30	10.6
Reason for not returning to place of origin				
Lack of shelter	200	78.4	129	45.6
Insecurity	25	9.8	139	49.1
Other	31	12.0	15	5.3

Table 1 Continued

	Chechnya		Ingushetia	
	n	%	n	%
Reasons for returning to Chechnen TACs				
Living circumstances in spontaneous settlements in Ingushetia	66	27.5	-	-
Homesick	60	25.0	-	-
Compensation offered by authorities	40	16.7	-	-
Directly forced to return	4	1.7	-	-
Indirectly forced to return (camps closed in Ingushetia)	28	11.7	-	-
Hope the situation improves	22	9.2	-	-
Other (missing data)	10 (26)	3.9 (10.2)	-	-
Living Circumstances in the Chechnen TACs, Ingushetian spontaneous settlements				
Poor shelter against weather	11	4.3	108	38.2
Unable to keep warm	47	18	113	40
Poor toilet facilities	184	72.4	255	90.1
Insufficient food (defined as on at least 5 days a week, having 1 meal or less per day)	34	13.3	32	11.3
Dependence on outside assistance	244	95.4	267	94.3

Displacement

Displacement mainly occurred in two periods, consistent with periods of severe conflict in Chechnya: 1994/1995 and 1999/2000. The majority of those interviewed had been displaced for at least four years and had changed location between two and five times. Most participants indicated a wish to return to their place of origin. The two groups stated different reasons for not returning. For those living in Chechnya lack of shelter was the main reason for not returning to their hometown (200, 78.4%) while insecurity was less important (25, 9.8%). For those interviewed in Ingushetia insecurity was rated much higher (139, 49.1%) and lack of shelter (129, 45.6%) was rated lower. The main stated reason for those who left Ingushetia to live in the Chechen TACs were: the poor living circumstances in the spontaneous settlements, homesickness and the prospect of compensation offered by the authorities.

Living conditions

In Ingushetia, lack of proper shelter (*C*: 11, 4.3%, *I*: 108, 38.2%) and inability to keep warm (*C*: 47, 18%, *I*: 113, 40%) was reported more frequently than in the Chechen

settlements. The two sites were equally poor in terms of toilet facilities (*C*: 184, 72.4%, *I*: 255, 90.1%) and food was a problem for one in ten (*C*: 34, 13.3%, *I*: 32, 11.3%). Almost all respondents were dependent on charity. It should be noted that while the TACs were intended for short stay only, a substantial number of people had been there for one to two years (87, 34.1%, n = 255), or longer (33, 12.9%).

Confrontation with violence

Month prior to the survey

Nearly twice as many people in Chechnya (C: 171, 66.8%, *I*: 106, 37.5%) indicated that they never or only occasionally felt safe (Table 2). A similar difference was found with respect to exposure to conflict-related violence in the last month: one in ten people (32; 12.5%) in Chechnya said they had been affected, reporting over 60 violence-related events. Most frequently mentioned were: mopping up operations (often violent operations used by the army to identify 'terrorists' among the civilian population) (22 occurrences) and to a lesser extent attacks and crossfire (both more than 8 occurrences). In Ingushetia fewer people (13, 4.6%) reported exposure to violence in the past month (31 violent events). Most of these incidents (25) were reported as being self-experienced by the participants (several participants experienced more than one event). For the majority (18 occurrences) of these cases the person interviewed had been detained/taken hostage.

Table 2 Experience of traumatic incidents occurring in the month before the survey

	Chechnya		Ingushetia	
	n=256	%	n=283	%
Fears for personal safety	171	66.8	106	37.5
Exposure to violence	32	12.5	13	4.6
Directly targeted by violence themselves	4	1.6	25	8.8
Loss of nuclear family member in past 2 months	19	7.4	24	8.5

Since start of the conflict

Exposure to violence since the start of the conflict was similar for both groups in Chechnya and Ingushetia (*C*: 241, 94%, *I*: 5, 98%). The most common events (Table 3) included mopping-up operations, aerial bombardment, mortar fire, attack on house or village, crossfire, burning of houses, and destruction of property.

Respondents from Chechnya and Ingushetia witnessed a similar number of violent events. More than one in five witnessed the killing of people (*C*: 58, 22.7%, *I*: 68,

24.1%) and nearly half had witnessed maltreatment (*C*: 144, 56.2%, *I*: 126, 44.5%). Several people had been witness to torture (*C*: 14, 5.4%, *I*: 16, 5.6%). While many people had heard about incidences of rape (*C*: 181, 71.1%, *I*: 204, 72.1%), only a few had witnessed it (*C*: 2, 0.8%, *I*: 7, 2.5%).

In Chechnya 88 (34.4%) respondents had personally experienced violence since the onset of the conflict. In Ingushetia this was slightly lower, at 80 (28.3%). The type of self-experienced violence was similar in both locations, the most frequently reported events being maltreatment, detention, arrest, and forced labour. Torture and mine injuries were also reported. Disappearances among members of the nuclear family (partners, siblings) affected one fifth of the interviewees (*C*: 57, 22.3%, *I*: 54, 19.1%).

Loss

(a) Material loss:

Nearly all respondents reported losing all possessions including their house (*C*: 254, 99.2%, *I*: 268, 94.7%).

(b) Mortality in the previous two months:

In Chechnya nineteen participants (7.4%) reported 28 deaths in their nuclear family over the past two months (see Table 4). Eleven of them (39.2%, n = 28) were reported as being violence-related such as mine accidents, terrorist acts, and bombardments. In Ingushetia 24 people (8.5%) reported 26 deaths in their nuclear family (Table 4). Five of these deaths were violence-related (19.2%, n = 26). The majority (*C*: 18, 64.3%, n = 28; *I*: 17, 65.4%, n = 26) of deaths were among males.

(c) Mortality since the start of the conflict:

Since the start of the conflict one third of the respondents in both Chechnya and Ingushetia (*C*: 101, 39.5%, *I*: 95, 33.6%) reported the loss of at least one nuclear family member (Table 4). Over two-thirds of people had lost a friend and/or neighbour (*C*: 189, 73.8%, *I*: 200, 70.7%). Many respondents actually witnessed the violent death of those close to them.

General Health

General Health Questionnaire

The GHQ 28 was found to be well accepted and easy to administer, but has not been validated for the Caucasus so results must be interpreted with caution (see Discussion). Using the standard cut-off score of 5 [16], it was found that almost everyone could be considered to be at risk of ill health (*C*: 253, 98.8%, CI: 96.6% – 99.8%; *I*: 278, 98.2%, CI: 95.9% – 99.4%). When the cut off score was raised to 11 (the average mean found in a similar study done following the Kosovar conflict [17]) still around 80% of the population was found to be at risk (*C*: 201, 78.5%, CI: 73.0% – 83.4%; *I*: 230, 81.3%, CI: 76.2% – 85.6%). The subscale (Figure 1) on somatic

Table 3 Overview of participants' experience of traumatic incidents occurring since the start of the conflict (1994). Participants could report more than one event

	Chechnya		Ingushetia	
	n=256	%	n=283	%
Exposure to violent events				
Attack on house/village	178	69.5	205	72.5
Cross-fire	158	61.7	170	59.7
Aerial bombardments	206	80.5	220	77.7
Mortar fire	183	71.5	194	68.6
Taking risks to find food	119	46.5	125	44.2
Burning of houses	114	44.5	117	41.3
Mopping-up operations	206	80.5	217	76.7
No exposure to conflict	15	6	5	2
Self-experienced events				
Maltreatment	66	25.8	58	20.5
Detention and hostage	25	9.8	27	9.5
Kidnapped	18	7	21	7.4
Forced labour	15	5.8	23	8.1
Torture	7	2.7	11	3.9
Injured by mine	1	0.4	5	1.8
Witnessed events				
Killings	58	22.7	68	24.1
Arrests	136	53.1	137	48.4
Maltreatment	144	56.2	126	44.5
Torture	14	5.4	16	5.6
Rape *Known instances of rape*	2 *181*	0.8 *71.1*	7 *204*	2.5 *72.1*
Arrests/disappearances:				
Nuclear family	57	22.3	54	19.1
Friend, neighbour	149	58.2	118	41.7
Other	126	49.2	108	38.2
Material losses				
Loss of house	249	97.3	250	88.3
Loss of all possessions	254	99.2	268	94.7

Table 4 Human loss reported by participants

	Chechnya		Ingushetia	
Reported Deaths (classified by participants relationship to individual affected)	**n=256**	**%**	**n=283**	**%**
Mortality in the 2 months preceding the survey				
Loss of nuclear family member in past 2 months	19	7.4	24	8.5
Mortality since the start of the conflict				
Nuclear family (parents, children, siblings)	101	39.5	95	33.6
- Witnessed	*35*	*13.7*	*38*	*13.4*
Extended family	107	41.8	112	39.6
*- Witnessed**	*20*	*7.8*	*29*	*10.3*
Friend, neighbour	189	73.8	200	70.7
*- Witnessed****	*27*	*10.5*	*32*	*11.3*
Other	163	63.7	155	54.8
*- Witnessed****	*20*	*7.8*	*25*	*8.8*

** Indicates participant directly witnessed the reported death*

symptoms (*C*: 36%, *I*: 34%) is the largest contributor to high GHQ scores, followed by anxiety (*C*: 27%, *I: 28%*) in both populations (see Figure 1).

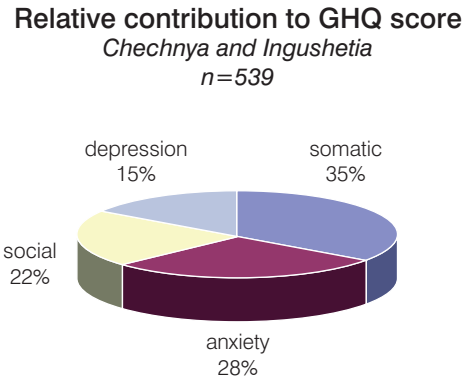

Figure 1 Outcomes of the General Health Questionnaire

Subjective health reports

The majority of respondents indicated feeling often (*C*: 131, 51.4%, *I*: 171, 60.3%) or sometimes (*C*: 78, 30.6%, *I*: 74, 26.2%) unhealthy in the past six months (Table 5). Respondents indicated to have an average of 2.6 (*C*) and 2.7 (I) symptoms at the time of interview (*C*: 659; *I*: 752, maximum four per participant). A considerable number of respondents indicated cardiovascular problems (*C*: 173, 26.3%, *I*: 89, 11.8%); headaches were the second most frequently reported complaint (*C*: 135, 20.5%, *I*: 160, 21.3%). Muscle or joint pain, chronic disease, nervous complaints and stomach complaints were also reported.

Availability and accessibility health services and drugs

A considerable number indicated that medical services were rarely (*C*: 96, 37.5%; *I*: 77, 27.2%) or not at all accessible (*C*: 43, 16.8%; *I*: 55, 19.4%). Over half reported difficulties in accessing drugs, stating they were rarely (*C*: 92, 35.9%; *I*: 85, 30.0%) or never available (*C*: 66, 25.8%; *I*: 70, 24.7%).

Table 5 Self reported health and health complaints over the past six months (maximum four complaints per participant)

	Chechnya		Ingushetia	
	n=255	%	n=282	%
Subjective (self reported) health Often feeling unhealthy in general	131	51.4	171	60.3
Sometimes	78	30.6	74	26.2
Rare	36	14.1	28	9.9
Health not a concern	10	3.9	9	3.2
Health problems experienced in last 6 months (percentages from total number of complaints)	**n=659 complaints**	**%**	**n=752 complaints**	**%**
Cardiovascular	173	26.3	89	11.8
Headache	135	20.5	160	21.3
Muscle/joint pain	73	11.1	198	26.3
Chronic diseases	92	14	85	11.3
Nervous complaints	65	9.9	55	7.3
Stomach complaints	41	6.2	55	7.3
Other	80	12.1	110	14.6

Coping mechanisms

Most respondents believed the conflict had triggered mental disturbance or feelings of being upset (*C*: 205, 80.1%; *I*: 189, 66.8%). To cope with their psychological distress people responded that their first most important coping strategy was 'turning their head' (a local term meaning to deny a problem exists) (*C*: 123, 48.1%, *I*: 131, 46.3%). In the second response category the preferred option was prayer (*C*: 137, 53.5%, *I*: 131, 46.3%). A third and last stated option was the support of the family members (Table 6).

Table 6 Coping mechanisms of the participants (maximum of three answers possible)

Managing stress	**Chechnya**		**Ingushetia**	
	n=256	**%**	**n=283**	**%**
First mentioned				
'Turn my head'	123	48.1	131	46.3
-Keep busy	50	19.5	59	20.9
-Aggressive behaviour	56	21.9	51	18
-Praying	27	10.5	40	14.1
-Other			2	0.7
Second mentioned	**n=256**	**%**	**n=283**	**%**
Praying	137	53.5	131	46.3
-Aggression	40	15.6	46	16.3
-Talking	32	12.5	40	14.1
-Keep busy	24	9.4	46	16.3
-Drug/alcohol use	13	5.1	26	9.2
- Other	10	3.9	10	3.5
Third mentioned	**n=255**	**%**	**n=220**	**%**
Support of family members	101	39.6	106	48.2
-Talking to others	66	25.9	7	3.2
-Drug/alcohol use	17	6.7	28	12.7
-Other	71	27.8	43	19.6

Suicide is considered a sin in the Muslim religion (as in many other societies) and therefore a taboo subject. Nevertheless, nearly one in ten respondents (*C*: 21, 8.2%; *I*: 28, 9.9%) knew somebody who had attempted suicide (although several respondents could be referring to the same incident).

General items

When asked what advice respondents could give MSF regarding its activities most responses advised MSF increasing their counselling activities (*C*: 81, 31.6%; *I*: 114, 40%). Some suggested MSF increase its medical activities (*C*: 50, 19.5%; *I*: 27, 9.5%). Notably, a number of people wanted MSF to advocate on their behalf (*C*: 38, 14.8%; *I*: 53, 18.7%).

Discussion

To our knowledge this is the first publication of the general and psychosocial health status of Chechen's internally displaced. The self-reported health conditions and the general health questionnaire showed high levels of medical and psychosocial needs. Access to health care (including mental health) was poor in both locations. The most frequently used coping mechanisms for psychological distress (denying the problem, praying, support of family members) did not seem to be effective. Living conditions in the Ingushetian spontaneous settlements were rated worse while people in the Chechen TACs had more security problems (feeling less safe, more incidents in the last month, most violent deaths in the last two months).

Our findings on the General Health Questionnaire 28 (GHQ 28) [18] indicated that nearly all IDPs were suffering from health complaints such as somatic complaints, anxiety/insomnia, depressive feelings or social dysfunction when applying the recommended cut-off score for this questionnaire. Even when a higher cut-off score was set, still around 80% of respondents were found to suffer from general health problems. This is substantially higher than findings from elsewhere: for example a study from Iran using the same instrument (with a normal cut off) found a prevalence of 17% [21]. Subjective health impressions further confirmed the poor general health found in the GHQ 28, with half of respondents in both locations reporting to often feel unhealthy. Also, the average number of complaints pointed in the same direction.

The types of complaints reported are associated with a high level of (traumatic) stress, with non-specific physical signs like headaches and muscle/joint/body pain commonly reported [18]. Cardiovascular complaints represent one quarter of all complaints mentioned; however, to what degree these are linked to the stress or the general situation of conflict is unclear, as incidence of cardiovascular complaints in the former Soviet Union is generally high. For displaced populations, the length of stay in temporary (and often precarious) accommodation is associated in other studies with higher likelihood of developing symptoms of psychological distress [22] [23] [24]. The average length of being displaced in both locations was five years. Most people had to move at least two times.

Chronic exposure to traumatic events is associated with higher levels of mental health problems and poorer physical health [25] [26], and witnessing and self-

experienced extreme violence is also associated with psychosocial and mental health problems, including depression [27], generalised anxiety disorder [28], and post-traumatic stress disorder [13] [11][12]. Both survey groups had experienced similar levels of violence since the start of the conflict (exposure, witnessed, self-experienced), possibly contributing to ill health outcomes.

Nearly all of the people interviewed wished to return to their place of origin. In Chechnya, lack of shelter was the main reason for not returning; in Ingushetia, insecurity was the most important concern. This difference may be explained by the fact that for people in Chechnya insecurity was a daily reality which cannot be changed, whereas for those in Ingushetia the security situation in Chechnya was perceived as a threat to avoid. Caution is required to avoid facile labelling the survey population with physical or mental diagnoses. There is a tendency to report on the mental health consequences in terms of psychiatric or psychological disorders often using post-traumatic stress disorder (PTSD) as the pathway to show the mental health consequences of war. It is incorrect to reduce the experience of conflict and violence to the individual using bio-psycho-medical terminology [29], and it may be unnecessarily stigmatising to label someone with PTSD when PTSD which is not the only possible disorder that can result from a traumatic event, even according to the DSM IV system (Diagnostic Statistic Manual for Mental Health Disorders number IV, [30].

Co-morbidity, most notably depression [29] and generalized anxiety disorder [28] [31] [32] has been found to be more prominent in trauma-affected people than was originally assumed. Another consideration is that although nearly all people confronted with war will suffer various negative responses such as nightmares, fears, startle reactions and despair, they will not all develop mental disorders. There are individual ways of adapting to extreme stress [4] that should not be overlooked. Lastly, transfer of Western conceptual frameworks of psychological stress and mental disorders to different countries and cultures is problematic [33].

Nevertheless, attention must be paid to stress and distress in the survey population since prolonged states of either can cause changes in patterns of living that are associated with physical and mental damage [19] [34]. The need for health (including mental health) support is further indicated by the fact that over a third of respondents in both locations indicated that MSF should increase their counselling activities. In response to these findings, MSF began a psychosocial intervention in the TACs in Chechnya in February 2004.

Possible limitations to the survey

The sampling method has been satisfactory: despite the sensitivity of the questions the completion rate was high (100%). There are, however, a number of potential limitations that merit consideration.

Compared to the overall population data of the authorities the number of people interviewed in Ingushetia was higher than the planned sample size (283 versus 257) suggesting that population figures given by the government are an underestimation. In both studies women were over-represented despite the sampling procedures. The most plausible reason for this is the timing of the interviews: survey teams only worked during the day, when most males were away from the household trying to find work; however, due to security concerns the survey times were limited to daylight hours. The high number of women may have resulted in an overestimation of health needs as women generally report more frequent health concerns compared to men. However, because of the female bias the values on the GHQ might be somewhat lower for the entire population, the main conclusions remain valid. Another possible consideration is that the survey timing may also have caused selection bias of ill people because they tend to stay home.

The survey has no precedence and therefore the GHQ 28 had not been validated for use in the region. We do not believe that this invalidates its value. Health data were assessed through three different methods (semi-structured, questionnaire, open-ended questions), with all findings pointing in the same direction, and triangulation of information generated from different health related topics (displacement, living conditions, confrontation with violence, loss, general health, coping) together establish a picture of violence-related suffering of those enduring the on-going conflict on the Caucasus. The use of other approaches such as structured clinical interview and clinical examination would certainly have added weight to the validity of our findings, but for operational security reasons this was not possible.

This survey included historical questions over a long timeframe (1994–2004), in addition to questions in the more recent past (30 or 60 days). Recall bias is always a potential confounding variable, particularly when reporting traumatic events. However, an important recent study [35] has shown that refugees remain consistent in reporting major traumatic events such as those we recorded, with more variability occurring in recall of minor historical details. Thus we believe that this bias does not pose a serious threat to the validity of this study.

The category of questions relating to exposure to violence may have included some events that should have been classed as self-experienced or witnessed events despite instructions to interviewers to exclude them from the exposure category, and this may have caused some over-reporting in the data on exposure to violence. Nevertheless, presentation of all categories including exposure remains relevant because proximity to violence is associated with increased risk of health problems or even pathology [11] [13]. The high level of war-related violence is also reflected in hospital admission data. According to hospital statistics around one in 20 admissions (783 out of 15,602) to the hospital and outpatient trauma point in Grozny in 2004 were

for war trauma. Of those, 384 (50%) were gunshot wounds and 276 (35%) were mine or other explosive wounds. Around a third of these patients died in hospital.

The findings on rape may be underreported. Sexual violence is a taboo topic in Chechnya, but is known to occur. Other organizations working with Chechen refugees have reported a high incidence of repeated sexual violence. In those surveys, it may be that women only felt free to bring up their experience because they were abroad, far away from potential community repercussions [36]. In our survey many people had heard about incidents of rape but only a few had witnessed it, and only one person reported being raped. According to Muslim and local traditional laws, a raped woman is often stigmatised and her whole family becomes a victim of the rape. A Chechen man will be very unlikely to admit to having been raped [36].

While time was taken to carefully explain the terms used in the questionnaire to both survey staff and respondents, we cannot entirely exclude subjective interpretation by interviewer or interviewee. Specifically, for sexual violence we used in our survey the World Health Organization's definition of sexual violence as being "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home or work" [37]. Given the strict religious and cultural norms on sexuality and the comments of our staff we were confident it was in agreement with the popular understanding among Chechens. Although we have no indications this assumption was wrong it is possible that some respondents used their own interpretation. Nevertheless, more objective definitions of questions relating to sexual violence would be useful for such studies.

Despite these potential limitations the survey provides valuable data on the confrontation with violence-related health problems from a conflict where data are near absent due to non-functioning surveillance systems and limited access for external actors.

Implications of our findings

Recent developments in the Caucasus have overtaken the situation surveyed in early 2004, with the authorities rapidly closing the spontaneous settlements in Ingushetia and sending the IDPs back to the Temporary Accommodation Centres (TACs) in Chechnya.

Our survey data showed that many who returned to Chechnya from Ingushetia were simply changing their status from being IDPs outside to being IDPs inside Chechnya. The fate of those IDPs accommodated in TACs remains an important longer-term question. As of March 2007 concerns remain about how the authorities manage the return process and whether considerations on the wellbeing and health of this group are being taken into account while planning this process.

International humanitarian assistance is an important external support to the population, both in Ingushetia and in Chechnya. However, the extremely high levels of insecurity threaten the aid operations in the Northern Caucasus: since 1995 more than 50 international humanitarian and workers have been abducted, and some of them have been murdered. As a result the number of international and national staff working in the region has been dramatically reduced. Due to the highly insecure context MSF has had to conduct "remote control" (minimal contact) operations in Chechnya with minimal direct expatriate supervision.

More importantly, the Russian authorities must guarantee a safe environment; ensure the protection of civilians, as well as appropriate living conditions (including access to health services, sufficient food, shelter and sanitation) for this displaced population. The international community should pay greater attention to the situation of these vulnerable groups that have been largely ignored for the last decade.

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Background on the Kashmir (India) survey
(August 2005)

The Kashmir Valley has been disputed territory between India and Pakistan since the Partition of India in 1947. After the first war between India and Pakistan in 1948, the Kashmir territory was divided into Indian-administered Jammu and Kashmir and a smaller area under Pakistani control. The ceasefire line between Pakistan and India, named the 'Line of Control' in 1972, still exists.

At the Partition, the Kashmiri population had been promised a choice of joining India or Pakistan but the plebiscite never took place. This injustice, seen by many Kashmiris as a denial of their democratic rights and institutions, is still felt today. The population of Indian-administered Kashmir is predominantly Sunni Muslim based on Sufi traditions. Other parts of Kashmir contain sizeable Hindu and Sikh populations. In general the Muslim majority is striving for an independent secular Kashmir or a Muslim Kashmir joined with Pakistan.

In Indian-administered Kashmir, from the late 1980s onwards, an independence movement led by young fighters of the Jammu and Kashmir Liberation Front (JLFK) fought a guerrilla war against what they perceived as government violence and human rights violations. As a result of the continuing struggle for independence and the associated oppression and intrastate wars, tens of thousands of individuals have fallen victim to human rights violations, torture, extra-judicial killings, kidnappings, disappearances and rape, perpetrated by all parties to the conflict. The conflict has led to the displacement of Kashmiri Hindu Pundits from Kashmir Valley. Also, a sizeable Muslim population has chosen to leave the Valley and the state to escape its consequences. The wounds inflicted on Kashmiri society are deep and go well beyond the socio-economic problems of neglect and poverty. The Kashmiri conflict seems endless and political solutions remote, as both India and Pakistan have declared it to be a matter of national identity. The conflict, including the substantial human rights violations, affects India's image as peaceful world power and it is in the interest of the Indian government to create a peaceful impression of Kashmir; Kashmir became a forgotten conflict.

In August 1982 the Indian Ministry of Health decided to implement a nationwide policy of community-based mental health care. An important objective was "to ensure availability and accessibility of minimum mental health care to all in the foreseeable future, particularly to the most vulnerable and unprivileged sections of the society". However, the absence of community-based services, against a background of persisting conflict and an MSF survey in 2005 that revealed high levels of psychosocial and mental health need, prompted MSF to set up a community-based service to draw the Indian government's attention to the urgency of implementing its own policies.

Photo: Kadir Van Lohuizen

Chapter 3

Conflict in the Indian Kashmir Valley I: Exposure to violence

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Abstract

Background: India and Pakistan have disputed ownership of the Kashmir Valley region for many years, resulting in several conflicts since the end of partition in 1947. Very little is known about the prevalence of violence and insecurity in this population.
Methods: We undertook a two-stage cluster household survey in two districts (30 villages) of the Indian part of Kashmir to assess experiences with violence and mental health status among the conflict-affected Kashmiri population. The article presents our findings for confrontations with violence. Data were collected for recent events (last 3 months) and those occurring since the start of the conflict. Informed consent was obtained for all interviews.
Results: 510 interviews were completed. Respondents reported frequent direct confrontations with violence since the start of conflict, including exposure to crossfire (85.7%), round up raids (82.7%), the witnessing of torture (66.9%), rape (13.3%), and self-experience of forced labour (33.7%), arrests/kidnapping (16.9%), torture (12.9%), and sexual violence (11.6%). Males reported more confrontations with violence than females, and had an increased likelihood of having directly experienced physical/mental maltreatment (OR 3.9, CI: 2.7–5.7), violation of their modesty (OR 3.6, CI: 1.9–6.8) and injury (OR 3.5, CI: 1.4–8.7). Males also had high odds of self-being arrested/kidnapped (OR 8.0, CI: 4.1–15.5).
Conclusion: The civilian population in Kashmir is exposed to high levels of violence, as demonstrated by the high frequency of deliberate events as detention, hostage, and torture. The reported violence may result in substantial health, including mental health problems. Males reported significantly more confrontations with almost all violent events; this can be explained by higher participation in outdoor activities.

Background

The British rule over Jammu and Kashmir terminated in 1947. During partition, the Kashmiri population – the majority of whom is Muslim – was promised a choice of joining either India or Pakistan through a popular vote but this plebiscite never took place. Instead, partition was the start of a long history of conflict affecting the roughly 8 million inhabitants of Kashmir [1]. Both India and Pakistan have made control of a unified Kashmir an essential cornerstone of their national identities and have fought several wars between 1947 and 2002 on this issue. The ceasefire line between Pakistan and India, named the "Line of Control" in 1972, still exists today, separating this territory of around 2.2 million square kilometres into three parts. India controls the largest part, with the rest governed by Pakistan and China [1].

Up to twenty years ago the conflict was mainly an interstate affair between Pakistan and India, but in 1988 Kashmiri militants started a liberation movement. The low level war ('militancy') between the liberation movement and the Indian army spiralled into a cycle of armed conflicts with the civilian population caught between the fighting parties. Officially, 20,000 have died and 4, 000 have disappeared since the start of the militancy – in 2004 alone, 1587 militancy incidents and 1263 deaths including 479 civilians were officially recorded [1] – however, according to other sources these figures are substantially higher [2]. The conflict has also led to displacement of Kashmiri Hindu or Pundits and Muslims from the Kashmir Valley.

Violence affects nearly everybody living in Kashmir. A recent population survey [3] found a lifetime prevalence of traumatic events of 59% among the inhabitants of four districts of the Indian part of Kashmir. The most frequent traumatic events encountered were: firing and explosions (81%) and exposure to combat zones (74%). Traumatic events and the way people cope with them have a crucial role in the development of psychological distress and pathology such as anxiety disorders (including Post Traumatic Stress Disorder) and major depressive disorder [4]. Very little is known about the psychological impact of the insecurity on the Kashmiri population.

To assist in determining the future direction of medical humanitarian assistance in the Indian part of Kashmir, Médecins Sans Frontières (MSF) undertook a quantitative population survey to assess the frequency and nature of violence confronted by the population living in the Indian part of Kashmir and its impact on psychological health and socio-economic functioning. This paper presents the main findings related to exposure, witnessing and self-experiencing of violence. Data on the mental health impact of the conflict is presented in a separate paper [5].

Methods

The study design was based on a methodology previously used in other conflict settings [6]. A two-stage cluster design was executed in two districts in the Indian part of Kashmir (Kupwara and Badgam). These districts were chosen because MSF intended to start working there, an operational decision based on anecdotal evidence of mental health problems among populations living in these areas. The districts have a combined population of 145,000 residents living in 101 villages (3750 square kilometres). The predominantly Muslim, rural and indigenous population of these districts do not differ from other districts in Kashmir except for the capital, Srinagar. Both districts are close to the Line of Control and have experienced high numbers of violent incidents, although to what degree the level of violence differs from other districts is unknown due to lack of reliable information.

For the calculation of sample size we assumed a prevalence of trauma-related psychological problems of 20% [4], and using a precision of 5% (confidence interval 95%) and a design effect of 2, the minimum sample size was estimated at 492. A two-stage cluster sampling design was used to cover 30 villages, resulting in 17 randomly selected households per village. Research teams started at the centre of the village, spun a bottle, and began the interviews according to the direction in which the bottle pointed. The first encountered household was selected, after which the next household in the same direction was approached. Within the household the participant was also selected randomly.

Ethics and interview procedures

The survey was conducted over a period of eleven weeks, from 4 June 2005 to 16 August 2005 in Badgam and from 4 July 2005 to 18 August 2005 in Kupwara. The informed consent procedure consisted of two steps. In the first step the head or most senior adult present in each selected household was asked permission to interview a person over the age of 18 years. The purpose of study, guarantees of anonymity and confidentiality, the use of data (including public dissemination and scientific publication), and the possibility to withdraw from interview at any time was explained. It was made clear that no (financial) compensation was given. Written consent was then sought. The head of household assisted the interviewer in making a list of all household members and from this list one person (the respondent) above 18 years of age was selected randomly. If the selected person was not at home, another person in the household (>18 years) was selected. Step two of the interview process consisted of repeating the above introduction to the potential participant. Once written consent was given, the interview was conducted.

The survey team consisted of four senior national and expatriate staff that supervised 20 trained local interviewers. Interviews were done in pairs, each pair

conducting two to three interviews each day. Each team consisted of both male and female interviewers and respondents could choose who did the interview. The average time for interviewing was 50–60 minutes. The interviewers were recruited from Srinagar University Department of Psychology and Sociology and received a salary for their work. Teams stopped their activities at any moment if they were worried about their own safety or that of the population or if they judged their activities to be counterproductive to the program (for instance, when security incidents such as strikes or 'Hartals' occurred, forcing the survey team to postpone the survey).

Interviewing people on traumatic experiences carries a risk of contributing to psychological distress of both interviewee and interviewer. To respond to this, one experienced counsellor supervised each survey team to give immediate (technical or emotional) support if required. Also, referral to MSF operated counselling centres in another location was offered to all interviewees and interviewers (although none were referred).

To manage potential overwhelming emotions among the interviewer, staff training was given in communication and handling of difficult or upsetting situations. Staff were debriefed daily for both technical and emotional issues. For those interviewers who were overwhelmed or needed follow-up support counselling services were available. The study received ethics approval from MSF's independent Ethical Review Board.

Instruments

The survey questionnaire was based on previous formats used in similar studies elsewhere [6] and focussed on the following four subjects: baseline demographics, confrontation with and consequences of violence, mental health, and sources of support. This paper focuses on the first two issues. Tools to assess mental health, and sources of support are described in a second paper [5].

We assessed confrontation with violence both since the beginning of the conflict and in the three months preceding the survey. Proximity to violence was defined as either exposure ('Being in the vicinity of a violent event but not witnessing or self-experiencing'), witnessing ('Witnessing an event so close it could have happened to you or you were forced to see it'), or self-experience ('The event happened to you'). Violence categories were based on a review of violent incidents as reported in newspaper articles (such as Kashmir Affairs, Greater Kashmir, and Jammu Kashmir) of the past two years and consultation with national staff. We used rape in the witnessing section and a broader concept of 'violation of modesty' in the self-experience section because national staff felt that interviewees would feel more comfortable with this term. Violation of modesty is the local equivalent for sexual violence and includes inappropriate touching, in accordance with the WHO's definition of sexual violence [7].

The survey was translated from English to Urdu and phonetic Kashmiri, then back-translated from Urdu and phonetic Kashmiri to English using a different translator. After revisions, the questionnaire was piloted in a community close to Srinagar. For the definition of the start of the conflict (1989), the definition of torture ('Unbearable physical pain deliberately inflicted by others who have complete control'), maltreatment ('cruel and inhumane treatment'), and round-up raids the local population and national staff were consulted. Examples of physical and mental maltreatment such as 'Being kicked at checkpoints', and 'For body searching males being forced to undress in front of their family' were discussed among interviewers, as were forced labour and violation of modesty.

Analysis

Data entry was standardised and checked by supervisors. As an additional control, 5% of the forms were randomly checked. Data were entered in an EXCEL program spreadsheet and exported into EPIINFO-2002 for analysis. Previous studies have consistently shown gender to be a risk factor for developing psychological problems (most notably post-traumatic stress disorder) after exposure to traumatic events [8] [9]. Analysis of our data also revealed gender as a confounder for many variables. Therefore we stratified results by gender (see Tables).

Results

510 of 548 (93%) interviews were completed. Reasons for refusal to participate (25) and stopping the interview (13) included: lack of time, distrust, and being emotionally upset. The survey was interrupted for 10 days due to security incidents and official strikes. The number of incidents that occurred was not considered exceptional for the area.

The average age of respondents was 37.7 years (range 17– 90) with an equal gender distribution (males = 53%; 270; $p > 0.05$), similar to general statistics on household composition in the district (53.4% males) [19]. Respondents reported having an average household of nine persons (8.94; males: 2425, females: 2126). Nearly all respondents were originally from the Kashmir area (498; 97.6%). The majority of respondents were married (75.2%; 379) and half (52.6%; 266) had no formal schooling. A quarter of respondents (24.9%; 127) reported high or total dependence on financial/material assistance from the authorities or from charity.

Confrontation with violence was reported both in the past (since 1989) and more recently (three months prior to the survey). Exposure to crossfire (Table 1) was commonly reported both since the start of conflict (61.4%; 313) and in the previous three months (14.3%; 73). Over eight in ten people (82.7%; 422) were exposed to round up raids, including in the previous 3 months (9.8%; 50).

Table 2 reports the incidence of witnessed events. Almost three quarters of people (73.3%; 374) witnessed physical or mental mistreatment, half (50%; 255) having witnessed such events on multiple occasions. Over two-third of people (66.9%; 341) witnessed someone being tortured, often on multiple occasions (38.4%; 196), including during the three months prior to the survey (13.5%; 69). Forty per cent of people (322) saw someone being killed, including in the three months prior to the survey (12.6%; 64).

Table 1 Exposure to violence by gender (n=510)

Exposure	Since 1989
Crossfire	85.7% (437)
Since 1989≥5x Past 3 months *Males* *Females*	61.4% (313) 14.3% (73) *88.1%* (P <.119; OR 1.5 , CI: 0.9-2.5) *82.9%*
Round-up raids	82.7% (422)
Since 1989≥5x Past 3 months *Males* *Females*	61.6% (314) 9.8% (50) *86.3%* (P <.003; OR 1.7 , CI: 1.1-2.7) *78.8%*
Explosion of mines/grenades	64.5% (329)
Since 1989≥5x Past 3 months *Males* *Females*	37.3% (190) 12.0% (61) *71.5%* (P <.001; OR 1..9, CI: 1.3-2.8) *56.7%*
Damage to property	39.0% (199)
Since 1989≥5x Past 3 months *Males* *Females*	17.3% (88) 2.8% (14) *45.2%* (P <.003; OR 1.7, CI: 1.2-2.5) *32.1%*
Burning of houses	26.3% (134)
Since 1989≥5x Past 3 months *Males* *Females*	13.1% (67) 2.0% (10) *31.3%* (P <.011; OR 1.7, CI: 1.1-2.0) *20.8%*

Note: P Chi square Yates corrected unless indicated differently

Table 2 Witnessing violence by gender (n=510)

Witness	Since 1989
Persons arrested	75.5% (385)
Since 1989≥5x Past 3 months *Males* *Females*	52.9% (270) 12.8% (65) *83.7%* (P <.000; OR 2.6, CI: 1.7-4.0) *66.3%*
Physical/ mental mistreatment	73.3% (374)
Since 1989≥5x Past 3 months *Males* *Females*	50% (255) 9.8% (50) *83%* (P <.000; OR 2.9, CI: 1.9-4.4) *62.5%*
Persons tortured	66.9% (341)
Since 1989≥5x Past 3 months *Males* *Females*	38.4% (196) 13.5% (69) *74.8%* (P <.000; OR 2.2, CI: 1.5-3.1) *57.9%*
Persons wounded	63.1% (322)
Since 1989≥5x Past 3 months *Males* *Females*	35.5% (181) 14.5% (74) *73%* (P <.000; OR 2.5, CI: 1.7-3.6) *52.1%*
Persons killed	40.0% (204)
Since 1989≥5x Past 3 months *Males* *Females*	17.3% (88) 12.6% (64) *44.1%* (P <.057; OR 1.4, CI: 1.0-2.1)* *35.4%*
Hear of cases of rape	63.9% (326)
Since 1989≥5x Past 3 months *Males* *Females*	38.2% (195) 10.8% (55) *75.2%* (P <.000; OR 2.9, CI: 2.0-4.2) *51.3%*
Seen Rape	13.3% (68)
Since 1989≥5x Past 3 months *Males* *Females*	5.1% (26) 2.2% (11) *17.4%* (P <.006; OR 2.2, CI: 1.3-3.8) *8.8%*

** Yates corrected*

Over one in ten people (13.3%; 68) had witnessed rape; sometimes on multiple occasions (5.1%; 26) including in the three previous months (2.2%; 11). Almost half of people interviewed (44.1%; 225) reported being physically or mentally mistreated themselves (self-experience, Table 3) since the start of the conflict, many repeatedly (18.6%; 95). A third (33.7%; 172) had undergone forced labour, the majority of these (55%; 95) on multiple occasions. One in six people (16.9%; 86) had been detained or held hostage, and the majority of these reported being tortured (76.7%; 66; n = 86). More than one in ten (11.6%; 59) had been subjected to a violation of modesty (sexual violence) themselves, many of them -repeatedly (47%; 28).

In all categories, but particularly for witnessing and self experiencing, males reported significantly more confrontations with violence. Males had an increased likelihood of being subjected to physical/mental maltreatment (OR 3.9, CI: 2.7–5.7), forced labour (OR 3.7, CI: 2.5–5.5), violation of modesty (OR 3.6, CI: 1.9–6.8) and injury (OR 3.5, CI: 1.4–8.7), and had a higher odds of being arrested/ kidnapped (OR 8.0, CI: 4.1–15.5).

Table 3 Self-experienced violence by gender (n=510)

Self-experienced	Since 1989	
Physically or mentally mistreated	44.1% (225)	
Since 1989≥5x Past 3 months *Males* *Females*	18.6 % (95) 3.9 % (20) *59.3%* *27.1%*	(P <.000; OR 3.9, CI: 2.7-5.7)
Forced labour	33.7% (172)	
Since 1989≥5x Past 3 months *Males* *Females*	18.2% (95) 2.0% (10) *46.7%* *19.2%*	(P <.000; OR 3.7, CI: 2.5-5.5)
Forced to house any of the parties	18.4% (94)	
Since 1989≥5x Past 3 months *Males* *Females*	7.5% (38) 1.2% (6) *24.8%* *11.3%*	(P <.000; OR 2.6, CI: 1.6-4.2)
Have you been arrested/kidnapped?	16.9% (86)	
Since 1989≥5x Past 3 months *Males* *Females*	2.2% (11) 0.6% (2) *27.8%* *4.6%*	(P <.000; OR 8.0, CI: 4.1-15.5)

Table 3 Continued

Self-experienced	Since 1989	
Tortured during detention/ hostage	*76.7% (66)*	
Since 1989≥5*x* Past 3 months *Males* *Females*	15.1% (13) 1.2% (1) *78.7%* *63.6%*	(P <.472 ; OR 2.1, CI: 0.6-8.1)
Violation of modesty	11.6% (59)	
Since 1989≥5*x* Past 3 months *Males* *Females*	5.5% (28) 1.6% (8) *17. 0%* *5.4%*	(P <.000; OR 3.6, CI: 1.9-6.8)
Injury	5.5% (28)	
Since 1989≥5*x* Past 3 months *Males* *Females*	0.4% (2) 0.4% (2) *8.1%* *2.5%*	(P <.009; OR 3.5, CI: 1.4-8.7)

Discussion

This paper presents findings related to confrontation with violence among the conflict-affected Kashmiri population. We did not assess who was responsible for the violence because it was not relevant for our medical needs assessment. We found a high exposure to violence (being in the vicinity but not witnessing or self-experiencing) among the civilian participants in our survey, reflecting a pervasive climate of violence in which the population is living. The frequency of exposure to violence on multiple occasions (>5 times) since the start of the conflict (Table 1) is high and comparable to a study from Afghanistan reporting that 62.0% of the participants experienced at least 4 traumatic events during the previous 10 years [10]. The violence in Kashmir, which began in 1989, was noted up until the date of the survey (August 2005).

High levels of confrontation with violence have been reported in another recent study from Kashmir. In this study, no substantial differences between males (59.51%) and females (57.39%) were found for lifetime prevalence of traumatic experiences [3] The study lacks details of specific violence-related events, and does not differentiate between exposure, witnessing and self-experiencing. Our study found the number of confrontations with violence was significantly higher for males, particular for events such as witnessing persons being arrested, maltreated, tortured, or wounded, or hearing

about and witnessing rape. Males also 'self-experienced' more violence such as maltreatment, forced labour and forced housing of one of the warring parties. Our findings are in line with a recent meta-analysis that showed a significant higher confrontation with violence for males than for females in other contexts [9], and may be due to the socio-economic activities of males that mean they spend a significant amount of time outdoors whereas women tend to spend more time in the home.

The high level of people reporting being tortured while detained or taken hostage is a particular concern, indicating that the violence against civilians is not simply circumstantial.

We used "violation of modesty" as the local equivalent for sexual violence [7]. The fact that men reported this more frequently than women that is surprising: in most studies females are more frequently subjected to sexual violence, partly because males are reluctant to report sexual violence [11] [12]. People may have misunderstood the concept 'violation of modesty' despite extensive piloting and consultation with national staff and counsellors many of whom are males themselves. The high frequency of violation of modesty reported by males might be partly explained by the high frequency of body searching to which Kashmiri men are subjected. Whether the body searching is perceived as inappropriate touching (part of the definition of 'Modesty violation') or the way of touching is remains unclear. A substantial number of males that reported being detained or taken hostage also reported being tortured (77%), and this may also have been understood as a 'violation of modesty'.

Potential limitations

The completion rate of the survey was good (93%), and the design was adapted to the purpose and the context. However, there are a number of potential limitations. First, there is a possible selection bias in the fact that only people who were home during the time of the survey were interviewed. This methodology was deemed necessary for security reasons. The selection of one person per household may lead to a bias as individuals in large households are underrepresented. However, we do not think this bias influenced our findings since the overall household size in our sample was large (9). Second, retrospective study designs are subject to recall bias, and we cannot exclude recall bias in the participants' answers on confrontations with violence. However, a recent study [13] has demonstrated that conflict-affected populations remain consistent in reporting on major traumatic events over time. Finally, there may have been confusion over definitions of terms such as violation of modesty as discussed above.

Conclusion

This survey aimed to determine exposure to violence and mental health impact as part of a routine programme assessment. We found that the Kashmiri population is confronted with high levels of violence committed by all parties to the conflict, with potentially substantial implications for mental health. This confrontation with violent events is not simply an environmental effect of living in a conflict-affected area, as demonstrated by the high frequency of deliberate events such as detention, hostage, and torture. The conflict continues with no end in sight, with civilian deaths reported as this article goes to print [14].

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Chapter 4

Conflict in the Indian Kashmir Valley II: Psychosocial impact

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Abstract

Background: India and Pakistan have disputed ownership of the Kashmir Valley region for many years, resulting in high levels of exposure to violence among the civilian population of Kashmir (India). A survey was done as part of routine programme evaluation to assess confrontation with violence and its consequences on mental health, health service usage, and socio-economic functioning.

Methods: We undertook a two-stage cluster household survey in two districts of Kashmir (India) using questionnaires adapted from other conflict areas. Analysis was stratified for gender.

Results: Over one-third of respondents (n = 510) were found to have symptoms of psychological distress (33.3%, CI: 28.3–38.4); women scoring significantly higher (OR 2.5; CI: 1.7–3.6). A third of respondents had contemplated suicide (33.3%, CI: 28.3–38.4). Feelings of insecurity were associated with higher levels of psychological distress for both genders (males: OR 2.4, CI: 1.3–4.4; females: OR 1.9, CI: 1.1–3.3). Among males, violation of modesty, (OR 3.3, CI: 1.6–6.8), forced displacement, (OR 3.5, CI: 1.7–7.1), and physical disability resulting from violence (OR 2.7, CI: 1.2–5.9) were associated with greater levels of psychological distress; for women, risk factors for psychological distress included dependency on others for daily living (OR 2.4, CI: 1.3–4.8), the witnessing of killing (OR 1.9, CI: 1.1–3.4), and torture (OR 2.1, CI: 1.2–3.7). Self-rated poor health (male: OR 4.4, CI: 2.4–8.1; female: OR 3.4, CI: 2.0–5.8) and being unable to work (male: OR 6.7, CI: 3.5–13.0; female: OR 2.6, CI: 1.5–4.4) were associated with mental distress.

Conclusion: The on-going conflict exacts a huge toll on the communities' mental well-being. We found high levels of psychological distress that impacts on daily life and places a burden on the health system. On-going feelings of personal vulnerability (not feeling safe) was associated with high levels of psychological distress. Community mental health programmes should be considered as a way reduce the pressure on the health system and improve socio-economic functioning of those suffering from mental health problems.

Background

The Partition of India in 1947 was the start of a long history of dispute between India and Pakistan for control of Kashmir, which today remains divided into three parts governed by India, Pakistan and China. Over the last 20 years, a liberation struggle between India and Kashmiri militants has led to at least 20,000 deaths and 4,000 disappearances in the Indian part of Kashmir [1].

A community survey done by Médecins Sans Frontières in 2005 found high levels of on-going violence across the region, with civilians caught in the middle. The majority of people surveyed stated having been exposed to crossfire (86%) and round-up raids (83%). High numbers of people reported being subjected to maltreatment (44%), forced labour (33%), kidnapping (17%), torture (13%) and sexual violence (12%) [2].

Exposure to violence has potentially important implications for mental health [3]. This paper presents the findings of the community assessment survey done by Médecins Sans Frontières in 2005. The study, which was done to inform program planning, assessed the mental health and socio-economic impact of the on-going violence, and the sources of support.

Methods

The survey was conducted in mid-2005 in the Indian part of Kashmir (Kupwara and Badgam, totalling 101 villages and a combined population 145,000 people). The methodology is described in detail elsewhere [2]. Briefly, sample size calculation assumed a prevalence of trauma-related psychological problems of 20% [4]; using a precision of 5% (confidence interval 95%) and a design effect of 2, the minimum sample size was estimated at 492. A two-stage cluster sampling design was used to cover 30 villages (randomly selected), resulted in 17 households per village. Within the household participants aged ≥ 18 years were selected randomly. Informed consent was attained for all participants and MSF's independent Ethical Review Board granted ethical approval.

Instruments

The overall survey questionnaire assessed baseline demographics, confrontation with violence (results presented elsewhere [2], mental health, health service usage, socioeconomic functioning and sources of support. Mental health was assessed using a Self-Reporting Questionnaire (SRQ), with a reference period of 30 days preceding the survey. The SRQ is an instrument developed by the World Health Organization (WHO) to measure general psychological distress, especially in developing countries.

It has good validity and reliability for adults (≥ 15 years) [5], and can be used both as a self- or interviewer-administrated questionnaire. It consists of 20 closed questions covering expression of distress, the total score corresponding to the sum of positive responses. Various studies have validated the use of the SRQ in India [6] [7] [8] [9]. Currently a cut off score of 11 or 12 is accepted [10] although this has been critiqued as being too high [11]. In our study we used a conservative cut-off score of 12, meaning those respondents scoring ≥ 12 are considered to be suffering from psychological distress.

Four categories of closed questions were applied to establish use of health services (categories: never; once; 2–3 times; 4+) and medications (Categories: never; 1–3 times; 4–6 times; 7+). Closed questions were also used to assess coping mechanisms for dealing with stress. The composition of categories for 'consequences of violence' and 'sources of support' was done with input from national staff.

To establish individual socio-economic functioning in relation to health during the past thirty days the H-section of the WHO-Disability Assessment Schedule-II (WHODAS- II) was used. This tool has good internal, convergent validity and good sensitivity for change [12].

The survey was forwarded and back translated from English to Urdu and phonetic Kashmiri and piloted prior to full implementation.

Analysis

Data entry was standardised and checked by supervisors, entered into EXCEL and analysed in EPIINFO-2002. Because males and females differed significantly in the number of confrontations with violence [2], we used univariate analysis to stratify for gender to determine relationships between psychological distress (SRQ ≥ 12) and demographic details, living circumstances, confrontations with violence (witnessing, self-experiencing), health outcomes (physical symptoms, health service use), and socioeconomic functioning. We excluded variables such as 'torture while being detained/held hostage' as these responses relate to a sub-sample of those surveyed. We also excluded exposure to violence from this analysis because the proximity to the violence was not defined in detail.

A multivariate statistical model was constructed to investigate relationships between mental health (SRQ ≥ 12) and the above-mentioned variables. We used a logistic regression model including variables that were significant in the univariate analysis ($p < 0.05$) with backward elimination. In our model we expected each type of event conferring an additional risk over and above any other event experienced. This is in accordance with studies reporting exposure to cumulative traumatic events as a risk factor for the development of PTSD [13] [14].

Results

510 of 548 (93%) interviews were completed. Reasons for refusal to participate (25) and stopping the interview (13) included: lack of time, distrust, and being emotionally upset. The average age of respondents was 37.7 years (range 17–90) with an equal gender distribution (males = 53%; 270; $p > 0.05$). Demographics are described in detail elsewhere [2].

Mental health status

Psychological distress was mostly expressed through symptoms such as nervousness, tiredness, being easily frightened and headache (Table 1). The prevalence of suicidal ideation is striking: one-third of those surveyed had had thoughts of ending their life in the past 30 days. Over a third of respondents were categorized as suffering from psychological distress (SRQ ≥ 12) using the Indian validated SRQ (33.3%, 170; CI:

Table 1 Self-Reporting Questionnaire 20 (n=510)

	Items SRQ 20	YES		Items SRQ 20	YES
1	Do you often have headaches?	53.6% (272)	11	Do you find it difficult to enjoy your daily activities?	0.0% (255)
2	Is your appetite poor?	40.8% (208)	12	Do you find it difficult to make a decision?	39.6% (202)
3	Do you have sleep disturbances?	5.5% (232)	13	Is your daily work suffering?	51.8% (264)
4	Are you easily frightened?	55.9% (285)	14	Do you feel you are usefully contributing in life? *	31.0% (158)
5	Do you feel nervous, tense, or worried?	62.7% (320)	15	Have you lost interest in things?	45.1% (230)
6	Do your hands tremble?	50.2% (256)	16	Do you feel that you are a worthless person?	37.8% (193)
7	Is your digestion poor?	25.1% (128)	17	Have you thought about ending your life?	33.9% (173)
8	Do you have trouble thinking clearly?	50.2% (256)	18	Do you feel tired all the time?	62.5% (319)
9	Do you feel unhappy?	50.0% (255)	19	Do you have uncomfortable feelings in your stomach?	39.8% (203)
10	Do you cry more than usual?	45.1% (230)	20	Are you easily tired?	66.7% (340)

** This question was changed from the original SRQ 20 questionnaire (Are you unable to play a useful part in life?). In the current format the No-answer was used as sign of psychological distress).*

Table 2 Univariate analysis of cases (SRQ ≥12) with non-cases on demographic variables, living circumstances, confrontations with violence (self-experience, witnessing), and personal consequences stratified by gender (n=510)

Variable	SRQ ≥12 Males n=270				SRQ ≥12 Females n=240				SRQ ≥12 all n=510			
	n	OR	CI	P [i]	n	OR	CI	P [i]	n	OR[iii]	CI	P [iii]
Demographics												
Marital status												
-Not married	65	1			60	1			125	1		
-Married	203	1.7	0.8-3.6	0.178	176	1.8	1.0-3.3	0.865	379	1.8*	1.1-2.8	0.023
Living circumstances												
Currently Feeling Safe												
-Always/most	144	1			120	1			264	1		
-Occasionally/never	126	2.3 **	1.3-4.1	0.006	118	2.0 *	1.2-3.3	0.014	224	2.1**	1.4-3.1	0.000
Dependency for Living												
-Self supportive, nearly	194	1			185	1			379	1		
-Highly, total dependant	74	1.6	0.9-3.0	0.147	53	2.4 **	1.3-4.6	0.007	127	2.0**	1.3-3.1	0.002
Having Two meals a day												
-Always, sometimes	258	1	1.1-15.9		229				487	1		
-Rarely, never	9	4.1		0.068	7	1.8	0.4-8.1	0.352 [ii]	16	2.8	1.0-7.6	0.07
Witnessing												
Seeing wounded people												
-No	73	1			115	1			188	1		
-Yes	197	2.1*	1.1-4.5	0.043	125	1.8*	1.0-3.1	0.030	322	2.0**	1.3-3.0	0.002
Witnessed people being arrested												
-No	44	1			81	1			125	1		
-Yes	226	2.8*	1.1-7.7	0.044	159	2.0*	1.2-3.6	0.018	385	2.3**	1.4-3.7	0.001
Witnessed people being killed												
-No	151	1			155	1			306	1		
-Yes	119	1.6	0.9-2.8	0.123	85	2.0*	1.6-3.4	0.018	204	1.8**	1.2-2.6	0.004

Witness people being tortured												
-No	68	1			101				169	1		
-Yes	202	1.7	0.9-3.4	0.179	139	2.3**	1.4-4.0	0.003	341	2.1**	1.3-3.1	0.001
Witnessed people being maltreated/molested												
-No	46	1			90				136	1		
-Yes	224	1.6	0.7-3.8	0.301	150	2.1*	1.2-3.6	0.016	374	1.9**	1.2-3.1	0.005
Heard about cases of rape	67	1			117	1			184	1		
-No	203	2.2	1.0-4.5	0.054	123	1.0	0.6-1.6	0.958	326	1.3	0.9-2.0	0.256
-Yes												
Witnessed rape												
-No	223	1			219	1			442	1		
-Yes	47	1.8	0.9-3.5	0.134	21	1.8	0.7-4.5	0.269	68	1.8*	1.0-3.1	0.045
Self-experienced												
Being maltreated												
-No	110	1			175	1			285	1		
-Yes	160	2.4**	1.3-4.5	0.007	65	2.0*	1.1-3.5	0.032	225	2.2**	1.4-3.3	<0.001
Being forced to do labour	144	1			194	1			338	1		
-No	126	2.5**	1.4-4.4	0.002	46	1.4	0.7-2.7	0.396	172	1.9**	1.3-2.9	0.003
-Yes												
Being forced housing any of the parties												
-No	203	1			213	1			426	1		
-Yes	67	2.4**	1.3-4.3	0.008	27	0.7	0.3-1.7	0.621	94	1.53[x]	0.95-2.5	0.100
Self-experienced (cont.)												
Being arrested/ kidnapped	195	1		<0.001	229	1	1.3-30.0		424	1		
-No	75	3.2***	1.8-5.8		11	6.3**		0.010[ii]	86	3.6**	2.1-6.2	<0.000
-Yes												
Modesty being violated												
-No	224	1			227	1			451	1		
-Yes	46	4.2***	2.1-8.1	<0.000	13	2.2	0.7-6.9	0.1416	59	3.5**	2.0-6.2	<0.000

Table 2 Continued

Variable	SRQ ≥12 Males n=270				SRQ ≥12 Females n=240				SRQ ≥12 all n=510			
	n	OR	CI	P [i]	n	OR	CI	P [i]	n	OR[iii]	CI	P [iiii]
Being injured because of conflict												
-Not injured	248	1			234	1	0.5-14.9	0.452	484	1		
-Injured	22	4.3 **	1.8-10.5	0.002	6	2.7			28	3.8**	1.7-8.5	0.001
Consequences of violence												
Moving voluntarily for safety reasons												
-No	131	1			143	1			274	1		
-Yes	139	2.3**	1.3-4.1	0.007	97	1.8*	1.0-3.0	0.048	236	2.0**	1.3-2.9	<0.000
Forced to move (being displaced)												
No	221	1			199	1			420	1		
Yes	48	4.2***	2.2-8.2	<0.000	40	2.0	1.0-3.9	0.075	88	2.9**	1.8-4.6	<0.000
Being disabled												
-No	232	1			228	1	0.8-12.7		460	1		
-Yes	38	3.9***	1.9-8.0	<0.000	10	3.2		0.079[ii]	48	3.7**	2.0-7.1	<0.000
Having lost house												
-No	253	1			225	1			478			
-Yes	17	1.3	0.4-3.9	0.404	13	1.6	0.5-4.9	0.592	30	1.5	0.7-3.1	0.468
Having lost possessions												
-No	197	1			183	1			380	1		
Yes	73	2.6**	1.4-4.5	0.002	57	1.6	0.9-3.0	0.1417	130	2.1	1.3-3.1	0.001

*i P Chi square Yates corrected unless indicated differently ii Fisher exact test iii OR adjusted for gender iiii P Mantel Heinzel Chi square corrected unless indicated differently * Signifiant P < 0.05 ** Significant P < 0.01 *** Significant P < 0.001 x Chi-square for differing Odds Ratios by gender is significant (p = 0.028) suggesting interaction*

28.3–38.4). The design effect for the SRQ was 1.4. Females scored significantly higher (43.8% vs. 24.1%, OR 2.5; CI: 1.7–3.6; $p < 0.001$).

Associations between psychological distress (SRQ ≥ 12) and violence, health, socio-economic and sources of support univariate analysis of violence and psychological distress (SRQ ≥ 12)

Feelings of personal insecurity were significantly associated with psychological distress (SRQ ≥ 12) for both males and females (Table 2). Psychological distress among males was significantly ($p < 0.01$) associated with all self-experiences (defined as 'ever happened to you') and most consequences of violence. Psychological distress among females was significantly ($p < 0.01$) associated with witnessing events (except hearing about/witnessing rape), as well as the self-experience of some events (maltreatment, arrested/kidnapped) and feelings of lack of safety and independence.

Multivariate analysis of mental health (SRQ ≥ 12) and violence

For both genders, not feeling safe is associated with at least twice the odds of suffering from psychological distress (Table 3). For males, violation of modesty, forced displacement, and disability were all associated with a significantly increased likelihood (three times the odds) of suffering from psychological distress. For women, the witnessing of people being killed or tortured or dependency on outside assistance doubled the odds of suffering psychological distress.

Associations between psychological distress (SRQ ≥ 12), health and socio economic outcomes

The majority of respondents (63.9%, 326) had recently visited a health post or clinic: nearly half had visited a health facility more than once (46.3%, 235) in the past 30 days. Overall, nearly half (49.6%, 253) of respondents rated the health facilities as poor. Women more frequently rated their physical health as bad or very bad (male: 24.1% vs. female: 36.3%, OR 1.8; CI: 1.2–2.6; $p < 0.005$), and visited the health facilities more than men (male: 40.0% vs. female: 54.7%, OR 1.8; CI: 1.3–2.6; $p = 0.005$). The number of women who had been on medication for six or more days was significantly higher than men (male: 30.7% vs. female: 46.0%, OR 1.9; CI: 1.3–2.8; $p < 0.001$). A high level of psychological distress (SRQ ≥ 12) was significantly ($p < 0.01$) associated with poor or very poor self-rated health for both males (OR 4.4) and females (OR 3.4). For males this was also associated with a higher likelihood of visiting the clinic two times or more (Table 4). For both males and females, high psychological distress was also associated with a higher likelihood of being unable to or having to cut back on work or performance of daily activities.

Table 3 Significant multivariate associations between psychological distress (SRQ≥12) and demographic variables, violent incidents (self-experience, witnessing), and personal consequences by gender (n= 510)

MALE SRQ≥12	OR	CI	P-value
Currently not feeling safe			
No	1		
Yes	2.4**	1.3-4.4	0.007
Modesty being violated			
No	1		
Yes	3.3**	1.6-6.8	0.001
Being forced to move			
No	1		
Yes	3.5***	1.7-7.1	<0.001
Being disabled			
No	1		
Yes	2.7*	1.2-5.9	0.015
FEMALE SRQ≥12			
Currently not feeling safe			
No	1		
Yes	1.9*	1.1-3.3	0.020
Being dependent for daily living			
No	1		
Yes	2.4**	1.3-4.8	0.007
Witnessed people being killed			
No	1		
Yes	1.9*	1.1-3.4	0.029
Witnessed people being tortured			
No	1		
Yes	2.1**	1.2-3.7	0.008

i Multi logistic regression
** Signifiant P < 0.05*
*** Significant P < 0.01*
**** Significant P < 0.001*

Coping mechanisms

The most common ways of coping were withdrawal (isolation, not talking to people) and aggression (Table 5). Religion was also reported as a helpful source of support.

Table 4 Associations between psychological distress (SRQ>=12) and health outcomes, socio-economic outcomes by gender (n=510)

	Males				Females			
	n	OR	CI	P value	n	OR	CI	P value
Health Outcomes								
Self rated health bad or very bad	65				87			
SRQ<12		1				1		
SRQ≥12		4.4**	2.4-8.1	<0.0001		3.4**	2.0-5.8	<0.0001
Visited health clinics ≥ 2 times	106				129			
SRQ<12		1				1		
SRQ≥12		3.2**	1.8-5.8	<0.0001		1.4	0.9-2.4	0.166
Medicine use > 6 days	81				106			
SRQ<12		1				1		
SRQ≥12		1.8	1.0-3.1	0.006		1.5	0.9-2.6	0.11
Socio-economic Outcomes								
Unable to work/ daily activities ≥4 days	117				124			
SRQ<12		1				1		
SRQ≥12		6.7**	3.5-13.0	<0.0001		2.6**	1.5-4.4	<0.001
Cut back/ reduce work or daily activities ≥4 days	120				125			
SRQ<12		1				1		
SRQ≥12		4.1**	2.2-7.6	<0.0001		4.5**	2.6-8.0	<0.001

*i P Chi square Yates corrected unless indicated differently ii Fisher exact test * Significant P < 0.05 ** Significant P < 0.01 *** Significant P < 0.001*

Table 5 Overview support mechanism used by the participants (up to three answers possible, n=510)

Sources of support	Frequency
Isolation	327 (64.1%)
Aggressive behaviour	235 (46.1%)
Praying/meditation	203 (39.8%)
Stop speaking to people	188 (36.9%)
Drug and alcohol use	186 (36.5%)
Talking to others	117 (22.9%)
Keeping busy	106 (20.8%)
Seeking support from family	63 (12.4%)
Other	44 (8.6%)

Discussion

The data presented in this article were gathered to inform MSF's programme to provide mental health support in Kashmir. Using the SRQ (a tool that has been validated in other Indian studies [6-10]) we found the population had been exposed to high levels of violence [2] which resulted in one third of the respondents suffering from psychological distress and considering suicide. For both genders, currently not feeling safe was associated with psychological distress. For males 'violation of modesty', displacement, and disability were associated with psychological distress while risk factors for females included witnessing killing and torture. Respondents with high psychological distress rated their own health and socio economic functioning as poor. The most common coping mechanism was withdrawal.

Overall, one-third of respondents reported psychological distress. This compares to a prevalence of 36% found in a study done among Afghan women in a refugee camp [15] using the same instrument and similar cut off score, but differs substantially from another SRQ study done in a non-conflict area in India [16] where 18% prevalence of psychological distress was found among low-income urban women, using a relatively low cut-off score (7/8). Using this lower cut-off would have given a prevalence of psychological distress of 71.4%. The contextual difference in these studies – exposure to chronic violence as compared to 'common' stressors of daily life for women in low urban settings – may account for this difference.

The Self Reporting Questionnaire (SRQ) showed that a third of respondents had contemplated suicide. Suicidal thoughts are common for depressive disorders [17] but do not always lead to a suicide attempt. Our findings are in line with a previous

study that reported high suicide rates in this region [18]. A high prevalence of suicidal thoughts is more often reported among populations suffering from chronic violence, with a similar prevalence (33%, 96, n = 297) reported in a population of Afghan refugee women in Pakistan using the same questionnaire (SRQ).

In our study women had significantly higher psychological distress than man. This is in line with other studies showing women suffering more from anxiety disorders than men after confrontation with violence [19]. Feeling safe was found in other studies to be an important precondition for being able to deal with adverse traumatic experiences [20] [21], and this was also found in our study.

For males, the most important risk factors for developing psychological distress were 'violation of modesty', displacement and disability. It is possible that these experiences are the most distressing because they interfere with the cultural values and roles of males in Kashmir society: upholding their dignity and being able to protect and feed their families. Those who self-experienced 'violation of modesty' had a threefold chance of suffering from psychological distress ($p = 0.001$). 'Violation of modesty' is regarded as very degrading and in the few studies on male sexual violence is associated with multiple perpetrators and high levels of physical beating [22][23], which can further contribute to psychological distress. For women most psychological distress was associated with feelings of powerlessness – dependency on others for daily living, and witnessing killing and torture. Women have lower confrontations with violence, which can be partly explained by their being largely confined to the home [2]. The significant association of witnessing and psychological distress among females may relate to feelings of helplessness and guilt caused by the witnessing may be more traumatic than experiencing the violence them-selves.

Both males and females with high levels of psychological distress rated their own health as much poorer compared to those who did not have high levels of psychological distress (male: OR 4.4; female: OR 3.4). Non-specific health complaints have been associated with (traumatic) stress in other studies [24] [25] [26]. It is also possible that people do not understand the relationship between physical symptoms and mental stress [27] or have difficulty to articulate their emotional status and use physical symptoms to articulate mental distress [28]. High psychological distress among males was significantly associated with visiting health services more frequently. Increased use of medical services by those suffering from traumatic-stress related problems are common [24][29], with up to a 25% increase in number of visits to health care facilities reported in other studies [30] [31] [27]. We found this relationship in our survey for males, but not for females. This may be explained by the fact that for both cultural and security reasons females depend on male escorts in order to access health services, restricting their movements.

In our population, high psychological distress is associated with substantially increased likelihood of socio-economic dysfunction, and this has been reported in

both Western [27] [32] and Asian [15] contexts. Socio-economic dysfunction can have broad implications, for example by reducing capacity of females to give care to the children or for males to generate income (according to traditional roles).

The most common coping mechanisms such as withdrawal (self-isolation, stop speaking) and aggression may also be symptomatic of depression and/or anxiety disorder (including post-traumatic stress disorder, PTSD). Religion and family assistance are mentioned less frequently as sources of support. This is in contrast to a study conducted in Afghanistan that showed religion and reading the Koran as the two main coping mechanisms for two being confronted with violence [15].

Potential limitations

General methodological limitations, including sampling methodology, retrospective study design, and terminology, have been discussed previously [2]. There are, in addition, a number of potential limitations related to this specific analysis. First, as this is a cross-sectional survey, no causal inferences between violence and mental health can be conclusively made. Second, individual respondents may have implicitly used the presence of mental health symptoms as a deciding factor for whether they have experienced a traumatic event in case of doubt (i.e. recall bias [33]). We consider this as unlikely as we asked respondents to recall violent events but did not ask them to identify which events were traumatic. Finally, we used the SRQ to avoid labelling populations with a psychiatric diagnosis, but using a self-reporting questionnaire has obvious limitations. A comparative study in India of five questionnaires showed good internal consistency and a high discriminating ability with the SRQ having the best results [9], but in comparison to clinical interview, questionnaires only showed strong positive predictive value when a considerable compromise on sensitivity was made. It was concluded that the choice of an optimum cut-off score (to balance sensitivity and positive predictive value) should be adapted to individual settings, and recommend a higher cut-off score for resource-limited primary-care settings [9]. We used a high cut off score of 12, in line with this recommendation. But in the absence of clinical interview no detailed analysis of the mental health status is possible.

In the context of predominantly Urdu-speaking population we considered, but did not use, cut off scores from other Urdu speaking cultures such as in Pakistan. A meta-analysis of psychiatric rating scales in Urdu [34] concluded that only a small number of instruments (including SRQ) were sufficiently evaluated. The same review concluded that for the SRQ no cross-culturally validated gold standard was used, cut-offs varied considerably, as did sensitivity (78–93%) and specificity (77–85%). We judged the Indian validation studies [9] as more appropriate because they used clinical interview as gold standard.

Conclusion

The high levels of violence confronted by the Kashmiri population have resulted in high prevalence (33%) of mental health problems. Poor self-rated health and likelihood of poor socio-economic functioning were associated with high levels of psychological distress. Mental health problems in this context of chronic violence should receive full attention through the provision of appropriate community-based services that would improve access to care and reduce the burden on the health system.

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Background to the Mogadishu (Somalia) survey (December 2007)

In 1991, the government of Somalia was overthrown by opposition groups, and civil war broke out between opposing Somali clans. The clans' traditional ruling systems failed to agree on a new national leader and Somalia plunged into turmoil of clan warfare and lawlessness. In August 2000, clan elders set up a Transitional National Government. The goal was to reconcile warring militias, but as the transitional government's mandate came to an end, little progress was made. In 2004 the main warlords and politicians succeeded in establishing a Transitional Federal Government (TFG) of Somalia with a 5-year mandate and the intention of forming a new Somali constitution followed by national elections. The new administration was Somalia's 14th attempt since 1991 to establish a central government.

The transitional government's authority was compromised in 2006 by the rise of militias loyal to the Union of Islamic Courts, a group of Sharia courts united to form a rival administration to the TFG. These Somali Islamist militias gained control of much of the south of Somalia, including the capital Mogadishu. In February 2007 the UN Security Council authorized a 6-month African Union peacekeeping mission for Somalia. Islamist insurgents fought these foreign invaders.

The activities of Somali insurgents, the TFG's armed forces, and intervening Ethiopian troops have destroyed the lives of tens of thousands of civilians throughout Somalia, particularly in Mogadishu, with bombings and crimes against humanity. As a result of indiscriminate attacks, killings, rape, use of civilians as human shields and looting, more than 1 million people have been displaced and around 4 million people in Somalia need food aid. Increasing attacks on aid workers in 2007 severely limited relief operations and contributed to an emerging humanitarian crisis. As violence in Somalia escalated to some of the worst levels in over 15 years, both assistance for and attention to one of the most acute humanitarian situations in the world seemed to wane.

In 2007 MSF was one of the few international organizations providing health services in Mogadishu to those unable to flee. Makeshift camps of little more than ripped cloth and plastic sheeting were found throughout the city. There were few men in these camps, leaving women to struggle to feed and care for their children. Despite the dangerous location of MSF's Mogadishu clinic, the numbers consulting were extremely high. Many of the complaints were stress-related. A mental health survey was organised among women and children visiting the women and children's health clinic, to look into these needs and report on the suffering of this vulnerable population.

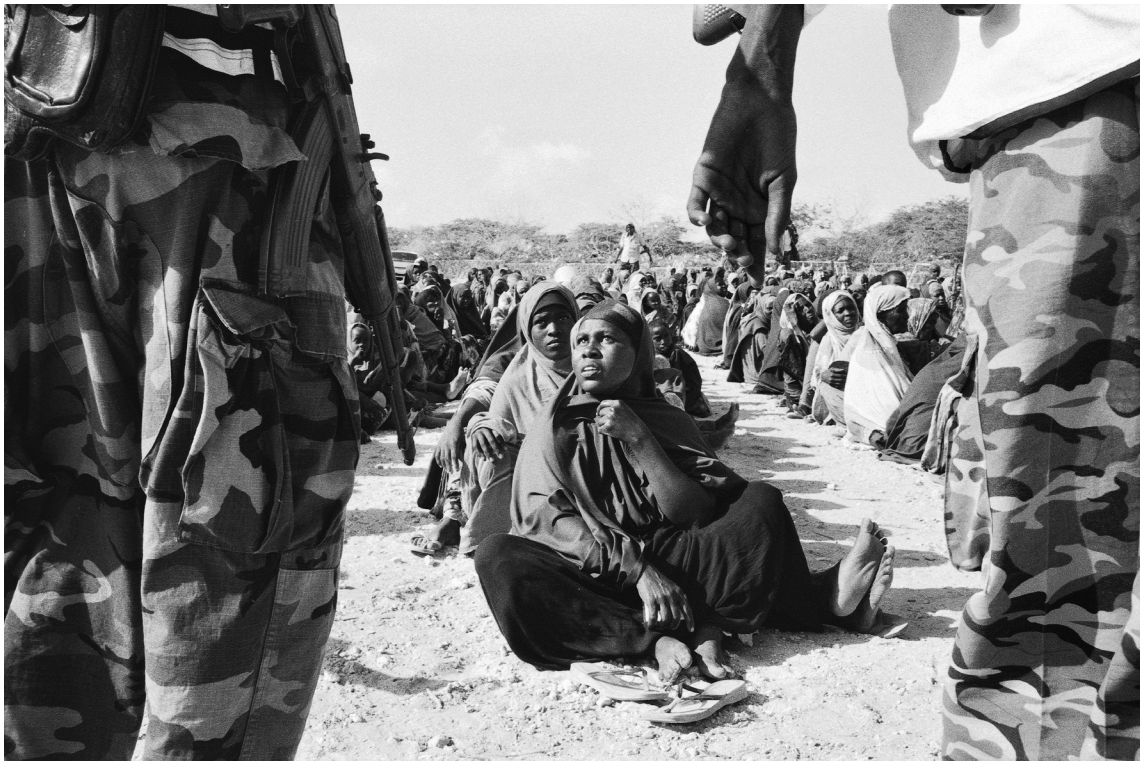

Photo: Eymeric Laurent-Gascoin

Chapter 5

Violence and mental health in a war stricken city

Mental health problems of pregnant women, caregivers and their children in Mogadishu, Somali

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Abstract

Posttraumatic stress disorder (PTSD) symptoms, exposure to traumatic stressors, and health care utilization were examined in 84 women attending a primary health care clinic in Mogadishu, Somalia. The Somalia-Posttraumatic Diagnostic Scale was used in this active warzone to measure symptoms. Nearly all women reported high levels of confrontations with violence; half described being exposed to a potentially traumatizing event. Nearly one third had significant PTSD symptoms. Compared to those who did not, women who reported exposure to a traumatic stressor reported more confrontations with violence (7.1 vs. 3.3; $p < .001$), health complaints (3.8 vs. 2.9; $p=.03$), and nearly 3 times as much ($p=.03$) health service utilization. A potentially traumatizing event was found to be a simplified proxy for assessing mental health distress in women attending a primary health care facility in highly insecure, unpredictable, resource-limited settings.

Introduction

Somalia's capital, Mogadishu, has experienced fierce fighting between rival factions since the collapse of the central government in 1991. Although peace negotiations in 2004 led to the creation of the Transitional Federal Government, the Somali Council of Islamic Courts rejected this government and seized the capital in June 2006. Subsequent military intervention in Mogadishu turned the city into a battleground, resulting in thousands of deaths [1]. By the end of November 2007, approximately 600,000 civilians had reportedly fled the capital [2]. At the time of this writing, Somalia was the country generating the highest number of refugees in the world, after Afghanistan and Iraq [3]. International concern is growing for the psychosocial consequences of conflict. In 2005, the World Health Organization (WHO) called for "support for the implementation of programs to repair the psychological damage of conflict and natural disasters" [4].

A frequently used indicator for mental illness and psychosocial needs among war-affected populations is posttraumatic stress disorder (PTSD) [5]. The use of a Western psychiatric diagnosis such as PTSD in non-Western settings, however, has been criticized [6] [7]. In addition, the definition of a traumatic event in active warzones has been challenged. It is possible that people living in areas of mass violence only perceive and report violent events as potentially traumatic when the events are out of proportion to the context, even if such events would in other settings be classified as traumatizing [8] [9].

Though knowledge of conflict-related psychological distress has grown with an increasing number of studies [10], most empirical studies use instruments that have limited or untested reliability for the specific setting [11]. The difficulty in using screening instruments to identify mental health needs in highly stressful environments is a challenge that has not yet been effectively addressed [11]. Promising methodologies for developing local validated screening instruments have been described [12] [13], but they are generally too time consuming for implementation in acute emergencies such as active warzones.

With heightening attention on the violent conflict in Somalia and its devastating effect on its citizens [14], we present here an assessment of the mental health of women attending a primary health care clinic in Mogadishu. The aim of the assessment was primarily to guide medical program planning of the international aid organization, Médecins Sans Frontières (MSF). To our knowledge, this is the first study reporting on the mental health vulnerability of women during an acute, active conflict in a non-Western setting using a locally validated assessment tool. Our study also highlights the difficulty in collecting such information in conflict settings and examines alternative (proxy) assessment indicators for measuring mental health vulnerability in highly unpredictable, insecure, resource-poor environments.

Method

Participants and procedures

The study took place in a MSF-supported primary health care clinic located in urban Mogadishu. Female caregivers ($n = 54$) of children visiting the outpatient department (OPD) and pregnant women ($n = 41$) visiting the antenatal care (ANC) clinic were invited to participate in a semi-structured interview assessing their exposure to violence and related consequences that could lead to posttraumatic stress symptomatology. In accordance with Somali cultural norms, female interviewers were used for the in-depth interviews regarding the Somali-Posttraumatic Diagnostic Scale (S-PDS). All interviewers had previous interviewing experience; this was augmented by 1-day training specific for this survey. A mental health professional was available for participant support as well as daily debriefing and optional counselling for interviewers.

The ANC and OPD activities were provided in the same compound. It was not possible to assess women outside the health services due to security constraints. Women were invited to participate in the survey after their clinical consultation. The number of women interviewed depended on the time needed to perform the consent procedure and the interview; we did not ask women to wait in the clinic to limit the number of potential casualties in case of attack. The selection of participants depended on the availability of the interviewers. Approximately every 20 minutes a woman who had finished her clinical consultation was approached. If the participant agreed, the interviewer continued with the informed consent procedure. Informed consent was sought verbally. It included the nature and purpose of the assessment, the right to refuse participation, and repeated assurances of confidentiality and anonymity. Nine women refused after informed consent. To avoid the impression of putting pressure on people, respondents who refused were not asked for their reasons. Participants did not receive any material compensation.

Measures

A questionnaire was used to record demographic information, including age, household composition, and history of displacement. Participants reported their history of health problems using a fixed list of common health complaints defined by a previous survey conducted in Somalia [15] [16]. Information regarding access to health services included the number of health-related clinical visits and obstacles to accessing health service. The recall period for all health-related questions was limited to the 2 months prior to the interview (corresponding to the end of Ramadan).

Exposure to violence was assessed using a list of violent events previously used in Somalia (Cronbach's $\alpha = .86$; [15]) with additional questions related to witnessing and/or experiencing torture, conflict, life-threatening events, or illnesses due to conflict-

related factors,. Somali staff from the MSF program assisted in adapting and defining relevant terms, including abortion, torture, and mistreatment.

The S-PDS was used for assessing PTSD symptomatology among female caregivers. It is a short psycho/diagnostic assessment instrument administered by trained local interviewers in their native language [15] . It was derived from the widely used Posttraumatic Diagnostic Scale (PDS) [17] and has been validated for the Somali language, culture, and Islamic religion in a study among ex-combatants [15]. Three criteria were required to have a positive result on the S-PDS: (a) identification and description of a potentially traumatizing event (PTE), defined as the violence-related event that was most stressful or upsetting happening to the interviewee or someone close; (b) PTSD symptom frequency; and (c) PTE impact on functioning. All three criteria must be fulfilled for a positive evaluation of the S-PDS to be made. The outcome of the S-PDS is associated with clinically elevated PTSD symptoms (e.g. [18]); however, such a diagnosis requires confirmation through clinical assessment. Criterion 1 of the S-PDS, the potentially traumatizing event, corresponds to Criterion A of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR [5]) for PTSD. To fulfil this criterion, the PTE must have happened at least 2 months prior to the interview and recalled as resulting in at least one of the following trauma-related characteristics: physical injury; feeling of one's own or another life being endangered; and feelings of fear, horror, or helplessness at the moment of occurrence. Criterion 2 of the S-PDS assesses the presence or absence of 17 symptoms of PTSD (criteria B–D of the DSM IV-TR) in reference to the chosen PTE. The criterion is fulfilled if at least one re-experiencing, three avoidance, and two arousal symptoms are reported. Self-reported frequency in the past month of each symptom is based on a 4-point scale: 1 = *Not at all or only 1 time*, 2 = *2-4 Times*, 3 = *5-16 Times,* 4 = *Almost always*. Criterion 3 of the S-PDS focuses on impairment in functioning, the F criterion of PTSD, and assesses general satisfaction in life, overall functioning, and specific functional impairment in major life areas such as work, ability to relax or study, learning ability, and relationships with family and friends. At least one functional impairment was necessary to fulfill Criterion 3.

Analysis

Data were analyzed using Epi Info 3.2 [19] and STATA 8.0 [20]. If data were missing the number of available data was used as the denominator. Two questionnaires were incomplete and removed from the sample analysis. Associations between dichotomous variables were analyzed with a χ^2 test and Fisher's exact test. A difference between the means of a variable for subgroups was analyzed using a *t* test; if the Bartlett's test for inequality of population variances was significant, the Kruskall-Wallis test for two groups was used.

Results

In-depth interviews of 84 women including 45 OPD and 39 ANC women were completed from December 10–13, 2007. Nine women did not consent to participate after study information was provided, and two questionnaires were incomplete due to lack of time. The median age was 27 years ($SD = 7.2$; range = 17–60 years) and the majority (76, 90.5%) of the women were married. The average reported household size was 9.0. Most respondents (66, 78.6%) had no formal education; 12 (14.3%) received a primary, 4 (4.8%) a secondary, and 2 (2.4%) a high school level education. Only 12 respondents (14.3%) reported never having been displaced since the start of the conflict in 1991; half (42, 50.0%) had been displaced three or more times. Participants recruited from the OPD clinic came from larger households compared to participants recruited from the ANC clinic (11.9 vs. 5.8; $p < .001$). No other differences in baseline characteristics of participants from each clinic were found.

Among the 84, 77 women reported 289 health complaints (average = 3.4, $SD = 1.9$) during the 2 months prior to the survey. The most frequently reported health complaints included headache (68, 23.5%), respiratory complaints (52, 18.0%), cough (38, 13.1%), generalized pain (37, 12.8%), fever (31, 10.7%), and stomach pain (30, 10.3%). Half of the participants (42, 50.0%) mentioned at least one additional complaint, including malaria, kidney pain, and palpitations. During the 2 months prior to the survey, 51% (42, $n = 83$) had visited a clinic at least once for their own health; of these, 21.6% (18) visited a clinic two or more times. Of the 68 women who wanted to visit a clinic, 38.2% (26) were unable to do so because of problems of access, mostly related to lack of financial resources (24, 92.3%).

Nearly all respondents (81, 96.4%) were confronted with at least one violent event during the 2 months prior to the survey (M=5.5 events, range=0–24, SD=4.3). Events most frequently reported included witnessing severely injured people, being caught in a combat zone, and being in close proximity to shelling or mortar attacks (Table 1). The majority of respondents had heard of incidents of sexual violence; four women reported being raped.

More than half (48, 57.1%) of the respondents reported a PTE, all directly related to war-related events in Mogadishu. Of those reporting a PTE, 45 women reported PTE-related trauma characteristics ($M = 4.1$ characteristics, range = 2–6, $SD = 1.9$). These included 9 (20.0%) women who experienced physical injury, 29 (64.4%) witnessing someone else being killed or injured, and 42 (95.5%) witnessing someone else's life in danger. In addition, 31 (68.9%) felt their own life was in danger, 37 (82.2%) experienced feelings of fear/terror, and 35 (77.8%) reported a sense of helplessness. The majority (38, 79.2%) of those reporting a PTE fulfilled presumed PTSD symptom criteria. Mean symptom severity score was 21.8 (range = 1–48, $SD = 11.8$) of a maximum 51. Of the 48 persons reporting a PTE, 41 (85.4%) stated that their basic

Table 1 Frequency during previous 2 months of exposure to traumatic stressors

Event	Freq.	%	Event	Freq.	%
Did you witness:			**Were you? (continued):**		
Abduction/ forced recruitment of someone close	10	11.9	Present in military or combat zone	38	45.2
Harassment by any army personnel	4	4.8	Imprisoned	5	6.0
Any mutilated people or dead bodies	17	20.2	The victim of robbery or looting	25	29.8
Anyone committing suicide	2	2.4	**Did you experience:**		
Anyone severely injured by conflict	46	54.8	Violent assault by a stranger	7	6.0
The killing or murder of someone	16	19.0	Life-threatening illness	8	9.5
Robbery or looting	30	35.7	Torture	4	4.8
Torture	9	10.7	Other life threatening events	19	22.6
Were you:			Abortion as a result of violence	15	17.9
Abducted or recruited by force	1	1.2	Property confiscated	16	19.0
Close to a shelling or a bomb attack	35	41.7	Heard about violent rape in Mogadishu	59	70.2
Close to crossfire or the shooting of snipers	28	33.3	- did you see this happen?	6	7.1
Very close to burning houses	21	25.0	- did this happen to someone you know?	7	8.3
Harassed by armed persons	7	8.3	- did it happen to you?	4	4.8
Forced to leave an area due to violence	17	20.2	Knew the perpetrator	1	1.2
Injured by a weapon	5	6.0			

Note. N = 84. Torture= Torture is the infliction of severe physical or psychological pain as an expression of cruelty, a means of intimidation, deterrent or punishment, or as a tool for the extraction of information or confessions. Violent assault= Includes being physically attacked, shot, stabbed, or held at gunpoint.

functioning (Criterion 3 of the S-PDS) had been affected, with a mean of 4.1 complaints (range = 0–8, *SD* = 2.7). Thirty (62.5%) people reported that PTE-related symptoms impinged on their "general satisfaction with life," and 31 (64.6%) said it had hindered their "overall function in all life areas." Common complaints included difficulty to relax (28, 58.3%), compromised relationships with friends (25, 52.1%) or family (26, 54.2%), and difficulty learning/acquiring skills (25, 53.2%). More than one quarter reported that their work functioning was affected (14, 29.2%). Of those reporting a PTE, half (25, 52.1%) fulfilled all three S-PDS criteria for PTSD symptomatology, representing 29.7% (95% CI [19.8, 39.7]) of the 84 women interviewed.

Those reporting a PTE compared to those not reporting a PTE had significantly higher exposure to violence, mean number of health complaints, and health visits to the clinic. Comparing those qualifying for all S-PDS criteria (presumed PTSD) with those not qualifying, we found no significant differences on the same variables (Table 2).

Table 2 Associations with both exposure to trauma and clinically elevated PTSD symptoms

PTE vs no PTE reported	OR (95% C.I.)	P - value
Age	-	.466
Mean exposure to violence	-	.0001**
Mean number health complaints	-	.028*
One or more health visits within previous 2 months	2.7 (1.07-6.8)	.028*
Displacement 3 times or more	2.2 (0.89-5.4)	.080
Unmarried	5.98 (0.66-53.9)	.070
Positive vs negative presumed PTSD		
Age	-	.179
Mean exposure to violence	-	.171
Mean number health complaints ¶	-	.424
One or more health visits within previous 2 months	1.4 (0.55-3.6)	.633
Displacement 3 times or more	2.3 (0.86-5.9)	.152
Unmarried	4.6 (1.0-21.3)	.047*

Note. (N = 84). PTE = potentially traumatizing event; PTSD = posttraumatic stress disorder.
**p < .05. **p < .001*

Discussion

To our knowledge this is the first published study on the prevalence of PTSD symptomatology for women consulting health services in a highly insecure, unpredictable, resource-limited context. As such, we can only compare our findings with results from related populations. The proportion of participants suffering from PTSD-related symptoms (30%) is in the upper range compared to findings among populations affected by war and migration, with previous studies reporting PTSD prevalence rates ranging from 14 to 37% [21] [22] [23] [24]. Using the same standardized questionnaire for posttraumatic symptomatology (as assessed by the S-PDS), women in our study more frequently screened positive on the S-PDS compared to a study conducted among ex-combatants in Somaliland (19% [15]). This is likely explained by differences in study populations: ex-combatants were predominantly male and men in general tend to report fewer problems associated with PTSD [25]. In addition, ex-combatants can be expected to be better prepared for extreme violence compared to civilians. Lastly, the difference in context may have influenced the results on the S-PDS; the ex-combatants' demobilization and reintegration program in North Somalia was a relatively peaceful setting compared to the extreme turmoil in Mogadishu. The active conflict in Mogadishu is strongly associated with considerable distress.

Though most women reported confrontations with extreme violence (average of 5.5 events during the 2 months prior to survey), only half reported a potentially traumatizing event (PTE). In Western settings, this may contradict the assumption that most people living in mass violence settings are traumatized. As mentioned earlier, people living in areas of mass violence may only perceive and report events as potentially traumatizing when the events are out of proportion to the context. This would imply that, for time-limited mental health assessments in contexts of mass violence, a reported PTE is more indicative of a person's potential mental traumatization than the number of confrontations with violence.

Furthermore, although a cumulative effect of exposure to war related events and increasing likelihood of developing anxiety disorders including PSTD has been found in post conflict settings [26], this relationship may be different for highly insecure, unpredictable, resource-limited settings, as our data do not confirm this relationship. The strong relationship between posttraumatic symptoms and health have been described elsewhere [27] [28], including among Somali refugees [29] and Somaliland ex-combatants [16]. We did not find any significant relationships between PTSD symptomatology and physical health variables (health complaints and frequency of health service utilization). We did find, however, that reporting a PTE was associated with a higher number of health complaints and greater health service utilization. Our results suggest that, while most mental health assessments in conflict settings focus

particularly on PTSD and depression [30], the focus on reporting a PTE may be a more feasible approach for the assessment of psychosocial and/or mental health needs in areas of acute mass violence. In emergency interventions, the focal point of mental health and psychosocial programs is ideally on the restoration of functioning of individuals and their communities [31] [32] [33]. Being unable to care for one-self in emergency circumstances jeopardizes survival.

Identification of what constitutes a vulnerable group is a key challenge for providers of care. Those who have experienced violence, increased health complaints, and who more frequently use health care services are among the most vulnerable. A simple indicator such as describing a PTE may be appropriate for assessing this vulnerability in a highly insecure, unpredictable, resource limited context. Given the strong criticisms raised against the application of Western psychiatric diagnostic labels such as PTSD in non-Western settings [6] [7], using PTE instead of the PTSD diagnosis would avoid the stigma of a psychiatric diagnosis and the cross-cultural validity constraints of those labels [34].

Humanitarian agencies working in emergency settings need valid, easily applicable, non-stigmatizing indicators to assess psychosocial needs and plan services accordingly. Such indicators will inform the agencies which mental health and psychosocial activities are effective. After more than a decade of pursuing *DSM*-related indicators, it might be time to apply more pragmatic indicators that focus on vulnerability rather than mental health diagnosis.

Collecting information in a highly insecure, unpredictable, resource-limited setting of mass violence such as Mogadishu is a trade-off between the desire to maintain the highest scientific standards of validity and reliability and what is actually feasible for the implementing agency and the community. In conflict settings, a balance has to be found between rigorous research standards and sound operational demand.

The assessment focused on the presence of PTSD symptomatology. To qualify for PTE and positive status on the S-PDS the experience had to be older than 2 months. We cannot exclude the distress caused by more recent experiences to influence the distress related to the PTE event. In areas of on-going violence, it is questionable whether recent events should be excluded as these events can also increase mental health vulnerability. This confirms the difficulty of using a PTSD diagnosis that requires an event older than 2 months in on-going war circumstances.

The S-PDS questionnaire has been validated in Somaliland (North Somalia) among male ex-combatants, but may have limited generalizability, including to our population (female clinic attendees). Although our questionnaire has been validated against a gold standard, this does not guarantee validity: to confirm a checklist PTSD diagnosis, a clinical interview should be used, but this was not possible due to the highly insecure environment. Furthermore, even clinical interviews have limitations in

terms of cultural validity [35] [36] and need local validation. Another potential limitation lies in the fact that our research used a retrospective questionnaire that carries an inherent risk of recall bias. Every effort, however, was made to choose a readily identifiable marker for the recall period (the end of Ramadan). Moreover, other studies have demonstrated that refugees remain rather constant in their reporting on key traumatic events over time [37]. A further limitation is that the extremely insecure and violent circumstances limited the sampling period (in this case only a few days recruitment was possible), sampling approach (non-random sampling), and target population (only women seeking health care in a primary health setting). These issues limit the generalization of our findings. Finally, nine women refused to participate, and this may contribute to selection bias, but as reasons for refusal were not asked (to avoid putting pressure on individuals), this is not possible to assess.

Conclusions

One third of the women who visited a primary health care unit in Mogadishu (Somalia) were diagnosed with PTSD symptomatology. In contrast to those having this symptomatology, reporting a potentially traumatizing event was found to be more strongly associated with events such as confrontations with violence, health complaints, and frequency of health service usage.

Our data suggest that simplified indicators such as reporting a PTE may suffice for time-limited assessments and psychosocial or mental health primary health care service planning in highly unpredictable, insecure, and resource-poor situations of mass violence.

Many participants who were confronted with repeated war-related incidents stated that they had not experienced a potentially traumatizing event. This suggests that what individuals appraise as potentially traumatizing depends on their perception of what is traumatizing in extreme contexts. More generally, it indicates that people label what is traumatic in relation to their environment.

Future mental health research and time-limited assessments in conflict areas should focus on identifying indicators that inform on locally appropriate vulnerability, rather than relying on PTSD symptomatology or other mental health diagnostic criteria alone. This will facilitate assessments of mental health vulnerability in acute emergencies and improve the rapidity and appropriateness of assistance provision to populations in need.

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Section III

Question 2

**What are the key components of
a framework for addressing the psychosocial consequences
of mass conflict?**

Background to Kosovo Crisis at time of publication (May 1999)

The province of Kosovo was a disputed borderland between Serbia and Albania. About 90% of the population are Kosovo Albanians (Kosovars). The Serbs, however, refer to Kosovo as the 'cradle of the Serb nation'. On 24th April 1987 the Serbian Communist leader Slobodan Milosevic visited Kosovo and stated: "No one should dare to beat you!". In the mid-1990s, Serbs took control of Kosovo. Major industrial enterprises were confiscated, school curricula were 'Serbianised' and Kosovar teachers were sacked. Kosovars organised Albanian-language 'parallel' university, school and health systems. Most Kosovars embraced non-violent resistance but became bitterly disillusioned with their leadership and the international community's passivity.

The self-styled Kosovo Liberation Army (KLA) unleashed a major guerrilla offensive and gained control of one-third of Kosovo. Throughout the conflict civilians were systematically attacked and massacred, and more than 200,000 were displaced.
To end the attacks on ethnic Albanian villages in Kosovo the NATO began a bombing campaign without approval from the UN Security Council in March 1999. It became impossible to provide humanitarian assistance or protection, and with the onset of NATO bombing Mr Milosevic only accelerated his campaign of systematic terror and forced migration. Over an 11-week period more than 800,000 people were forcibly expelled from Kosovo. Most fled to Albania, Montenegro and Macedonia.

Médecins Sans Frontières (MSF) started its activities in Kosovo in 1993, providing medical supplies to official health structures. Forced to leave Kosovo by the NATO bombing, MSF began providing relief to Kosovar refugees in Albania, Macedonia and Montenegro. Refugees in the cities, and camps received medical, water and sanitation support. Implementing mental health activities at the start of a large-scale emergency was a new type of intervention for MSF. At its peak the successful initiative engaged 67 international and 265 national staff, and lessons learned were shared internationally.

Photo: Tom Stoddart

Chapter 6

Mental health care for refugees from Kosovo: The experience of Médecins Sans Frontières

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Introduction

Since the mass expulsion of ethnic Albanians from Kosovo began in March, 1999, the media have reported stories of the suffering of thousands of refugees who have arrived in Albania, Macedonia, and Montenegro. Witnesses recount experiences of violence, executions, and destruction. Some were forced to leave at gunpoint, while others were given just a few hours to leave their homes. Many people have lost family and friends; some were witness to their execution. Beliefs in security, the future, and the benevolence of other people are shattered.

The psychological impact of war in emergency situations is a neglected issue. We examine the need for mental health support in the emergency refugee crisis in the Balkans. The international humanitarian aid organisation Médecins Sans Frontières is conducting mental health programmes at the border crossing points of Brazda, in Macedonia, and Kukes, in Albania, where thousands of refugees are sheltered in camps. In Tetovo district, Macedonia, many people have found refuge in the homes of local people, and there is a separate programme to provide psychosocial services for these refugees.

Lessons from Bosnia

The principles of the MSF psychosocial interventions in Kosovo are largely based on experience gained over 4 years in the former Yugoslavian republic of Bosnia-Herzegovina. Sarajevo was besieged for more than 3 years and in this urban population original networks of families and friends broke down and cultural identity was shattered. The social disintegration and the daily confrontation with violence and death contributed to high levels of chronic and acute stress. The humiliation of being controlled from outside and the dependency on a divided international community undermined the self-esteem of the inhabitants.

The core elements of the MSF mental health-care programme in Bosnia were: the establishment of accessible counselling centres; in-depth training of local counsellors and supervisors; and the provision of specific short-term interventions. The various forms of assistance provided ranged from psychological education and media sessions to crisis intervention and brief psychotherapeutic counselling. Between the autumn of 1994 and January, 1998, about 10 000 people were helped through this programme. In situations of massive destruction and human tragedy, the tendency to focus on the immediate negative effects of violence on the human psyche is understandable. However, victims of violence should not be simply reduced to patients with serious mental disorders. Both in Bosnia and now in the Balkans people have developed, and will continue to develop, coping mechanisms to replace

or restore the lost protective factors offered by social networks, religion, and culture. Mental health programmes should stimulate these mechanisms of adaptation.

The concept of a "normal" coping response to extreme stress is crucial. During the emergency phase and in a situation of continuing violence, mental stresses should be regarded as normal reactions to abnormal circumstances. In Bosnia, the widespread labelling of extreme stress as pathological disturbances contributed to the stigmatisation and victimisation of those already in a vulnerable position.

Training of local staff was of vital importance. In the Balkan hospital based and drugs-orientated health system, psychiatric care is focused only on chronic and severe cases. MSF's training of local people was interactive: experts in trauma from other countries discussed concepts with Bosnian specialists. This interaction and its implicit message of respect was important for the Bosnian staff: providing support for their own people created a wider sense of dignity and self-control and a sense of future perspective. The staff training was effective only when it was continued and followed up by education on the job. This vital part of training is commonly neglected by aid organisations involved in psychosocial programmes.

MSF focused its interventions on the provision of emergency primary health care in community settings. Limited counselling of no more than 10–15 sessions was effective. Group interventions were preferred because of the secondary benefits of sharing and mutual support. War-related disorders, particularly depression and post-traumatic stress disorder, meant that long-term treatment was not deemed appropriate. The media was also used to disseminate psycho-education to help create an environment in which war-related emotional problems could be acknowledged. A weekly radio programme explained the notion of traumatic stress, the normality of various responses to stress, the principles of self-help and support to others, and the possibilities of professional help. The programme was listened to by two-thirds of the population.

The past year in Kosovo

In March, 1998, a crackdown on ethnic Albanian separatists in Kosovo by Serbian forces began a conflict that has killed thousands of people and left hundreds of thousands homeless. In December and January, a period of comparative stability when people had returned from the hills and found shelter, MSF carried out a mental health assessment among the internally displaced population in Kosovo. During this period, MSF used mobile clinics to meet the primary health needs of the displaced population. The mental health assessment was undertaken as a result of requests from the physicians who worked in these clinics and observed a high rate of psychosocial and war-related symptoms in the population. These symptoms included

headaches, stomach pains, fear, sleep disturbances, flashbacks and, less frequently, visual and auditory hallucinations, muteness, and social withdrawal; traumatic stress complaints were very common. MSF found that communities were generally supportive of each other. Focus group discussions revealed that people were willing to discuss their fears and the tensions caused by most of the internally displaced people interviewed had witnessed traumatising events or been subjected to life endangering situations. Since the assessment showed that the population would benefit from psychological support, a counseling element was added to the mobile clinics.

Current needs of refugees

Kosovar Albanians have overcome over 8 years of repression. Their cultural strong family relationships, the sense of responsibility towards the community, and their resilience in the face of continual marginalisation resulted in an independent Kosovar Albanian education, social, and health system. Mental health programmes should foster these self-help mechanisms and avoid conditioning helplessness.

In the current emergency in the Balkans, formal training programmes are not possible. At this early stage, expatriate staff have a prominent role in individual training and providing help. The focus of MSF activities is support for refugees through outpatient departments in the refugee camps. The MSF programmes in Brazda and Kukes focus on the immediate psychosocial needs presented in our clinics and identification of vulnerable people through outreach work. Most refugees are exhausted when they arrive and food, shelter, rest, and medical attention must be provided. During the current chaotic phase, much distress is caused by the separation from, or disappearance of, family members. Consequently, MSF has identified three key objectives for its psychosocial programme.

The first aim is to identify people who are not able to care for themselves (physically, mentally, or socially) and refer them to health or social services. Specific groups in need are people with chronic psychiatric illness, mental disability, severe trauma, the elderly, and mothers with young children. The second objective is to provide backup for the physicians who are working with refugees. Medical services are overworked and doctors are only able to cope with emergency cases and urgent physical problems. MSF's experience indicates that once the patient is helped physically, the urge to talk about their experiences is pressing. Medical staff are frequently confronted with an inhumane choice: silence the patient or listen and lose time. The presence of counsellors trained to listen is beneficial for the medical staff and mental health of the refugees. During this immediate phase, the counsellor should refrain from in-depth probing of emotional details. The third goal is to provide

back-up services for acute and chronic psychiatry. Once in safety some people break down, others are in a psychotic state. Moreover, among the refugees are patients with chronic mental illness who have been expelled from hospitals and institutions and who need appropriate care. Most of these people are given medication and referred to facilities for patients.

Once the physician has made a diagnosis of stress-related disorders, patients are referred to our psychosocial services. Sedatives and psychotropic drugs are prescribed for patients with psychiatric illness or acute anxiety. At this stage, the counselling services are mostly on an individual basis, although group services are possible. The support focuses on providing practical support, listening to personal stories, providing psycho-education, and giving advice. Limited outreach services in the refugee camps are provided by community workers who offer social support such as familiarising the refugee with the camp facilities. Community workers also monitor people who have received counselling. People in need of health care or psychosocial support are referred to the MSF health services. When necessary, and in the absence of other organisations, MSF community workers can be involved in addressing the immediate social needs of the refugees for such things as food, blankets, and toilets. Indeed, assistance is often of a very concrete nature.

Concerns about advocacy

Many organisations are active in gathering testimonies of refugees from Kosovo. The aim of such activities at this stage is to advocate on basic needs and also the levels of assistance and protection given to refugees or deportees by the UN High Commissioner for Refugees. At a later stage, the accurate reporting of human rights violations can serve to record the history of events and support international efforts to bring the perpetrators to justice. The immediate work allows for the objective recognition of a collective trauma and will also help the individual to come to terms with his or her trauma. However, advocacy must not be confused with counselling; the specific information obtained through counselling sessions is not used for advocacy. When pressure is put on a person for information, it can have a damaging effect. Such activities must, therefore, be sensitive to the psychological vulnerability of the individual.

Conclusions

Among the main medical aid agencies working in the current refugee crisis in the Balkans, many, but not all, consider mental health to be important: Unicef, Save the

Children, and Oxfam all have current mental health programmes with a focus on crisis counselling and a long-term perspective. However, divisions remain among aid agencies as to whether mental health is a priority during the emergency phase or whether it should be developed at a later stage.

MSF believes it is important to initiate mental health programmes during the emergency phase of a refugee crisis: local staff must be identified and trained, time is required to understand the local cultural context, and people need to become aware that such help exists.

Other medical programmes become overburdened during the emergency phase and mental health programmes can help to alleviate this burden. Helping traumatised people is a matter of restoring the bond between the individual and the surrounding society. MSF programmes are implemented in cooperation and with the active input of trained national staff. National staff is vital to overcome language and cultural barriers, and are ultimately the only way to ensure acceptance and sustainability of the programmes.

Photo: Lene Esthave

Chapter 7

Early psychosocial interventions for war-affected populations

Kaz de Jong, Rolf Kleber

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Introduction

Médecins Sans Frontières (MSF) is an independent, humanitarian organisation working with international and national volunteer staff in 87 countries world-wide. In its 29 years of existence MSF has developed specialist knowledge in providing health support to populations in emergency and crisis settings.

MSF has been involved in mental health interventions since 1990. The decision to intervene in the early stage of an emergency is largely based on operational observations and compassion of field workers. The usefulness of intervening in early stages of a crisis has been documented in a number of settings [1]. However, the relative novelty of psychosocial care programmes in large emergencies (often in non-western settings) requires an on-going search for valid cross cultural appraisal techniques, appropriate frameworks for intervention and program evaluation. This chapter aims to add to the knowledge base that informs provision of early psychosocial intervention programmes in emergencies involving refugees and war affected populations and seeks to foster discussion about this form of help. In particular we draw attention to key principles that inform MSF service provision. A description is also offered that outlines a general framework and activities incorporated in MSF psychosocial programmes for refugees and displaced people after man-made disasters. The chapter is concluded with lessons learned to date.

Focus on the psychosocial effects of violence

In its role as a provider of relief in emergencies MSF seeks to prioritise interventions focusing on the psychosocial needs that arise in the course of a crisis. The operational definition of psychosocial needs and problems adopted by the organisation refers to those problems and needs that have a psychological (referring to emotions, behaviour, cognition and individual coping resources) and, or a social (mainly referring to the support mechanisms necessary for a collective coping process) origin.

Basic principles of an intervention

Cultural sensitivity

Respect for cultural differences is a prerequisite when planning early intervention for refugees and societies affected by war. Programmes of help and support should aim to create a common and shared approach plus avoid enforcing Western methods and values upon other culture and populations.

To ensure appropriate cultural input from the onset MSF trains locally based personnel to provide psychosocial support to people in their own communities. Implementation is facilitated by expatriate staff who assist and guide national staff in the planning and delivery of services that are tailored to specific cultures or needs. Although the local culture is respected the general ethical principles which underpin

the work of MSF are paramount. For instance, whilst in some early intervention programmes it is culturally desirable to involve traditional healers it is also important to have some oversight over their activities so as not to endanger the physical and mental integrity of those who make use of available services. Finding a balance between specific cultural values and general ethical principles is a crucial consideration and it is rarely a routine or simple aspect of care planning and implementation.

A programme by local people for local people

MSF has come to appreciate that local capacity building is a prerequisite for early intervention to be viable and sustainable. By adopting the principle of implementing 'programmes by local people for local people' an attitude of self-control and self-help is engendered. Expatriate staff seek to support and facilitate processes that promote self-repair and healing. In order to build and consolidate a local professional capacity as well as to guarantee quality standards set for the developing services, the national staff are trained and coached on the job by MSF expatriate staff or nationals with appropriate training and experience, if these are available. Only in exceptional cases is therapeutic assistance and treatment provided by expatriate workers.

Overcoming helplessness

Poor and difficult conditions of living and the loss of a life perspective that incorporates a sense of purpose carried into the future often lead to profound feelings of helplessness. Adaptation to and coping with extreme stresses are facilitated by fostering conditions in which a person can be helped to feel more in control during and after an event [2]. Basic assumptions of trust, certainty and control are shattered and in need of repair [3]. Whether subjective or factual, a sense of mastery is essential. MSF psychosocial programmes therefore specifically concentrate on enhancement of control that counteracts patterns of learned helplessness [4]. In the experience of this organisation the most effective way of achieving this is to train national staff and foster community focused approaches.

Coping with extreme stress

War is not a singular traumatic event but a sequence of extremely disruptive events to which are added prolonged hardships. The concept of post-traumatic stress disorder (PTSD) is frequently used in connection with traumatic events [5] but may in fact be rather less useful for service planners than has often been assumed. An analysis of human responses to extreme and catastrophic experiences reveal these to be much more diverse and varied than what is included in symptom criteria that that comprise PTSD.

A first consideration is that not all mental distress after traumatic events can be described in terms of PTSD. In other words it is not necessarily the only expression of

extreme distress manifest after traumatic events. This is recognised by implication within the classification system offered by DSM-IV [6]. For instance co-morbidities such as depression, substance abuse, dissociative disturbances etc. have been found to be much more prominent in trauma patients than was originally assumed [7]. A further and in our opinion more important consideration is that although many people confronted with war experience suffer some negative responses such as nightmares, fears, shock reactions and despair, approximately 60 to 90 percent do not go on to develop diagnosable mental disorders [2]. An exclusive emphasis on PTSD overlooks the normal and healthy ways in which many victims adapt to extreme stress. As explained by cognitive theories the general psychological and physical processes that follow in the wake of trauma can be useful in helping to integrate traumatic experiences and should therefore in principle not be regarded as pathological responses [8].

A framework for early intervention

Cognitive processing models [9] [8] describe the integration of traumatic experiences as occurring through oscillations between intrusions involving some form of re-experiencing of critical events and avoidance of distressing reminders. It is assumed this is part of a process of adjustment that helps realise adaptations to what has happened.

These processes do not occur in isolation [10]. Many factors shape the coping process in a positive way so as to engender protection from adverse effects of trauma whilst others may increase the risk of negative outcome. The interaction between such factors determines, together with the traumatic situation itself, the eventual outcomes of coping processes [2]. Many humanitarian crises are characterised by omnipresent risks whilst protective mechanisms such as social support may be largely absent. Under such circumstances coping is likely to be more difficult and the number of people at risk of developing severe traumatic stress-related complaints, psychosocial problems or even chronic mental disorders is higher than under less disruptive or non-violent conditions.

It is for these reasons that MSF's psychosocial programmes do not specifically set out to address psychopathology (see Figure 1). Rather they seek to provide support at an early stage of a humanitarian crisis with the explicit aim of helping put in place help and support that will strengthen the coping resources available to survivor populations. One of the aims is to foster greater resilience. The aim is not necessarily to heal or to cure. Curative approaches (e.g. counselling, brief therapy) are indicated under some circumstances especially if there is recognised need to prevent or help minimise the development of further psychopathology. If patients require treatment for severe mental disorders referrals can be made to specialist services. But in war situations where confrontations and violence is persistent and on-going such idealistic aims cannot always be realised.

In line with the framework for early intervention described above MSF psychosocial programme activities are characterised by three themes: Cultural awareness, Prevention and Support or Treatment.

MSF psychosocial programme activities

Cultural awareness while capacity building

Psychosocial or primary mental health care services are poorly developed in many countries affected by major traumatic disruptions. Where such services exist they are frequently insufficiently equipped or resourced to deal with the increased demands for support and help that arise in the early aftermath of an emergency. Such was the situation that arose when MSF became involved in Bosnia-Herzegovina in 1994. What follows is an example of how help and support can be offered.

In Sarajevo and other parts of the country staff were recruited to new counselling centres from health services (nurses, medical doctors, psychologists, psychiatrists), social services departments (social workers) and educational organisations that had been fully operational before the war. Relevant authorities were engaged in selection of staff so as to avoid further depleting scarce resources and expertise available in the community provision.

After recruitment a training course was organised based on the principle of 'learning by doing'. The preferred strategy was to enrol national mental health experts as trainers. However, as proves to be the case in many countries, the availability of local personnel was limited. MSF was therefore forced to largely depend on expatriate staff to run these courses. The training in Bosnia-Herzegovina lasted three months [11] and set out to increase knowledge about traumatic stress reactions as well as to foster skills and applied strategies for supporting and treating traumatised people. The course consisted of various topics: the concepts of stress and trauma, the psychosocial consequences of violence and the evidence base provided by social psychiatry. Skills training focused on counselling (listening, interviewing, confronting, and structuring) with particular reference to the needs of internally displaced, women and children. Introductory training in group and family therapy was also provided.

During the training sessions that were based on the principles of brief trauma focused therapy [1] opportunities were offered for the participants to talk about and try to work through their own traumatic experiences. This part of the training was perceived by trainees to be particularly important because of the beneficial effects it had upon their own psychological condition. Also the experience of being put in the position of a client or service user added to the learning process.

The training programme provided the setting for an encounter between two cultures. West European knowledge was mixed with, translated or adapted so that it could be incorporated into the prevailing culture and language. This was largely achieved by time set aside during training for participants and trainers to exchange views

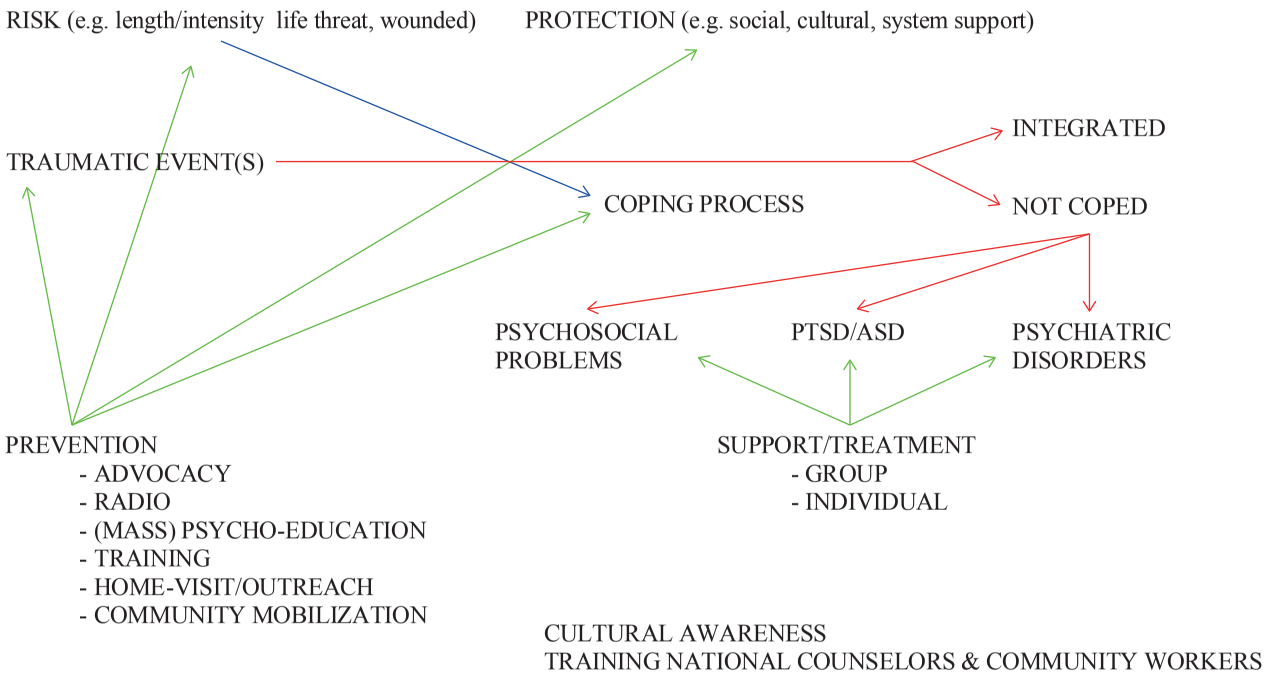

Figure 1 Overview of adaptation processes after traumatic experiences and the focus of MSF psychosocial programme activities

about and make joint decisions about culturally acceptable intervention techniques, appropriate monitoring of clients plus use of rituals that enjoyed a high level of local acceptance. Culturally appropriate psycho-education tools (brochures and posters) and methods of dissemination (mass media, groups) were also developed.

This training provided participants with sufficient knowledge and skills to start to address the psychosocial problems of their clients [11]. However the training provided by MSF in Bosnia-Herzegovina was regarded as a means to an end rather than an end in itself. All too often agencies involved in implementing early psychosocial interventions regard formal training and developing local competencies as their main objective. In the Bosnia-Herzegovina programme our experience was that by far the most important learning processes for counsellors started when they implemented the planned services. This involved exposure to experiences of working with clients presenting with real life problems and difficulties. Through training on the job, supervision and supplementary follow-up workshops on special topics like sexual violence and orphan caregivers support, the programme established opportunities for continuous learning. For expatriate staff this on-going training process helped promote a deeper understanding of local norms and attitudes as well as the nature of local, culture specific healing systems and practices.

This notion of on-going mutual exchanges of experience and learning is now incorporated in all MSF psychosocial programmes. The level and duration of training depend on the extent of existing knowledge and expertise amongst local staff, the needs of target population and the phase a crisis may have reached. For instance, in other emergency settings such as Macedonia [12] , Sierra Leone [13], Tajikistan and Lebanon crash courses were held of varying length ranging from several days to two months.

Prevention

Advocacy to reduce risk factors

Through direct contact with traumatised populations as well as observations and experiences of expatriates it was possible for staff in Bosnia-Herzegovina to speak out publicly about the abuse suffered by their clients. Such reporting of human rights violations serves to support international efforts to bring perpetrators to justice and to record a history of events. It also allows for the objective recognition of collective trauma. However, advocacy should not be confused with counselling since the specific information obtained through this form of service provision must be kept confidential and should therefore not be used for advocacy.

Advocacy is not restricted to human rights abuses only. In the Sierra Leone emergency programme staff contributed more directly to the reduction of human suffering through advocacy for basic resources required for making food, clean water and shelter. In Sri Lanka it was possible to prevent further traumatisation through advocacy for rights of minority groups.

Mass psycho-education in support of the normal coping process

The process of adjusting to major trauma is invariably difficult. It is however what most people do, and have to do after such events. They suffer from various symptoms, feel ill or may be extremely distressed. In Bosnia-Herzegovina psycho-education was used to explain the origins of symptoms being experienced, the normality of these reactions, self-help measures that might reduce their impact, how to help others and where to go when additional support was needed.

To increase the effect of psycho-education several means of disseminating the essential messages were used. Through a weekly, live phone in radio programme awareness was raised in the general public. The stigma of weakness, the acknowledgement of suffering and the shame that so often surrounds traumatised people became a collective experience. Greater closeness with those who needed support and help was established through a tailor-made approach for neighbourhoods and vulnerable groups. Counsellors raised awareness and educated people in factories, homes for the elderly, orphanages, community centres etc. Their presence stimulated self-help mechanisms and modelled a caring attitude in the community.

Lastly, primary health care workers and staff in the emergency health services received special training in how to give psycho-education to their patients and identify those experiencing major violence related problems.

Increasing protective factors through community mobilisation

Restoring social networks and stimulating social support [14] [15] can facilitate coping with and adjusting to trauma. The extent of social support correlates negatively with symptoms of illness [16] and even with mortality [17].

During emergencies disruptions occur in protective mechanisms usually provided by families, the community, familiar environments and rituals. The sense of a previously existing social cohesion may be lost. However, the resilience of people even under the horrendous conditions caused by war should not be overlooked. The personal strengths and social resources of a local population must be recognised and developed further in psychosocial programmes.

In Bosnia-Herzegovina outreach activities were organised to identify and support those who had withdrawn from social life or had isolated themselves. Activities included monitoring the status of vulnerable individuals and groups such as refugees, women, children, and the elderly. Whenever possible the individuals concerned were linked to care givers in their environment. Self help initiatives for groups or individuals within the community were given direct support. Counsellors established strong links with local organisations that sought to foster new levels of social activities for orphans, the resumption of local arts and crafts and community theatre groups. This public mobilisation was structured through the establishment of regular meetings with local authorities, organisations and non-governmental organisations (NGOs).

In other MSF early intervention programmes implemented in Indonesia and Sierra Leone cultural repair and restoration of community systems were facilitated through involvement of individuals recognised to hold particularly important cultural positions. For instance, traditional healers and religious leaders acted as advisors or implementing partners in the programmes.

A guiding principle of these low profile inputs is to foster a measure of community mobilisation without being seen to take local control. The natural protective and healing capacities available within communities are stimulated and learned helplessness is minimised. Furthermore, the focus on communities rather than specific target populations prevents the marginalization and stigmatisation of survivors of violence.

Support or treatment?

Clients identified as being in need of special support either presented themselves directly to the established counselling centres in Bosnia-Herzegovina or were referred there by local health workers. After having their need assessed by means of interview and questionnaires clients received assistance through a local counsellor. They sought to apply the specific interventions and counselling techniques learned and developed during the training programme described above. To a large group of those who sought help were given the opportunity to discuss their problems and advice was given as to what might be helpful under prevailing circumstances. To support self help mechanisms they also received psycho-education as well as instruction in various skills that promote problem solving or improve conflict management.

To help traumatised survivors of violence the Bosnia-Herzegovina programme, as well as other MSF psychosocial projects, draw extensively on principles derived from brief trauma focused therapy [1] [18]. Its core components comprise the following. First, the process of regaining control is stimulated through providing psycho-education. Existing, positive coping mechanisms are reinforced and new self-help techniques are taught. A second important component of this assistance is to focus on confrontation with traumatic experiences and related losses. Counsellors listen to the story told by their clients and structure their content. Depending on the client and the narrative recited attempts are made to link event to experienced emotions [19]. A last element of the psychosocial care is the restoration of bonds between survivors and the communities to which they belong. In this way families or community systems become involved in healing processes. Clients are also asked to reengage with their communities by taking up social activities. Advice is given on how to deal with daily problems and where to go for specific social support. These elements were an integral part of the psychosocial project in Bosnia-Herzegovina [11].

When implementing this part of MSF programmes group interventions are, whenever appropriate, preferred because of the secondary benefits that derive directly from sharing and providing mutual support [20]. Despite this preference

individual support is also made available. Treatment provision for traumatised people is usually time limited to approximately 10-15 sessions [21]. By keeping the period of treatment short it is possible for staff to help a greater number of traumatised clients. Offering long-term treatment would have reduced the overall number of beneficiaries. Moreover, it has been found that brief therapy focusing specifically on trauma-related reactions, including PTSD can make a clinically significant impact [21]. Prescription of psychotropic drugs was kept to a minimum and was only undertaken by professional medical staff. Psychiatric cases or those requiring more intensive, specialist services were referred on as appropriate.

National and expatriate mental health professionals supervised counselling support provided for clients. In the Bosnia-Herzegovina project individual case supervision was provided on request. Arrangements were in place for weekly sessions in which the counsellors discussed case management of difficult clients in small groups. During these group discussions facilitators would include elements of counsellors' own emotions. This proved an opportunity to vent frustrations felt in conjunction with their work.

Daily confrontations with the stories of their clients and the exposure to intense human misery placed our staff at risk of secondary traumatisation. A 'Helping the Helpers' service was therefore organised through a national expert who provided individual counselling support to our staff. This level of provision is now mandatory in all MSF psychosocial programmes. Where there are no national experts available to provide help expatriates provide this early intervention service for staff.

Program evaluation and audit

The systematic monitoring of programme activities and the benefits accruing for clients receiving assistance are important elements of MSF early psychosocial interventions. For instance, as part of its provision in Bosnia-Herzegovina, MSF and Utrecht University in The Netherlands developed a comprehensive monitoring system [22].

Perspectives

Mental health and psychosocial problems have until recently been largely neglected in international humanitarian assistance. It is therefore regrettable that the boom in provision of such programmes has often resulted in exaggerated expectations on the part of the beneficiaries, overoptimistic claims made about their likely impact and subsequent criticisms of poorly formulated or ill advised service delivery [23].

The years ahead are therefore going to be particularly important for the development of programmes of early psychosocial intervention. Acquired knowledge

and accumulated experience needs to be expanded and shared. There are also fundamental issues that need to be addressed through systematic research. In particular these include cross-cultural assessments of psychosocial problems and needs, cross-cultural validation of PTSD and other stress related concepts, cross cultural assessments of the relevance of assistance to be offered, appropriate early intervention programmes and program evaluation. Operational issues such as the basic principles that should inform planning and delivery of early intervention, setting programme objectives and deciding on what constitutes appropriate programme activities warrant more detailed discussion. In this respect a promising initiative is the formulation of draft guidelines for psychosocial programmes [24].

The chief lessons learned over the past ten years are that fine tuning interventions to the cultural settings and specific community contexts in which they are to be provided is vital for their acceptance and uptake of services. Knowledge about processes and practicalities of bridging cross-cultural differences and how to adapt services to local needs are limited and rarely applied with due consideration. To overcome this problem it is strongly recommended that both NGOs and expatriates adopt a more listening attitude and a more modest disposition in which helping takes precedence over healing. MSF has found that over time the content and methodology of our training and support has undergone marked changes. Our initial interventions in non-western settings such as Lebanon, Sierra Leone, Indonesia, Colombia and Tajikistan taught us to balance our western MSF perspectives with the explanatory models and language used by beneficiaries. It is our experience that national staff are well able to act as cross-cultural translators and negotiators when given the opportunity to do so.

Furthermore, MSF has found that training of national staff cannot be achieved by single 'one off' training programmes. Regular and systematised coaching on the job and case supervision should complement formal training. These are regarded as essential to ensuring that learning becomes a continuous process for all involved. It also goes some way towards guaranteeing the quality of services provided. This support should be available and accessible every day. To implement early intervention programmes for refugees and populations affected by war usually requires a longer term commitment to local involvement, and consistency in provision.

Another important finding relates to the balance between psychological and social aspects of assistance. Too much emphasis on clinical services may have resulted in stigmatisation and in underused services. If local populations are not informed of what services are setting out to do in their communities their expectations may be unrealistic. Conversely, an exaggerated emphasis on the social and awareness components of psychosocial programmes can result in ever increasing demands for more in-depth support, counselling and therapy that are not available. It is our experience that the balance between the 'psycho' and 'social' needs and

provision is subject to cultural variations and fluctuate according to contextual factors. In spite of the lack of information regarding psychosocial programmes the experience of MSF strongly supports the notion that early psychosocial programmes are commendable. During emergencies the shattered emotional worlds, the broken trust and the eroded belief in the benevolence of human beings need to be addressed. Early support of coping and adaptation processes plus the prompt provision of practical help and the immediate facilitation and restoration of a sense of community carries the implicit and crucial message that someone cares.

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7

Background to the civil war in Sierra Leone
(December 1999)

Sierra Leone has been the scene of intense conflict since the start of the 1990s. In May 1997, military officers of the self-proclaimed Armed Forces Revolutionary Council (AFRC) and the insurgent Revolutionary United Front (RUF) overthrew the democratically elected government of President Kabbah. In 1998, the West African peacekeeping force ECOMOG ousted the combined AFRC/RUF forces, whose remaining fighters fled to the countryside. The president was reinstated in office in March 1998. In December 1998 the launch of a massive offensive by the combined AFRC/RUF forces brought the fighting into the capital, Freetown.

The fighting in Freetown in January 1999 was an intense, violent repetition of the brutality that has become common in Sierra Leone. The rebel forces attacked the civilian population indiscriminately, committing thousands of executions, abductions, and rapes. Arson and looting were widespread. ECOMOG forces were implicated in the summary execution of hundreds of suspected RUF fighters. Altogether, around 6000 people died in Freetown over a 3-week period and around 150,000 were displaced from their homes. When they were forced to retreat, the rebels cruelly amputated arms, legs and ears of civilians in their custody.

In Mid-1999 the various parties signed a Peace Accord in Lome. Since then, armed clashes have been sporadic, travel through most of the country is now possible and Freetown is being rebuilt.

In Freetown, Médecins Sans Frontières provides surgical care in the main hospital and supports two other hospitals and a range of clinics in camps for the displaced; psychosocial counsellors work with war trauma victims.

Background to the civil war in Northern Uganda
(Lira 2004)

Since 1986, violent conflict has gripped the region of northern Uganda. During nearly two decades of conflict between the Lord's Resistance Army (LRA) and the Uganda Peoples' Defence Force (UPDF), severe human-rights violations by both state and non-state perpetrators included the abduction of more than 10,000 children, indiscriminate attacks against civilians, and rape. As a result of the violence, more than half the population were living in internally displaced peoples (IDP) camps.
In 2004 the LRA attacked Barlonyo camp in Lira killing more than 300 civilians. Many people ran to their grass huts as the insurgents surrounded the camp, and were burned as the insurgents torched their makeshift houses. Fifty-six people were taken to the hospital with burns, shrapnel and gunshot wounds. The mental health officer executing a needs assessment in the camps provided immediate psychosocial support to most victims.

The aftermath of this particularly gruesome event triggered a large-scale mental health program in Lira and Pader districts. A mental health survey in Pader town centre revealed that almost all respondents had been exposed to severe traumatic events since 2002: 63% reported the disappearance or abduction of a family member and 58% the death of a family member as a result of the insurgency; 79% have witnessed torture, and 40% have witnessed a killing. Another disturbing figure is that 5% of the population have been forced to physically harm another person. The survey also revealed that 62% of the women interviewed think about committing suicide. In its clinic in Pader, MSF has already treated several patients for the consequences of failed suicide attempts.

Psychosocial services were integrated into the primary health services of four camp clinics, the 350-bed therapeutic feeding centre and a supplementary feeding programme. In Pader, medical activities were extended, with psychosocial support activities in both large camps. The successful implementation and execution of the mental health activities integrated in medical activities was used to further develop the psychosocial intervention model.

Photo: Robert Knoth

Chapter 8

Emergency conflict related psychosocial interventions in Sierra Leone and Uganda

Lessons from Médecins Sans Frontières

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Abstract

Médecins Sans Frontières has been involved in emergency mental health or psychosocial programmes since 1990. In this article the intervention model developed for emergency settings is shared. Psychosocial programmes distinguish two elements. The 'psycho'-component facilitates the reconnection of the affected individual to his environment. The 'socio'-element aims to create an environment that facilitates the individual to re-integrate. The nature of mental health and psychosocial programmes requires a multidisciplinary approach. Emotional support can also be provided by regular medical staff and does not always require a specialist. The years ahead of us are important for the development of psychosocial interventions. Fundamental issues such as programme evaluation need systematic research.

Introduction

Médecins Sans Frontières (MSF) is an independent, humanitarian organization working with international and national staff in 87 countries worldwide. In its 29 years of existence MSF has developed specialist knowledge in providing health support to populations in emergency and crisis settings.

MSF has been involved in mental health interventions since 1990. The decision to intervene in the early stage of an emergency is largely based on operational observations and compassion of field workers. The usefulness of intervening in the early stages of a crisis has been documented in a number of settings [1]. This article aims to add to the knowledge base that informs provision of early psychosocial intervention programmes in emergencies involving refugees and war-affected populations with particular reference to Africa more specifically Sierra Leone and Uganda.

We outline a general framework and activities incorporated in MSF psychosocial programmes for refugees and displaced people after man-made disasters. We discuss the impact of these programmes on our work in Sierra Leone and Uganda. The article concludes with lessons learned to date.

Violence in Africa: Some examples

WHO's World report on violence and health [2] defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal development or deprivation. When using this definition of violence the number of conflicts in Africa is high. According to the IDMC report [3], there is war and/or conflict in 20 African countries. Daily violence is the reality for many Africans now or has been in the past. To give an impression of what people actually experience some findings of two MSF surveys conducted in Africa follow.

Sierra Leone suffered from a brutal internal war from 1991 until 2001. The internal strife was instigated by outside powers that had an eye on the country's rich mineral resources and led to a decade of savagery, barbarism and horror for most of its inhabitants. In addition to killings many people were displaced or became refugees in neighbouring countries. Currently, Sierra Leone is stable and peaceful. Figure 1 shows the exposure to violence of civilian respondents ($N = 245$) in a Sierra Leonean survey conducted by MSF [4].

Incidents include direct warfare: attacks on village (84%), exposed to cross-fire (84%), explosion of mines (28%), aerial bombing (83%), mortar fire (65%), burning of properties (62%) and destruction of houses (73%). In addition to the direct threats

caused by the hostilities, the lack of food and other commodities forced people to take extra risks (74%). Some people (57%) had to walk long distances to find a safer place. The risk of abduction was clearly present since 43 per cent of the respondents reported to have been abducted. Generally, half of the respondents indicated that the event had taken place more than three times in the past 10 years.

A different study into the violence in Sierra Leone particularly focused on sexual violence [5]. This survey showed some 9 per cent of the respondents and 8 per cent of female household members experienced war-related sexual assaults. Comparison to other conflict areas such as Sri Lanka (2%) and Chechnya (0%) shows this to be a rather high rate [6] [7].

It is equally dreadful to see that [5] non-war-related sexual assaults in the same context as being equally high (9%). In other areas in Africa such as South Africa, women reported even higher numbers of incidents of sexual violence: three out of 10 women surveyed in the Southern Metropolitan region of Johannesburg reported that they had been victims of sexual violence in the previous year [8].

Figures and differences on rates of sexual violence should be interpreted carefully, however. The topic is taboo and that may result in underreporting in some settings. Furthermore, we experience often that definitions of sexual violence held by those affected differ substantially.

In contrast to the Sierra Leonean conflict that was characterized by full-blown war, Uganda suffers from a low-intensity, chronic and geographically confined

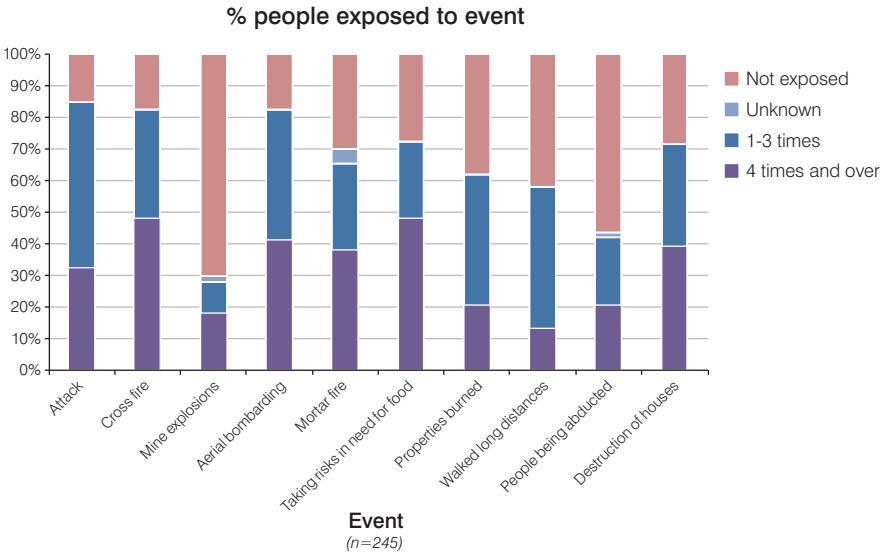

Figure 1 Exposure to violence in Sierra Leona from 1991–1999 [4]

conflict. The Lord Resistance Army (LRA) of Joseph Kono has been in conflict with the Government of Uganda for the last 30 years. The rebel group started as a resistance group and has emerged as a brutal guerrilla group with 80 per cent of fighters consisting of abducted children. They terrorize among others their own ethnic group (Acholis) by unpredictable tactics of ambushes, killings, lootings and abductions. Despite the different type of conflict exposure, violence is not very different (Figure. 2). Nearly one-third reported in an MSF study (2004) to have lost a family member (death or disappearance), others experienced violence (17%), or destruction of property (11%).

Some consequences of violence

The material consequences of violence are well known and often visible. Human loss is expressed in anonymous and depersonalized numbers. To give a human dimension

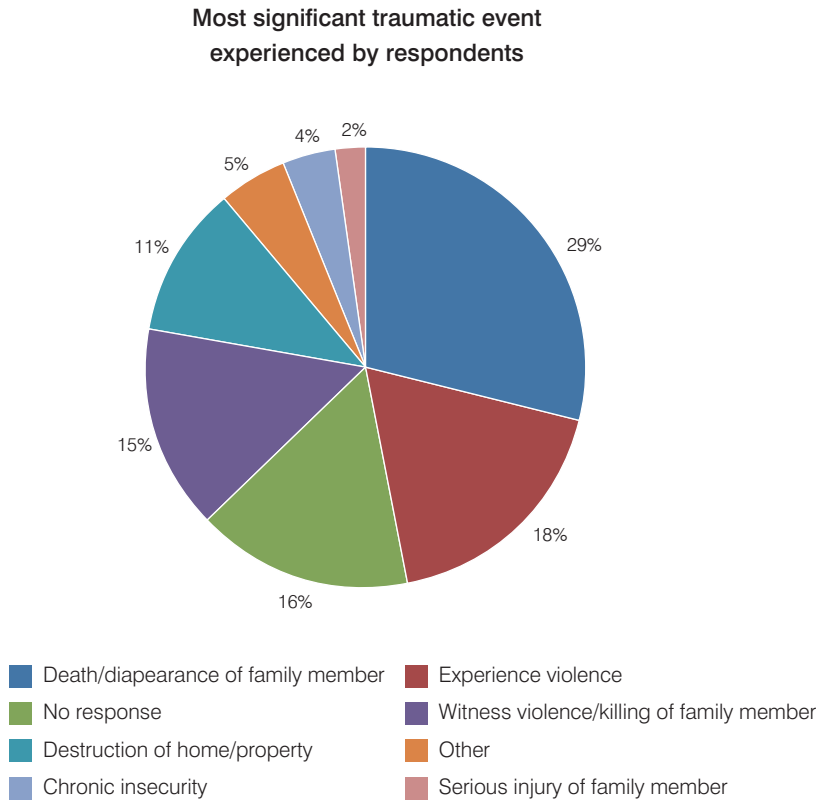

Figure 2 Exposure to violence in Lira, Kitgum Pader areas of Northern Uganda [9]

to loss, we constructed in our Sierra Leonean survey [4] an inventory of what human loss people suffered. The loss in the nuclear family (partner (5%), father (5%), mother (7%), child(ren) (9%) and siblings (16%)) was reported less than the loss of more 'distant' family members (aunt, uncles (14%)). The percentages reported on death of neighbours (53%) and friends (50%), was clearly higher as there are more of them. These data indicate that at least 50 per cent of the respondents lost someone they knew very closely. Many respondents witnessed the death of a close person: 30 per cent witnessed the death of a friend; 41 per cent the death of a neighbour. An additional 7 per cent witnessed the death of their own child.

The physical consequences of violence often receive wide coverage and attention; the mental health effects of violence less so. In our Uganda survey it was found that both men and women reported on-going symptoms of traumatic stress (see Figure 3). When asked to think of 'the most frightening event that has happened since 2002', women reported feeling the following symptoms 'a lot' of the time within seven days before the survey: irritability/anger (59.2%), experiencing reminders of the traumatic event (47.4%), waves of strong feeling (35.5%), dreaming about the event (34.2) and physical reactions, like shaking/sweating (32.9%). Men reported feeling the following symptoms 'a lot' of the time within seven days of the survey: reminders of the traumatic event (56.3%), irritability/anger (53.1%). The following symptoms were reported 'moderately': trouble concentrating (38.5%), trouble falling asleep (38.5%), intrusive thoughts (37.5%) and recurring mental images (32.3%).

Interventions

The guiding framework for MSF's intervention

Psychological health rests on a continuum of psychological well-being. Partly depending on the cultural ideas of a community, an individual's psychological state can be defined as normal and healthy, or as abnormal and mentally ill. Between these two 'extremes' is a large middle category of psychosocial problems (see Figure 3).

The answer to the question: 'What focus is appropriate for a mental health or psychosocial intervention?' depends on the type of emergency situation at hand. All medical interventions need to have psychological and social components. However, in *acute emergencies* such as Sierra Leone health projects focus on those mental disturbances that cause immediate danger to physical survival. Meanwhile, in *chronic crises* such as Uganda, they generally focus less on mental disturbances and more on psychosocial problems that hamper people's process of coping with the extreme stress. The interdependency between the individual and his environment is an important element of the coping process. Programmes that address the psychological consequences of violence have to pay attention to this specific relationship. In psychosocial projects a joint approach of both individual care and community support is vital. The 'psycho' and 'social' elements should be complementary in

order to ensure that individual and environmental healing capacities are mobilized [10] [11].

The process of coping and adaptation starts at the onset of an emergency. Therefore, mental health disturbances and psychosocial problems need to be addressed from the beginning of an emergency. Provided they are implemented in an appropriate way, research increasingly confirms the importance of early intervention [12][13] [14] [12].

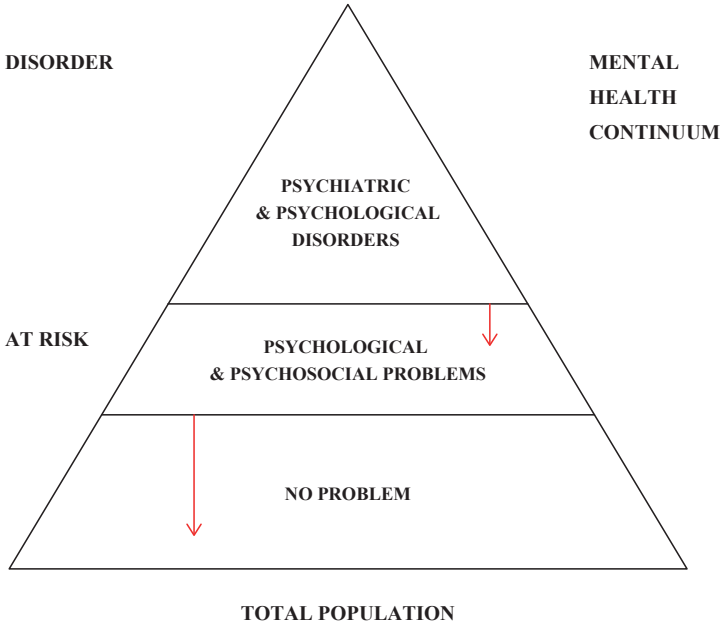

Figure 3 Mental health continuum (Arrows indicate changes caused by mass violence)

Objectives of MSF's intervention projects

Mental health or psychosocial projects?

Depending on the definition of mental health one can distinguish between mental health or psychosocial projects. If mental health is regarded as a continuum that includes psychiatric disorders, psychosocial and psychological problems as well as people considered to be non-symptomatic a differentiation between mental health and psychosocial projects is not necessary (see Figure 3). If mental health is defined as only dealing with the top of the public health pyramid then it makes sense to define mental health and psychosocial projects differently.

Mental health projects

Mental health interventions are aimed at reducing suffering caused by mental disturbances. Especially in the first stage of an emergency, drug therapy and (secondary) psychosocial support are combined.

Psychosocial projects

Psychosocial projects interventions aim to reduce the psychological consequences of mass violence. To achieve this, two elements are distinguished. The 'psycho'-component provides support on the individual level. It facilitates the reconnection of the affected individual to his environment, his community and his culture (Herman, 1992). The 'socio'-element aims to create an environment that facilitates the individual, or rather groups of affected individuals, to re-integrate.

Both elements need to be addressed in any psychosocial project. The importance of and the balance between both elements (the 'psycho' and 'socio') in the project implementation depends on cultural, environmental circumstances, phase of emergency, etc. [10].

Package of psychosocial activities

'Psycho'logical package

The psychological element of the project is delivered as a package (see Figure 4). *All* components of this 'psycho'logical package must be in place, either in the form of direct services or of a referral, to ensure a comprehensive programme. The 'psycho'-logical package includes the following components.

Psychiatric support

In acute emergencies expatriate and national specialists give (temporary) psychiatric support to beneficiaries. To avoid dependency on external specialists in chronic crises, psychiatric support is usually provided through referral of the clients to existing medical or psychiatric services.

In Sierra Leone even the most basic psychiatric services were absent [15]. With one psychiatrist in the country and one institution that was hardly staffed MSF doctors provided basic psychiatric treatment in the MSF-run primary health care settings in addition to the basic technical support that was given to the institution. The integration of mental health support in the MSF primary health care clinics increased accessibility of the psychosocial support in the places where we worked. The doctors referred patients and clients that increased the credibility of the psychosocial services. The effectiveness of our primary health care services as a whole increased because medical staff could focus their activities on the physically and mentally ill. Similarly, the quality augmented because psychosocial cases or people suffering from somatization could be referred to counselling services. The integration of both physical and mental

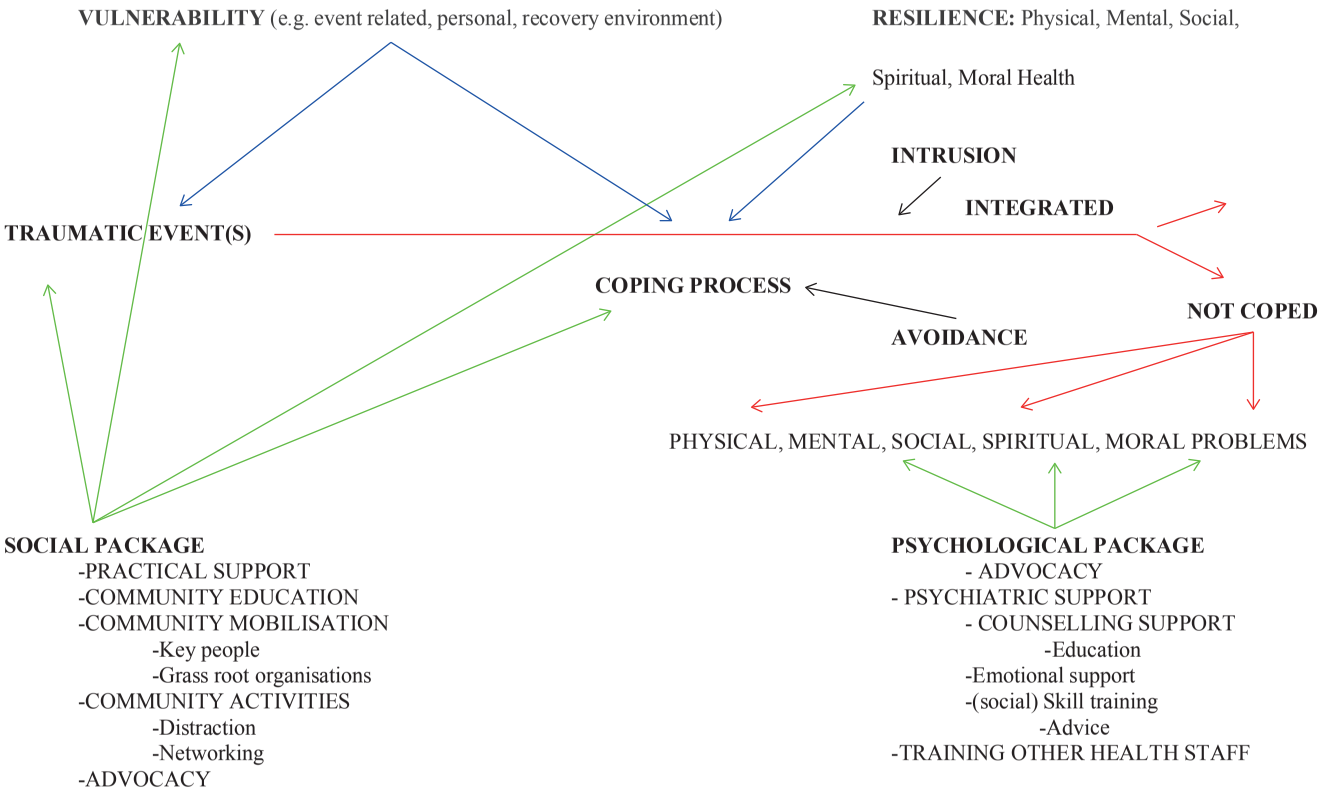

Figure 4 Intervention model for psychosocial projects to address the psychological consequences of violence through individual and community interventions [11]

health messages in the communities led to a better understanding of health and the relationship between physical and mental aspects in the community.

Supportive counselling

Counselling is offered as systematic support to individuals and small groups. The counselling interventions are based on cognitive behaviour techniques and brief therapy principles that are translated to the existing cultural environment. The counselling does not aim primarily to heal or to cure people of their psychosocial problems. In situations of acute or on-going humanitarian crisis and exposure to traumatic events, healing or curing is not realistic. The role of the counsellor is to support and improve the coping mechanisms of beneficiaries. Supportive counselling provides people with some emotional support, and practical advice.

In both our Uganda and Sierra Leone programmes people often turned to the counsellors because of lack of food or other necessities. Though referral to social services or other NGOs was done clients were also counselled on their problem-solving skills. Counselling should not only be limited to complaint reduction it should also help people to increase their self-control through education, social skill improvement and to boost their resilience through mobilization of self-support factors (physical, mental or social). Approaches focusing only on the psychological, physical or social dimension of the client's experiences have limited value. A separation between these entities assumes, incorrectly, a separation of body and mind, or the human from the environment. This separation is part of western medical-philosophical tradition and does not necessarily hold for non-western worldviews.

The process of coping with traumatic experiences includes the capacity to give meaning to the experience. In many non-western societies meaning is given through the spiritual world. The areas of moral and spiritual health are difficult for western NGOs and psychosocial counsellors to address. In Sierra Leone MSF included creditable spiritual leaders as advisors and as referral options in its programmes. They executed cleansing rituals and ceremonies to support clients. In Uganda MSF was unable to include them in the activities as their herbal and exorcism-based practices differed too much from our own ethical principles and quality standards.

Training

Training of national staff is necessary to introduce or to increase skills and knowledge. However, the objective of the training is not to make counsellors become 'clinical psychologists' applying western techniques and therapies. The objective is to foster an attitude of non-judgemental listening. Training counsellors on how to connect to their clients requires trainers that can facilitate this process. This process starts with the exploration of what caring capacity is known and accepted locally. To experience that and how counselling works trainee-counsellors use each other. Through this

mutual counselling process a local counselling toolset is created. It is important that trainers reinforce the counselling attitude and model a listening attitude themselves from the start of the training. In the Sierra Leone programme initial training was technical and western skilled oriented. This led to confusion among counsellors. Being afraid to do things wrong counsellors became either paralysed or very technical. Because this was difficult to change MSF decide to develop a 'standard' training for national counsellors [16].

Advocacy

Proximity to beneficiaries is essential for showing empathy, solidarity and compassion. The changing environment requires on-going monitoring of needs. Human rights violations necessitate speaking out or advocating for those who cannot speak. Counsellors in MSF psychosocial programmes work in the clinic as well as in the community. The proximity of the counsellors helped MSF to identify cases of sexual violence that would otherwise have passed by unattended because of the taboo on it. MSF staff presented the matter also to local authorities who took measures based on the information.

'Social' package

The social component of a project addresses psychosocial problems at a group level. A package of activities is proposed to stimulate the re-integration of traumatized people and to facilitate the coping of large groups of people. All components of the 'social' package should be delivered, otherwise resilience or protective factors can only be partly mobilized. The 'social' package includes the following components.

Practical support

Traumatized people and populations need considerable practical, physical support to enhance their recovery environment. Medical services, water and sanitation assistance or food support are just some examples. The prevalence of needs is often overwhelming. Therefore, to ensure appropriate referrals of those in need for practical support, expatriates, national counsellors and community workers need to know what is available in the community (social map). To provide adequate support and to foster self-help mechanisms the national staff's understanding of socially and culturally appropriate methods is vital. Since not all the support can be expected from the community, close co-operation among NGOs needs to be stimulated.

Community education

Large-scale education about prevailing psychosocial problems in the community is necessary to increase self-control and self-help. Education also assists to diminish taboos about mental health and psychosocial problems. Furthermore, it increases awareness about counselling services.

Community mobilization

The social fabric of communities is often affected by mass violence. This results in a reduction of people's protective mechanisms. After mass violence the regeneration and revitalization of new or former community structures often requires facilitation from outside. Cultural leaders such as chiefs, religious leaders or the elderly must be stimulated to re-assume their roles. Grass root initiatives need assistance and stimulation. They often prove to be important mechanisms for the provision of practical support. Local cultural groups like theatre, or folk play companies are often instrumental in creating a better atmosphere.

In the camps in Northern Uganda people were without employment. The communities were shattered and the care capacity reduced. To mobilize the community MSF facilitated the establishment of a community shelter. The people built the facility themselves. The process of organizing and building led to a boost in community life. The shelter was later used for community gathering, an 'indoor' market and a variety of psychosocial and other activities.

Community activities

The atmosphere in refugee and internally displaced camps is often far from uplifting. Community activities can be used to improve the general atmosphere, to stimulate community action on general issues like hygiene promotion or to re-start community cultural customs like dancing or storytelling. Despite the serious emergency conditions MSF organized in its Sierra Leone programme football competitions to improve the community cohesion and to create a better atmosphere. These activities improved the sense of belonging. The community started to organize their distraction activities such as child dance groups and handy craft. This required extensive networking with both significant people in the community and (folk) artists to start it. After the initial push the community activities took on their own life as the community owned them.

Speaking out

Human rights are universal and must be respected. Counsellors and expatriates have the right to speak out (advocacy) against human rights abuses and to raise awareness about human rights abuses. To raise attention for the suffering in Sierra Leone and Uganda MSF published reports and articles in scientific journals (see [4] [9]. Though the effectiveness of these reports is difficult to establish the wide media attention they attracted ensured that the suffering was acknowledged.

It is difficult to measure and monitor the effectiveness of psychosocial programmes [17] [18] in emergencies due to several factors. Conventional monitoring and evaluation criteria are not applicable or valid in changing, unpredictable and unstable contexts. Field reality challenges conventional evaluation criteria such as

determinants of effectiveness. Furthermore, documentation and systematic measurement of outputs are often not possible in emergencies. Epidemiological evaluation models advocated by western psychiatry are insufficient to prove the effectiveness of humanitarian actions [19]. For example, evidence-based psychology and medicine use effectiveness or impact as justification for psychosocial interventions, but epidemiological data do not tell us anything about the fundamental motives for humanitarianism: compassion, empathy and a sense of justice. In addition to this most evidence is based on western situations and for higher technological interventions. The cultural differences in the perception of trauma, expression of suffering and the mechanisms for coping make it difficult to generalize from one context to the other [20]. Culture-specific models and instruments to evaluate that programme outputs improve resilience require extensive time and resources (i.e. a long-term investment on behalf of MSF).

In Uganda we looked into the beneficiary perspective on the effectiveness of our services [21]. Thirty former clients of the programme were interviewed on their self-reported change in the following domains: general complaints; health; daily functioning; skills; practical problems; mood; symptoms; and coping. Clients were measured on these indicators using 'increase, decrease, stay the same'-ratings.

A majority of respondents (55%) reported a complaint reduction due to counselling, 41 per cent claimed their daily functioning to have improved, 62 per cent claimed their mood improved and 65 per cent stated their coping skills increased. The general trend of all indicators showed 65 per cent of clients reporting improvement in most of the domains from the time of the counselling intervention to the period of evaluation. Approximately 20 per cent of respondents claimed to have worsened in the domains of health, daily functioning and practical problems. Neuner, Schauer, Klaschik, Karunakara and Elbert [22] found similar improvement rates (71%) after a psychological intervention among Sudanese refugees living in Uganda.

MSF is not a scientific organization and needs to focus its attention on the provision of medical emergency support to people in need. However, it can profit from the efforts of others such as Bolton [23] [24] who developed new methods of psychological and psychiatric assessment in non-western settings. The body of knowledge regarding psychological interventions in African settings is growing. For Uganda both Bolton et al. [25] and Neuner et al. [22] established promising results on psychological treatment in refugee settings. Within this context MSF can contribute to the development of creditable evidence regarding psychosocial intervention in the future.

Integration in health programmes

The nature of mental health and psychosocial care requires a multi-disciplinary approach. The evident *relationship* between *traumatic exposure* and *poor health* suggests intensifying the collaboration between primary and specialty medical care [26].

Medical professionals like community health workers, nurses and medical doctors come into regular intimate contact with the emotional and psychological worlds of their clients. The curative and palliative role of the practitioners cannot simply end with the provision of technical support. Providing emotional support is critical to a comprehensive treatment process that takes into consideration people's psychological, social, spiritual and moral functioning. It involves being compassionate about people's feelings, applying basic communication skills and sharing knowledge on, for instance, techniques for recovery from the psychological consequences of violence. Providing emotional support to a client directly benefits the healing process and does not require a specialist.

Psychosocial care components are integrated in a variety of ways in basic health care services (see Figure 5). When the provision of emotional support given by the medical staff is insufficient to meet the psychosocial needs of a client, referral to other existing psychosocial service may be necessary. Clients should only be referred to non-MSF services that have been quality-checked by the medical team. In the absence of local psychosocial support services a trained local counsellor or expatriate mental health specialist can take the case referrals.

When the psychosocial needs overwhelm the existing local or expatriate services, a *community based* psychosocial component is implemented. The component has to be integrated into existing Ministry of Health or medical services provided by an international NGO.

Psychosocial activities should also be linked to other types of medical activities like nutritional, HIV/AIDS, health education, sexual violence, reproductive health, safe motherhood and tuberculosis programme activities.

To emphasize the intense collaboration between mental and physical health in humanitarian medical interventions all project proposals have to contain physical and mental health activities. This is only realized if staff hold on to an attitude of comprehensive medical thinking (patient instead of disease oriented) and an integrated management style.

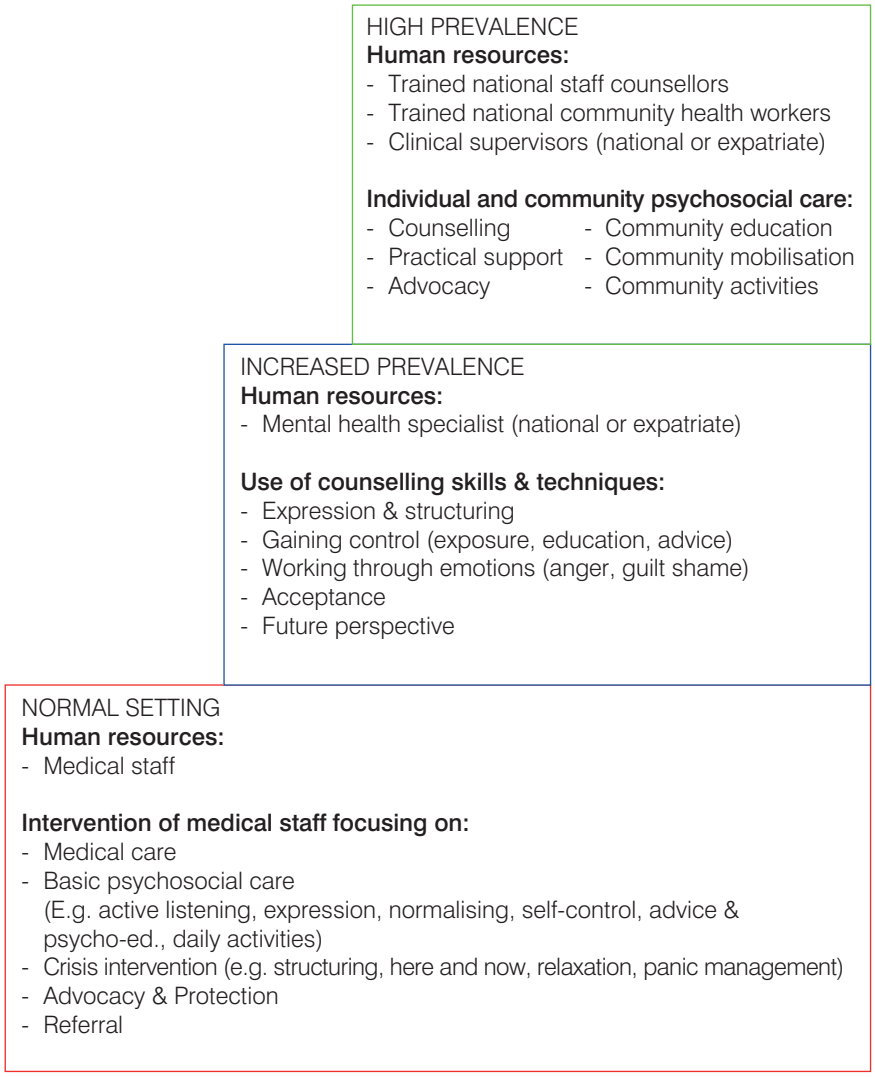

Figure 5 Building blocks: different levels of psychosocial integration in primary health

The way forward

Mental health and psychosocial problems have until recently been largely neglected in international humanitarian assistance. It is therefore regrettable that the boom in provision of such programmes has often resulted in exaggerated expectations on the part of the beneficiaries, overoptimistic claims made about their likely impact and subsequent criticisms of poorly formulated or ill-advised service delivery [27].

The years ahead are therefore going to be particularly important for the development of programmes of early psychosocial intervention. Acquired knowledge and accumulated experience needs to be expanded and shared. There are also fundamental issues that need to be addressed through systematic research. In particular these include cross-cultural assessments of psychosocial problems and needs, cross-cultural validation of Post-traumatic Stress Disorder (PTSD) and other stress-related concepts, cross-cultural assessments of the relevance of assistance to be offered, appropriate early intervention programmes and programme evaluation [28]. Operational issues such as the basic principles that should inform planning and delivery of early intervention, setting programme objectives and deciding on what constitutes appropriate programme activities warrant more detailed discussion. In this respect a promising initiative is the formulation of draft guidelines for psychosocial programmes [29] [30].

The chief lessons learned over the past 10 years are that fine-tuning interventions to the cultural settings and specific community contexts in which they are to be provided is vital for their acceptance and uptake of services. Knowledge about processes and practicalities of bridging cross-cultural differences and how to adapt services to local needs are limited and rarely applied with due consideration. To overcome this problem it is strongly recommended that both NGOs and expatriates adopt a more listening attitude and a more modest disposition in which helping takes precedence over healing. MSF has found that over time the content and methodology of our training and support has undergone marked changes. Our initial interventions in non-western settings such as Lebanon, Sierra Leone, Indonesia, Colombia and Tajikistan taught us to balance our western MSF perspectives with the explanatory models and language used by beneficiaries. It is our experience that national staff are well able to act as cross-cultural translators and negotiators when given the opportunity to do so.

Furthermore, MSF has found that training of national staff cannot be achieved through single 'one-off' training programmes. Regular and systematized coaching on the job and case supervision should complement formal training. These are regarded as essential to ensuring that learning becomes a continuous process for all involved. It also goes some way towards guaranteeing the quality of services provided. This support should be available and accessible every day. The implementation of early

intervention programmes for refugees and populations affected by war usually requires a longer-term commitment to local involvement, and consistency in provision.

Another important finding relates to the balance between psychological and social aspects of assistance. Too much emphasis on clinical services may result in stigmatization and in underused services. If local populations are not informed of what services are setting out to do in their communities their expectations may be unrealistic. Conversely, an exaggerated emphasis on the social and awareness components of psychosocial programmes can result in ever-increasing demands for more in-depth support, counselling and therapy that are not available. It is our experience that the balance between the 'psycho' and 'social' needs and provision is subject to cultural variations and fluctuates according to contextual factors.

In spite of the dearth of information regarding psychosocial programmes the experience of MSF strongly supports the notion that early psychosocial programmes are important. During emergencies the shattered emotional worlds, the broken trust and the eroded belief in the benevolence of human beings need to be addressed. Early support of coping and adaptation processes plus the prompt provision of practical help and the immediate facilitation and restoration of a sense of community carries the implicit and crucial message that someone cares.

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Section IV

Question 3

In areas of on-going conflict, how effective are interventions to address psychosocial consequences of mass violence?

Background on the Bosnian conflict
(1995)

The disintegration of Yugoslavia started slowly after the death of Marshal Tito. With the collapse of communism in 1989 this process accelerated. Nationalist feelings were fuelled by politicians for political purposes. Ethnic and religious identity re-emerged as an important political and social factor in society. In 1991 the partitioning of Slovenia and Croatia started the formal break-up of the country.

Bosnia is most characterised by a mixed population. The close living together of people of mixed ethnic and religious background is an important element in Bosnian culture. The increased nationalistic dimension in politics in Yugoslavia therefore posed a specific and essential threat to Bosnian culture and society.

Partly in response to the perceived Serb dominance in the remainder of the Federal Republic of Yugoslavia Bosnia declared its independence in 1992. Many of the Serb community did not accept independence and established their own political unit, Republica Srpska, closely linked to Serbia and Montenegro. It controlled most of North and East Bosnia.

At the outbreak of the war, Bosnians controlled most of Central Bosnia including the city of Sarajevo, while the area around the city was controlled by the Bosnian Serbs. Sarajevo was effectively under siege from April 1992 until September 1995. Access to the city was virtually impossible until the establishment of an air bridge in June 1992 and a tunnel in May 1993. In the winter of 1992/93 most of the area of the Republica Srpska was ethnically cleansed. After intense international diplomacy a general cease-fire could be reached in August 1995.

Médecins Sans Frontières (MSF) was present throughout the conflict implementing surgical programs, primary health care support, and a winterisation programme (distribution of warm clothes, fuel). MSF started its mental health in the beginning of 1994, unique in its approach and the first programme of its kind by MSF. The programme extended to Central Bosnia (Zenica, Vitez, Travnik). The mental health programme in Sarajevo was executed in co-operation with the Sarajevo Institute of Public Health for the training local mental health workers. Counsellor centres were established to provide psychosocial support to the population. End 1994, early 1995 MSF operated 6 counselling centres in besieged Sarajevo and a radio program to provide psycho-education. In 1999 a total of 10 counselling were handed over to HealthNet international. To measure the program effectiveness MSF and the University of Utrecht implemented an extensive monitoring program. In 2003 the results of intervention were published internationally.

Photo: Tom Stoddart

Chapter 9

The impact of a mental health program in Bosnia-Herzegovina: Effects on coping and general health

Trudy Mooren, Kaz de Jong, Rolf Kleber, Sheila Kulenovic, Yadranka Ruvic

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Abstract

Effects of a community based psychosocial program in Bosnia-Herzegovina during the war and immediate post-war years (1994-1999) were evaluated and described in this article. Ten centres provided various kinds of psychological help in the besieged city of Sarajevo, and the towns of Zenica, Travnik and Vitez. Since the start in 1994, an intensive monitoring system has documented data on clients, interventions and outcomes. This study focused on the impact of counselling interventions on the distress related to coping with traumatic memories and subjective health. The sample consisted of 3283 and 1785 inhabitants of Sarajevo, Zenica, Travnik and Vitez who filled out the GHQ-28 and IES respectively. Pre- and post-assessments were compared throughout subsequent years (1994-1999) and across age-groups and both sexes. Outcomes of these scales reflected very high scores, especially among people between 30 and 40 years of age. Furthermore, intake scores increased rather than decreased in time. Differences between pre- and post measurements are highly significant – throughout the years. Analyses revealed substantial proportions of clinically recovered or generally improved individual functioning, although some clients showed no improvement.

Introduction

The sequence of violent events that struck the Balkan regions of Croatia and Bosnia-Herzegovina in the years of 1991-1995 (e.g. the ethnical cleansing) and the embarrassment about the inability to stop this, prompted the international world, to act. Many mental health programs were implemented acknowledging that the majority of the civilian population were directly and severely affected by the psychological drama of the war [1] [2]. The massive presence of mental health professionals in this war had been unprecedented [3].

Generally, mental health programs aimed to improve the balance between existing psycho-social protective factors and psycho-social stress factors at different levels of intervention [4]. Many services focused on coping with traumatic war stress. The idea of counteracting the immediate psychosocial consequences of dramatic war experiences is relevant, for several reasons. First of all, the confrontation with violence, terror, humiliation and harsh living conditions (lack of food, electricity, heat, water) have for many been hard to escape. Although to some extent dependent upon the place of living, the horrifying battlefields were omnipresent and unpredictable. Moreover, the division of the Balkan population along lines of ethnic heritage, as well as the subsequent massive displacement, has disrupted communities, families and marriages [5]. Due to the war, many Bosnian and Croatian people experienced situations that could be termed extreme or traumatic. That is, experiences that were outside their control, causing great distress and acute disruption of one's life [6]. Secondly, taking the lessons of World War II seriously could prevent waiting fifty years to find out that long-term consequences may exist or will emerge. In several research reports the importance of the focal events of World War II have been emphasized in explaining the occurrence of psychosocial dysfunction (for instance, Posttraumatic Stress Disorder (PTSD [7]) decades later (e.g. [8] [5] [9]. A third and last argument for the large-scale introduction of mental health services in this region, is the local state of the mental health facilities at the outbreak of war. Ironically, the war offered the opportunity to start new psychosocial facilities in a domain dominated by a hospitalized and medicalized approach. Because the war confronted the mental health professionals with 'new', often stress-related symptoms [10] [11], a need for development of intervention methods was noted. The emigration of many colleagues in the field overburdened those who remained behind. For instance, Sarajevo University mental health clinic had to deal with 300 inpatients and 150 outpatients each day [10]. NGO's (nongovernmental organizations) were welcomed to take away some of the workload.

Any guarantee for the quality of services has been missing so far. Although satisfaction rates are generally very high [12] [13], systematic evaluations of the merits of the efforts are rare. Structured assessments of the short-term, or even better

long-term effects are warranted and wished for [14] [15]. This manuscript provides an evaluation of the short-term effects of a comprehensive psychosocial program in Bosnia-Herzegovina during 1994-1999. Pre- and post measurements using standardized instruments for individual clients are used to obtain insight in the efficacy of the facilities offered.

The psychosocial program

In 1994, a mental health program was started by Médecins Sans Frontières (MSF) in Sarajevo, Bosnia-Herzegovina. Thereafter, the program was expanded to include Central Bosnia (in the towns of Zenica, Vitez and Travnik). It was continued in 1998 under the authority of HealthNet International (HNI). The overall objective of the program was to provide support for those suffering from war-related mental health difficulties and to prevent severe psychopathology through the establishment of primary mental health services [16]. These services were implemented through the establishment of counselling centres physically close to, and as part of the existing health care system. Through the co-operation with health authorities the acceptance of the centres was promoted.

Theoretically, the program was grounded on four elements.

1. Culturally-appropriate support. In the context of a society that formerly knew pride of its tolerant and multi-ethnic character (for instance in Sarajevo) and that was subsequently torn apart by ethno-cleansing and nationalism, the program directed at encouragement of cultural self help and community-based protective mechanisms.
2. Stimulation of psychological mechanisms of coping with extreme stress. It was anticipated that a substantial proportion of the Bosnian people had been confronted with disruptive situations that outgrew their possibilities of control and certainty. Material belongings that were destroyed, the loss of friends and family and the basic beliefs in the future and in the benevolence of other people that had been shattered, were expected to cause distress, extreme tiredness, helplessness, anxiety, and loss of control and certainty. The emphasis was on two processes: (a) the recurrence of intrusive memories and (b) the tendency to avoid stimuli that trigger painful memories [17] [18]. Distress associated with coping with these memories is considered as normal reactions to abnormal circumstances.
3. Counteracting helplessness. Many Bosnian civilians were living in circumstances from which it was difficult, if not impossible, to escape. Sarajevo, for instance, was under siege for more than three years. The scars of war (ruins, graveyards) were everywhere. It was anticipated that under these conditions it could be hard to keep up hope and spirit [19].

4. The reinforcement of protective factors. The resilience of people, even in the horrendous war circumstances in a shattered and demolished country, should not be underestimated. Social networks and social support play a positive role in health and adjustment [20].

Treatment was offered, both individually and in groups. Group interactions were preferred, especially for the secondary benefits of sharing and providing mutual support [21] [22]. Treatment of people lasted approximately 10-15 sessions. The period of treatment was kept short for several reasons, among which the substantial number of people in need [23] [24], the efficacy of brief therapy focused on trauma-related disorders [25] and the professional capabilities of the staff. A central element of the counselling treatment (individual or group) was to facilitate the expression of thoughts and feelings with regard to the interruptive (war) experiences. Telling the story of the event helps victims to integrate the experience into their own life [26] [27]. This integration can be achieved by narrative approaches ('talking cure') and other forms of expression, such as drawing, play and more collective activities (ceremonies) and rituals). This disclosure has repeatedly been found to be helpful [28].

Treatment was based on principles derived from brief trauma-focused therapy [29] [30]. The basic components of treatment were: psycho-education, psychological structuring of experiences, working on control, reconnecting experiences to emotions, working on integration and future perspective, and self-help techniques. Examples of intervention techniques included: relaxation, guided meditation, guided communication, systematic desensitization, and behaviour prescription. To increase self-help and understanding and to create a safe environment for the client the social system surrounding the client (e.g. spouse, family members) was (if possible) also part of the intervention.

Lastly, psycho-education, individually or on group and community level (through the broadcast of a radio-program) was conducted in order to inform the public of the services.

The monitoring of data

In order to evaluate the effects of intervention, the mental health program in Bosnia has included a registration system. Such a case register [31] serves management as well as clinical purposes, but it is also intended to provide insight in the short-term impact of intervention. Variables related to the clients and interventions were registered. Pre-and post-tests for psychosocial functioning were taken. One of the most salient questions was for the efficacy of the mental health services. Can a program implemented already during the war render positive effects? This article describes results of these structured pre- and post-tests in a substantial proportion of all clients seen in the program in the war and post-war period (1994-1999). Three specific questions will be answered. (1) Which problems (general health issues, and

(post)trauma responses) do Bosnian war survivors suffer from?, and (2) Are there any differences between: men and women; age-groups or period of help? (3) Is there a significant improvement with regard to these problems after intervention?

Methods

The case register

Information was systematically gathered on every client that obtained professional help in one of the ten project counselling centres in Sarajevo or Central Bosnia. A client case register was implemented, with every client uniquely identified with a code. Clients were informed on the gathering of information and anonymity was guaranteed. The registration consisted of different sections, each tapping different kinds of information.

Samples

From this client register, two samples were drawn. All clients who filled out (one of) the instruments focused on coping with extreme stressful events and general health were selected. Only complete (both pre- and post assessments present) cases were included. As a result, 1783 persons (84%) provided information on distress concerning particular war events (Impact of Event Scale, IES (see below)) while 3283 (84%) persons provided information on their current subjective health (General Health Questionnaire, GHQ).

The GHQ was filled out by twice as much women (67,3%) as men (32,9%). Most of the GHQ's were collected in 1996 and 1997. Clients had an average age of 34,4 years (SD=16.4). Relatively many of them could be appointed to the age-groups of youngsters (13-18 years, 25.9%), and (young) adults (31-40 18.7%, 41-50 19.1%).

The IES also was filled out by more women than men (60.8% versus 39.2%). All ages, within the range of 10-97 were represented with an average of 36.6 (SD=15.1) years. In time, a decline was noted in the number of IES's presented to clients (in the last year 369 were gathered while in the first year of the project 688 IES's were included). Most of the clients were offered either individual or group treatment. Within the GHQ-sample, treatment in groups was most prevalent (41.0% versus 39.6% individual counselling). Among the clients with an IES, there were more who were met on an individual base (46.6% versus 38.2% in groups). Other types of intervention (such as family counselling or participation in self help groups) were enlisted by a substantial lesser proportion of these samples (Table 1).

Clients may have preliminary stopped treatment for various reasons. On the IES, completers did not differ from drop-outs in their average scores at pre-test or in age or sex. On the GHQ, however, completers were significantly younger ($t(942.0)=2.6$, $p<.001$) and had higher starting (total) scores ($t(3917)=-0.95$, $p<.01$).

Both samples selected from the case register were compared with an independent sample of 102 Bosnian citizens in a parallel study conducted in 1996. These respondents were asked to fill out a questionnaire by the counsellors of the centres. The counsellors were free to ask whoever they wanted, relatives or friends, as long as the respondents did not receive any kind of therapeutic intervention. This sample was comparable with regard to the represented sex and age of participants. We included this sample as a comparison group for the help-seeking sample.

Table 1 Demographic data in samples of ghq and ies-respondents

		GHQ-28 N=3283		IES N=1783		non-clients '96; N=102	
MSF/HNI-MH monitoring (Nov. 1994-May 1999)		**N**	**%**	**N**	**%**	**N**	**%**
Gender	Men	1069	32.9	694	38.9	40	39.2
	Women	2178	67.1	1089	61.1	62	60.8
Intake	start->95	125	3.8	688	38.6		
	1996	1158	35.3	149	8.4	102	100.0
	1997	1258	38.3	577	32.4		
	1998-spring >99	741	22.6	369	20.7		
Age	M (SD)	34.4 (16.4)		36.6 (15.1)		38.8 (12.1)	
	7-12	5	0.2	2	0.1	-	0.0
	13-18	841	25.9	297	16.7	8	7.9
	19-24	356	11.0	163	9.1	8	7.9
	25-30	236	7.3	171	9.6	4	4.0
	31-40	608	18.7	432	24.2	31	30.7
	41-50	620	19.1	392	22.0	36	35.6
	51-60	317	9.8	184	10.3	11	10.9
	61 and older	266	8.2	142	8.0	3	3.0
Treatment	Individual	1300	39.6	830	46.6		
	Group	1345	41.0	681	38.2		
	Other (e.g. family counselling or participation in a self-help group)	638	19.4	272	15.3		

Measures

Coping with traumatic events.

To study intrusion and avoidance we used the Impact of Event Scale (IES) [32]. It consists of fifteen items with four answering categories, ranging from 'not at all' to 'often', reflecting the occurrence of reactions during the past seven days. Each item is weighted and sub-scores consist of the total of the values. The total score is obtained by summing both sub-scores. A description of the experienced event on which the fifteen statements are based is requested. The Impact of Event Scale is internationally tested and used very frequently. Its psychometric qualities have been affirmed consistently [33]. Although cut-off scores for the IES have limited value due to the differences in intensity of traumatic stressors, in time elapsed since the event, and in cultural contexts, cut-off scores of 26 and 35 have been mentioned [34] [35]. Clients were requested to fill out one or more events that were specifically stressful to them. The second occasion items were presented referring to these same events. The responses varied by the nature of events experienced (e.g., death of a relative or friend, bombardments and shootings, loss of property, injury and illness, separation) and the number of events listed.

General health.

The General Health Questionnaire, developed by Goldberg and Hillier [36], is an internationally widely used questionnaire to assess general health. Four clusters of complaints have been found: (a) somatic (b) anxiety and insomnia, (c) social and (d) depressive feeling. Each of the 28 items need to be answered by choosing one of four categories: (a) less than usual, (b) as usual, (c) more than usual and (d) much more than usual. Because 'as usual' is hard to define in times of and after war, we adapted the answering categories into 'never', 'sometimes', 'usually' and 'almost all of the time'. Koeter and Ormel [37], in line with Goldberg and Hillier [36], recommended scoring the two first categories by assigning value 0 while assigning value 1 to the last two answering categories. The GHQ- total score is obtained by summing the item scores. For sub-scales, however, it is recommended to use a Likert scoring (0-1-2-3). We could compute these differentiated scores only for a sub-sample (N=2424; 74%). In other cases, 0-1 scoring had been entered in the computer. Average sub-scale scores for a Dutch normal sample have been provided by Koeter and Ormel [37].

We used principal component analysis (with varimax rotation) to test the factor-composition of the GHQ in this sample. Items were found to consistently load on the scales they were expected to (explained variance 54,1 %; 35,9% by the first component which assesses problems related to anxiety and insomnia). Using the 30-item version, Radovanovic and Eric [38] found an optimal cut-off point of 5/6 in a sample of students in Belgrade.

Translation of instruments

Both instruments were translated to the Bosnian language by a bilingual employee. A blind back-translation by Bosnian colleagues (working at another location) was used to check for accuracy, sensitivity, and validity of the translation. The focus was on maximizing the cultural relevance of the items.

Procedure

Both standardized questionnaires were filled out twice - both at the start and at the end of intervention. Usually, it was not before the second meeting when the questionnaires were presented. Explanation of services provided and establishing a relation of trust were considered of higher priority.

Statistical analysis

First, statistical analyses were directed at all sub-group differences. Sub-samples were created, differentiating among ages, sexes and subsequent periods of receiving help. These sub-groups differences were tested using t-tests for independent samples (when looking at sexes) and one-way analyses of variance (ANOVA's; when differences among age-groups and periods were considered). Pre-test scores were included as a covariate when the differences between pre and post assessments were examined. Secondly, for the assessment of the differences between post- and pre-tests, the proportions of clients that were significantly improved at the end of treatment were computed [39]. The association of the effect of treatment with the independent variables such as kind of treatment, sex, age and period of intake, were tested using contingency tables and loglinear models. The statistical package SPSS for Windows 9.0 was used for the analyses (SPSS Inc., 1998).

Definition of effect: A question of criteria

The question with regard to the significant improvement warrants elaboration. Several methods have been suggested to evaluate therapeutic outcome when pre- and post-tests on key variables are available. Traditionally, the efficacy of a treatment mode has been evaluated by statistical analyses involving comparisons of group means. However, group means represent averages that tell little about the variability of individual outcomes within a sample [40] [41] [39]. Furthermore, if sample sizes are large, significant differences may be found in cases where the actual change is relatively small, producing results that are statistically significant but not clinically meaningful. Among the alternatives suggested (e.g. the computation of effect sizes), the method introduced by Jacobson and colleagues is considered most useful [42]. According to this method a difference between pre- and post measurement is clinically significant when a client at pre-test belonging to a disordered group has moved to the group (distribution) of normals by means of the intervention. Ideally,

norms are available to define a cut-off score. When norms are absent, the researcher sets cut-off scores at either 2 SD's below the disordered average or 2 SD's above the normal mean. Next to this clinically significant criterion, it is argued that the amount of change should be of sufficient magnitude and exceeding the margin of measurement error. This can be determined by the Reliable Change Index (RCI). The formula involved dividing the magnitude of change by the standard error of the difference score (see formula).

$$RC = \frac{X_1 - X_2}{S_{diff}}$$

$$S_{diff} = \sqrt{2(Se)2}$$

$$Se = S_1\sqrt{1 - r_{xx}}$$

Results

Coping with experiences

The average scores on the IES of the client population at the start of counselling were very high for all age-groups and in all subsequent years (Table 2). The total IES-scores varied between 43 and 50 across years. These outcomes are quite similar to the scores of Dutch outpatients suffering from severe PTSD [43]. Even though the average total score of the sample of non-help seeking civilians (N=102) is substantially lower (M=36.9, SD=16.3) than of the clients of the mental health program, still a very high level of distress is reflected. Throughout the years, average intake scores of clients for both avoidant and intrusive tendencies increase. Average scores for intrusion and avoidance (and total scores) have decreased significantly by the end of intervention, $t_{intrusion}(1782)=47.31$, $p<.001$; $t_{avoidance}(1782)=39.75$, $p<.001$. They fall below the average scores of the sample of non help-seeking Bosnian civilians. Nevertheless, average total IES-scores are in the range of 25 to 32 and, therefore, still high.

Subjective health state

The total score on the GHQ fluctuated throughout the years, $F(3, 3278)=42.24$, $p<.001$, with a rise in the last period of 1998-1999. Average scores were high in all years. Sub-scales (scored with 0-1-2-3 weights; $n=2424$) revealed an increase throughout the years (Table 2). Compared to the non help-seeking sample, there was a marked difference on total score and on the sub-scales of somatic complaints and depressive feeling. The sample that had not consulted a mental health professional,

Table 2 Average (SD) outcomes for pre- and post measurement in subsequent years (GHQ: N=3283; IES: N=1783) and compared with a control-group (N=102)

(Sub-) scale	start-1995 M (SD)	1996 M (SD)	1997 M (SD)	1998-1999 M (SD)	Total M (SD)	Non-clients ('96) M (SD)
M1 Somatic complaints*	7.0 (8.0)	8.6 (4.9)	9.6 (4.2)	11.1 (3.6)	9.9 (4.3)	7.7 (3.7)
M1 Anxiety & insomnia	6.6 (6.8)	9.2 (5.5)	10.0 (4.6)	11.5 (3.7)	10.3 (4.7)	10.4 (1.8)
M1 Social dysfunction	5.7 (5.5)	9.0 (4.3)	10.5 (3.9)	11.9 (3.7)	10.6 (4.0)	11.1 (2.0)
M1 Depressive feeling	5.0 (6.4)	5.9 (5.1)	5.9 (4.8)	6.9 (4.5)	6.2 (4.8)	4.5 (2.5)
M1 Total GHQ	12.6 (7.7)	10.8 (7.2)	11.9 (7.0)	14.4 (6.2)	12.1 (7.0)	8.7 (3.9)
M2 Somatic complaints	8.2 (5.5)	6.5 (3.8)	6.6 (3.3)	8.1 (2.8)	7.0 (3.4)	
M2 Anxiety & insomnia	10.8 (6.5)	6.2 (4.1)	6.3 (3.5)	7.8 (3.0)	6.8 (3.6)	
M2 Social dysfunction	8.5 (3.8)	7.0 (3.1)	8.0 (3.5)	9.4 (3.3)	8.2 (3.5)	
M2 Depressive feeling	6.8 (6.0)	3.7 (4.0)	3.3 (3.4)	4.4 (3.4)	3.7 (3.5)	
M2 Total GHQ	5.3 (5.6)	4.8 (4.9)	5.4 (4.7)	7.1 (4.8)	5.6 (4.9)	
M1 Intrusion	21.9 (8.0)	21.3 (8.4)	22.9 (7.9)	24.7 (7.2)	22.7 (7.9)	19.2 (9.2)
M1 Avoidance	22.1 (8.2)	22.5 (8.7)	24.1 (7.9)	25.3 (7.5)	23.4 (8.1)	17.7 (9.9)
M1 Total IES	44.0 (13.4)	43.7 (14.2)	46.9 (13.6)	49.9 (12.5)	46.2 (13.6)	36.9 (16.3)
M2 Intrusion	15.2 (7.6)	11.6 (8.3)	12.1 (7.4)	14.9 (6.2)	13.9 (7.5)	
M2 Avoidance	16.5 (8.2)	14.7 (9.0)	13.4 (7.5)	15.9 (6.4)	15.2 (7.8)	
M2 Total IES	31.7 (13.8)	26.3 (15.6)	25.6 (13.5)	30.9 (11.2)	29.1 (13.6)	

** The average outcomes of the GHQ sub-scales were computed for the cases for which Likert-scoring (0-1-2-3) was available; this concerns a sub-sample (N=2424) of all clients in the register with GHQ's.*

scored lower ($\underline{M}_{somatic}$=7.7, $\underline{SD}$=3.7; $\underline{M}_{depressive}$=4.5, $\underline{SD}$=2.5 versus $\underline{M}_{somatic}$ =9.9, $\underline{SD}$=4.3; $\underline{M}_{depressive}$ =6.2, $\underline{SD}$=4.8 in the MH-clients respectively). For the outcomes of the sub-scales of anxiety and insomnia, scores are quite similar for this sample compared to the sample of mental health clients.

The total score on the GHQ showed a significant decrease (by 6,5 points) at the end of intervention, $t(3282)=-60.01$; $p<.001$. The scores on all four sub-scales of the GHQ revealed a clear decrease between first and second measurement. Somatic problems, symptoms associated with anxiety and insomnia, social dysfunction and depressive feeling were reduced at the end of intervention.

Differences between men and women

Men had higher average scores (indicating more problems) on all GHQ sub-scales both at first and second measurement. The difference was significant only for one sub-scale of the GHQ at T1 (depressive feelings; $t(1462.8)=2.65$, $p<.01$) and for two sub-scales at T2 (anxiety and insomnia and depressive feelings)(anxiety and insomnia: $t(2384)=3.41$, $p<.01$; social dysfunction: $t(2384)=1.91$, $p<.01$). This is in contrast to the general finding that women report more health complaints. Although no significant differences between men and women were found on the IES, men tended to have higher scores on this instrument as well. Intrusion and total scores at post-test showed a tendency towards significance, $t_{intrusion}(1781)=1.99$, $p=.05$; $t_{total}(1781)=2.0$, $p=.05$.

Differences among age-groups

Age groups differed on their IES total score, most significantly at first measurement, $F(7, 1775)=12.06$, $p<.001$. The group with age 13-18 could be distinguished by a relatively low total score on all sub-scales. Significant high average scores were found in the oldest group.

The GHQ reflected a significant difference between the several age-groups, both at the start and the end. The differences were strongest at the first assessment, however. The youngest clients who filled out the GHQ (13-18 years) had a relatively low total score ($M=9,2$; $SD=6,1$). The older the clients, the higher the scores. This was the case for all GHQ sub-scales, both at the start and the end of intervention.

Outcomes throughout the years 1994-1999

Significant differences were found between mean IES scale outcomes in time, $F(3, 1979)=18.0$, $p<.001$. The scores increased with every year indicating more coping problems. Using Scheffé criterion, the fourth period (1998-1999) could be distinguished as having significantly higher average scores for both intrusion and total IES. Avoidance tendencies are significantly higher in the later years (1997-1999) and relatively low during 1995 and 1996.

On the GHQ, similar results were found. Sub-scale scores increased throughout the years. Total GHQ outcome showed this increase as well with an exception for the first period (1994-1995) – in this year relatively high scores were obtained.

The impact of intervention

To get a tentative idea of the short-term impact of intervention for the whole group of clients, first of all, ANCOVA's were performed, directed at testing the contribution of factors in explaining the variation in pre- and post test differences while controlling for the pre-test symptom level. These tests revealed a significant contribution of the period of intake to the explanation of the variation within all sub-scales and of total outcomes of both IES and GHQ. Scores increased throughout time. The gender of clients exerted no influence on the explanation of variation among outcomes on (sub-) scales, except for two GHQ-sub-scales: anxiety & insomnia and depressive feeling. On these scales men obtained higher scores than women. Furthermore, age contributed clearly to the explanation of variance of all GHQ-sub-scales, and did not have an impact on the IES-outcomes. Lastly, the effect of including type of intervention (individual or group) was examined. This variable did not exert substantial influence on either of the GHQ sub-scales, though it offered significant contribution to the models of the IES-scale.

Because with these methods, information was obtained about the sample as a whole, but not about the number of people in fact supported by the program, differences between pre- and post measurements on all scales were disentangled by testing them against several criteria. Tables 3 and 4 presented the proportion of clients in the program that were clinically recovered, had improved functioning or were not improved at the end of intervention. Cut-off scores of 5 (Table 3) were used for the GHQ-total score, while for the IES scores of 25 and below indicated improvement. Except for passing the cut-off score, clients also had to have shown a reliable decrease in score, that is beyond the risk of measurement error, in order to be recovered. According to these criteria, 12.8% had clinically recovered from symptoms on the GHQ, 15.5% had recovered on the IES.

Clients who did not fulfil the criterion of a reliable change (index <1.96), but nevertheless did trespass the cut-off score, were considered improved (but not recovered). Based on the total outcomes, 54.5% of the clients who filled out the GHQ and 23.1% of the clients with an IES were improved at the end of treatment. Taken together, the majority of clients was improved based on the GHQ (67.3%) while on the IES, 38.6% was improved (or recovered) at second assessment. 32.7% of GHQ's and 61.4% of the IES's showed no improvement during course of intervention. A small proportion of clients had deteriorated (negative RCI; 8.7% GHQ, 9.7% IES).

In Table 4 the outcomes for the different sub-scales were given. For the GHQ domains of somatic complaints, anxiety and insomnia, social dysfunction and depressive feeling average outcomes of a (Dutch) normal sample are available – though based on a Likert scoring. Besides using these outcomes for the determination of cut-off scores ($(M_1 + M_2)/2$), the outcomes in the study among non-help seeking Bosnian civilians (N=102) were used as a baseline assessment. For the IES

Table 3 Proportion of clients clinically recovered, improved and not improved at the end of treatment (N_{GHQ}=3283; N_{IES}=1785)

	Total GHQ %	Total IES %
Recovered	12.8	15.5
Improved	54.5	23.1
Not improved	32.7	61.4

sub-scales of intrusion and avoidance, no normative scores were available (for clear reasons). Intrusive and avoidance outcomes were therefore only compared with the outcomes in the non-help seeking Bosnian sample.

These analyses using different cut-off scores revealed marked differences especially with respect to the sub-scales of anxiety and insomnia and social dysfunction and to a lesser degree to depressive feeling. Obviously the base-line scores by including the Bosnian community sample, are higher than in the Dutch normative sample. Higher proportions of clients were marked improved and lower proportions seemed not to have been supported by the program when the cut-off scores obtained by Bosnian fellow-citizens, were used.

The impact of participation in the program was rather similar for intrusion and avoidance as indicated by the proportions of recovered and improved clients at the end of treatment. The intrusive tendency seemed to be somewhat more susceptible to the applied intervention techniques, since the proportions of recovered and improved clients are slightly higher than for the avoidance sub-scale. Overall, the project had a reducing effect on the distress related to coping with traumatic events as well as on the general health domains, especially when the non-help seeking community sample was taken as reference.

The effect of intervention for different sub-samples

In further analyses the effect of intervention was tested while discriminating between clients according to the type of intervention (individual or group), the age-group, sex and period of intake. We included only cases with both completed IES and GHQ (n=849). First of all, the proportions of clients in the three effect categories (recovered, improved and not improved) were almost identical to the ones obtained for the larger (and partly independent) samples (Table 3). That is, judged by the GHQ, more clients improved (52.4%), recovered (16.0%) and less failed to improve (31.6%) than based on the IES (respectively 23.6%, 16.5% and 60.0%).

Log-linear analysis of the impact of intervention by period of intake revealed no significant interaction effect for the GHQ. The best model was predicted by the main

Table 4 Proportion of clients clinically recovered, improved and not improved for the GHQ sub-scales (Likert scoring) at the end of treatment according to different GHQ-cut-off scores (n=2424) as well as the GHQ-total outcomes (N=3283) and IES(sub-) scores (N=1785)

	Cut-off based on normative studies			Cut-off according to Bosnian community sample (N=102)		
	Recovered	Improved	Not improved	Recovered	Improved	Not improved
Somatic complaints	9.7	39.4	50.9	7.0	42.0	50.9
Anxiety and insomnia	8.4	46.0	45.5	9.1	61.3	29.6
Social dysfunction	5.4	33.5	61.0	5.8	49.5	44.7
Depressive feeling	5.2	32.8	61.9	6.0	41.3	52.8
GHQ total	12.8	54.5	32.7	13.6	60.9	25.5
Intrusion	-	-	-	15.9	57.3	26.8
Avoidance	-	-	-	13.7	54.7	31.6
IES total	15.5	23.1	61.4	19.7	57.2	23.1

effects of intervention category and period independently ($\chi^2(6, n=xx)=6.70$, $p=.35$). Residuals however, were relatively large for the prediction of all categories of treatment effect in 1997. That is, a better prediction could possibly occur, after the inclusion of other variables. The best model for the explanation of the distribution among cells on the IES, did include an interaction of effect by period of intake however. In particular, the negative odds for the last period ('98-'99) to end up in the category of clinically recovered ($z=-2,8$) were large, as were the positive parameter estimates for a not-improved outcome in this period ($z=3.1$) on the IES.

A significant interaction effect was found for the relation between sex and treatment effect ($8_{improved*male}=-0.15$, $z=-3.15$). The odds for men to end up in the categories improved (but also recovered) were substantial and negative. For the IES on the contrast, no effect of intervention was dependent upon gender.

Treatment effect and type of intervention (individual, group or other) were significantly associated for the GHQ. Clients were more prone to end up in the recovered group after individual treatment ($8_{recovered*individual}=0.31$, $z=3.05$) and to a lesser extent in the category improvement ($8_{improved*individual}=-0.18$, $z=-2.62$). On the IES

however, no interaction was found. Treatment effect was best predicted based on a model with independent factors treatment effect and type of intervention.

Lastly the interaction of treatment effect with age-group was tested. Only one coefficient was found to exert significant influence on the distribution among cells. The interaction between belonging to the group of young adults (19-25 years) and treatment effect (ending up in recovered category) as measured by the GHQ was significant ($8_{recovered*19\text{-}25}=0.51$, $\underline{z}=2.77$). Overall the best estimation of the model was obtained by including just both main effects. This accounted for both the GHQ and IES.

Discussion

This study described an analysis of data that were gathered as part of a comprehensive mental health program implemented during the war in Bosnia-Herzegovina and continued for at least five years. The study focused on indices of subjective mental health and coping with extreme stress. With this emphasis it has reflected on only a part of the psychosocial program. The program aimed to facilitate and support strategies to cope with the sequence of both drastic events as well as of daily hassles and difficult living circumstances in a war-stricken country. In doing so, the attempt was to counteract early symptoms of mental dysfunction and to prevent the development of severe disorders. Clearly it has been the aim to implement services that were community-based with a low threshold for access. The current study focused on the effects of counselling on individual mental health and coping, in terms of the cognitive processing of intrusive and avoidant stimuli related to painful (war-related) experiences. As was expressed by Somasundaram et al.[44] the underlying assumption was that when people are able to assign meaning to what happened, they are better able to use the resources they have. The mental health services were meant to be one of many ways to help people find solutions.

The results of the assessments at the beginning of intervention revealed significant distress. The average scores were very high, compared to both international studies as well as to outcomes of a sample of non-help seeking Bosnian civilians. A slight decrease of average scores in 1996 could perhaps be interpreted as the euphoria related to the end of the war and a focus on the promise of a future. Disappointment with post-war developments or – the lack of them – led to increase of intake scores again in the next years. Another explanation for the worse functioning at intake throughout the years, may also lie in the selection of clients that found their way to the counselling centres. More severe cases may have applied for help in the later periods.

The differences found for men and women were in an unexpected direction. While generally women tend to have higher problem scores (e.g. [37]), the men in these samples more often were bothered by feelings of depression, anxiety and

insomnia. A relationship of health and coping outcomes with age was found. In the youngsters, relatively few problems were found, while the occurrence of problems increased with age.

War, of course, has quite different consequences and meaning for different groups of society. It may well be that the differences between age-groups and sexes found for health and coping, are related to different war experiences. The presence of more problematic functioning among men might be explained by a higher occurrence of stressful circumstances for men than for women. It is well-known that many Bosnian adults have been in the frontlines. Another explanation might be derived from a more social and cultural perspective. It could be argued that due to the war, Bosnian men have lost most. Many have lost their jobs and as a consequence their social life has changed drastically (their role as generator of income). Life after the Dayton Agreement was signed has not brought a better promise for the near future in this regard.

The availability of this material provided insight in the merits of a large-scale psychosocial program, information that is usually not at hand [45]. The data revealed a positive impact on many who participated. The level of improvement and recovery as a result of counselling proofed to be a matter of criteria. When strict cut-off scores, obtained by studies including 'normals', (persons not-stricken by war), were used, the results were modest. Remarkably, the interventions booked larger effects for the general health domains than for the distress related to coping with disruptive events.

Intrusion and avoidance are core characteristics [18] of post-trauma responses and the IES has been found to be a very sensitive inventory in therapy outcome research [29]. These findings could be well understood when it is taken in mind that the circumstances of the war and related disruption of society, have been so harmful that memories and specifically related reactions dissolve less quickly than general facets of health.

With different reference data, however, results were more positive. When the scores of a non-help seeking community sample, assessed in Bosnia shortly after the war, were used as a baseline, the proportions of clients recovered or improved were comparable with regard to the indices for general health and coping with trauma.

Furthermore, looking at a sub-sample of clients, those who had completed both questionnaires, the interventions – at least on the short term, appeared most helpful when one was female and had participated group treatment. No significant interactions were found for effect of intervention and belonging to a particular age-group or period of intake. Therefore, although outcomes at the start of intervention increased over the years, the impact of the intervention remained constant. It should be noted that only second-level interaction effects were tested. Higher-order effects, for instance the effect of the interaction by type of intervention by period could reveal a more sophisticated answer.

Nevertheless, the lack of impact of type of intervention on counselling effect, could be well explained. Clients were not assigned to either individual or group treatment at random. Intake procedures were directed at deciding the kind of treatment that was considered best for this particular client and problem. The lack of influence in this regard, could be well perceived as an indication of adequate procedures.

A structured analysis as described in the current article, was hampered by several methodological difficulties, many of them related to the design of a field study during and after a bloody war. The registration of data was started during the war, in the fall of 1994 and it was continued systematically up till Spring 1999 (at that time, the registration system was renewed). Despite all tremendous efforts to accurately present forms, explain purposes, gather and put data in the computer, errors were made at all steps. Not all clients were presented with both instruments assessing health variables. Moreover, counselling received highest priority.

Despite methodological shortcomings, the commitment to the register together with the precise attitude toward the data, have led to the availability of a large database of which the fundaments were laid in the hectic of war and that was continued and improved continuously since. These efforts have provided the opportunity to structurally look into empirical data on the effects of a well-intended psychosocial program. In times of evidence-based health care programming, these data have been mostly missing [12] [14].

For the evaluation of interventions, a method proposed by Jacobson and colleagues was used. This included a definition of positive treatment effect in terms of (a) reliable change and (b) the upgrading of a client from a population of 'distressed' persons towards a population of 'normals' in the course of intervention. Applying the first criterion means excluding measurement error. Applying the second criterion implies defining cut-off scores for significant improvement. The advantage of this method lies in its definition of treatment effect in terms of clinical significance. It is important to know not only whether treated clients felt better, but also how many were recovered at the end of treatment. However, disadvantages could be mentioned as well. These criteria are rather strict. In this study we compared two alternative baselines. First, we used Serbian [38] and Dutch norm groups [37] in defining cut-off scores. Second, we included Bosnian non-help seeking civilians as a reference.

The issue is whether these cut-off scores have been adequate. On the one hand, the use of the Bosnian comparison sample may have been too liberal, resulting in too optimistic outcomes. Some of the participants in this sample may have consulted mental health facilities later. On the other hand, the norms provided by the Dutch and Belgrade samples may have been too strict. The horrible consequences of the war and the poor living circumstances in the post-war period cannot be compared to living in a non-war situation. The inclusion of a baseline sample is a rather adequate choice in this regard (occurrence of false positives and negatives [46].

The comparison group was not included as a control group in the strict sense of a experimental design. In such a design, pre- and post assessments would have been gathered from people in a waiting-list condition. In the daily practice of this program in a war-stricken country, it was considered unethical to have people on a waiting list. Logistically it was also rather impossible during war circumstances. Again, the inclusion of a comparison group was regarded the best alternative.

Lastly, no follow-up data were available. No information can be given with regard to the sustainability of the impact of treatment. Neither is there any clue with respect to a later onset of treatment effect. In all, a program was developed, implemented and evaluated in the circumstances of war and post-war years. The methods needed to be adapted to the special logistic difficulties of conducting research in this complex field, a reality that asks for some pragmatic view [14].

What can be said about the merits and costs of psychosocial programs in the light of the scale on which they were implemented? Various criticism on the large-scale implementation of mental health projects has been expressed [2] [47]. The current study provided arguments in favour of the development of well-formulated mental health projects. For instance, one of the strengths of the MSF/HNI program was its sustainability once the war was over. The aim has been to assist in meeting the need for transformation of the mental health care system in Bosnia-Herzegovina.

The fact that large numbers of clients found their way to not only to the MSF/HNI centres but also other counselling services, could be considered as supportive of the newly introduced services. At the same time, it is well-known that utilization rates are influenced by availability also [31]. Based on the case register, however, no exact proportions can be given on the prevalence and incidence of residents in need of help. It remains important to try to continue and improve registration, although realistically it is hard to get insight in the on-going change of the Bosnian population, due to migration fluxes.

As interesting as the question related to whether interventions worked or not, is the question of why interventions have proven effective. What ingredients have caused the reduction in symptoms. This touches upon the criticisms that the psychosocial programs in the emergency relief field increasingly receive. Is it the general atmosphere, the devoted attention in a vis-a-vis situation with an interested person, or could it be argued that more technical aspects of counselling (such as the practice of relaxation exercises, the invitation to emotionally disclose), are responsible for the impact? Unfortunately, these specific questions could not be answered with findings from the current client register. Nor could any answer be given to the issues of generalizability and effect duration, because no follow-up assessments were available. Clearly, future activities in this field would do well to include such evaluations.

The scores on distress and health symptoms at the end of counselling were still high. This could be related to the on-going stream of violence or the war's heritage of

loss and turmoil in Bosnia. It may be associated with a certain response set (a tendency to high scores) in this society. But an acknowledgement of the strong but limited power of counselling – it helps but cannot make things undone - is entitled.

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Photo: Tom Stoddart

Chapter 10

The efficacy of psychosocial interventions for adults in contexts of on-going man-made violence

A systematic review

Kaz de Jong, Jeroen Knipscheer, Nathan Ford, Rolf Kleber

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Abstract

Compared to psychosocial programs implemented in post-conflict settings those executed in areas of on-going conflicts may have different effects. Their evidence of efficacy has never been systematically reviewed. We searched PubMed, PsychInfo and the Dutch Tropical Institute Literature Portal from inception to January 31 2013 to identify studies on community-oriented psychosocial and psychiatric/clinical services for adults during on-going man-made conflict or its direct aftermath. Of 6358 articles screened, 16 met our inclusion criteria. The interventions varied from psycho-educational to psychotropic drugs. The review is presented using outcome indicators such as PTSD, anxiety, depression, physical health, functioning and well being. A substantial improvement of some outcome was found though the small number of studies and their heterogeneity did not justify strong conclusions. PTSD symptoms improved significantly by treatments that included exposure (such as narrative exposure therapy). A number of studies (eight) showed notable improvement of the client's functioning through counselling interventions. Depression and anxiety both improved considerably using culturally adapted interventions (two studies), whereas non-culturalized interventions did not. We found a notable lack of studies on the efficacy of medication and on preferred western, evidence-based interventions for PTSD such Eye Movement Desensitization. To measure outcomes only two studies applied locally-developed diagnostic labels and validated instruments. Future research should encourage the use of robust research methods that are culturally valid, including mixed-methods research to combine measurable outputs with qualitative research aimed at improved understanding from the client's perspective.

Introduction

Interventions to strengthen community and family support systems, often referred to as psychosocial programs, are reported to be effective in improving the mental health status of populations in humanitarian contexts [1]. However, the length of time since the conflict has passed affects the prevalence and type of mental health problems. In on-going conflict areas there is a greater risk to develop mental health and psychosocial problems than in post-conflict situations [2]. It has been suggested that daily stressors such as poverty, inadequate medical care, marginalization, and lack of basic resources such as food or shelter rather than war related experiences may explain a substantial part of the variance in mental health symptoms in contexts of on-going violence [3]. A study done among Bosnian refugees undertaken more than three years after the conflict [4] found that despite an overall reduction of psychological problems, probably caused by the reduction of conflict and direct related daily stressors, serious mental health pathology persists or even develops for a specific group.

We speculate that the effectiveness of typical psychosocial interventions such as counselling may differ because a different set of problems and symptoms is addressed in different stages of the conflict.

A recent review summarized the evidence for mental health and psychosocial support in humanitarian settings [1]. However, the review made no distinction between conflict and post conflict interventions. We therefore sought to complement this review by conducting a systematic review of psychosocial and mental health interventions for adults in the context of on-going, including 3 years after cessation of the hostilities, man-made violence. Three questions guided our literature search: (1) what was the focus of the psychosocial programs in areas of on-going conflict? (2), what was the evidence of their benefits? (3), and what was the methodological quality of the research?

Methods

We searched for studies published from database inception until 31 January 2013 in PubMed (medical) and PsychInfo (social sciences) that reported outcomes of mental health programmes in conflict. We used the following combination of search terms:

- Psychosocial, War + Evaluation/ Impact/ Efficacy/ Randomized Controlled Trial/ RCT/ Controlled studies/ Outcome assessment;
- Mental health, War + Effect/ Randomized controlled trial/ RCT/ Controlled study/ Outcome study; Psychosocial, Conflict + Evaluation/ Impact/ Efficacy/ Effect/ Randomized Controlled Trial/ RCT/ Controlled Study/ Outcome Assessment;

- Mental Health, Conflict + Evaluation/ Impact/ Effect/ Efficacy/ Randomized Controlled Trial/ RCT/ Controlled Study/ Outcome Assessment;
- Posttraumatic Stress Disorder, Psychosocial + Impact/ Outcome Assessment;
- Posttraumatic Stress Disorder, Mental Health + Evaluation + Adults/ Randomized Controlled Trial/ RCT/ Controlled Study.

From 2009 until 31 January 2013 the Dutch Tropical Institute Literature Portal provided us with selected literature updates on trauma and mental health identified through their search engines. We monitored relevant email literature alerts and requested information from colleagues.

All Dutch, English, French and German language publications in peer-reviewed journals were screened. We included studies of community-oriented psychosocial

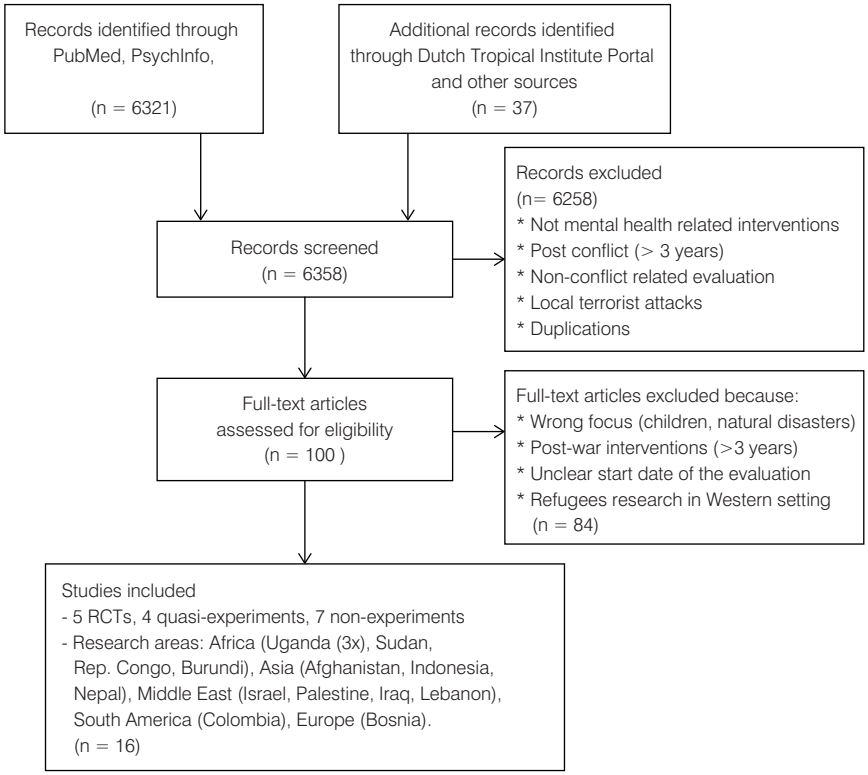

Figure 1 Selection of outcome studies on mental health, psychosocial interventions in areas of ongoing violence. Figure shows different phases of the selection process, the number of articles included and major reasons for exclusion

or psychiatric and clinical services that aimed to improve beneficiary's mental health or psychosocial status. We followed the Inter-Agency Standard Committee (IASC) definition of 'mental health and psychosocial support' and thus included studies of 'any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder' ([5], p: 17). We excluded programmes focusing only on services such as nutrition and general education but not psycho-education.

We included Randomized Controlled Trials (RCTs), controlled trials (non-randomized but with a control group) and non-experimental studies (no randomization, no control group and only pre-post measurements). Included studies were conducted during on-going man-made mass conflict or its direct aftermath, defined as not more than three years after cessation of hostilities. Single or multiple (but geographically confined) violent incidents (such as terrorists attacks) in high-resource countries were excluded. We also excluded studies focusing on children.

Results

Of the initial 6358 articles screened, 16 met our inclusion criteria (Figure 1). We found 5 Randomized Controlled Trails (Table 1), 4 controlled trials (Table 2), 7 non-experimental studies (Table 3). Twelve studies were conducted during on-going conflicts, one was started during war and finished 3 years post-war [6]; and three were undertaken during the post-conflict period but within the 3-year pre-specified period [7] [8] [9].

Populations were IDPs or refugees living in non-camp settings (9) or IDP/refugee camps (5) or general community settings (2). Most studies focused on victims of general war-related violence. Two studies included specific types of violence such as torture and domestic violence [10] [11].

Interventions

The wide variety of interventions was divided into three main categories:

- Five studies included psycho-educational interventions (for PTSD), either alone or combined with psychotherapy [12] [13] [11] [8] [10];
- Eight studies included counselling with trauma-focused or problem-focused objectives using interventions such as stress reduction, emotional ventilation, expressing, symptom reduction, improving coping skills and social skills training [9] [13] [14] [10] [15] [11] [16] [7];
- Nine studies included psychotherapeutic approaches such as narrative exposure therapy (NET, [17]), cognitive behaviour therapy (CBT), psychological inoculation [18], healing/ reconciliation intervention [19], a psycho-dynamic model based on Winnicott [20], manualised local developed counselling based on Watzlawick [21], Antonovsky [22] and manualised internet therapy [23].

Table 1 Brief description of randomized controlled trials meeting all inclusion criteria. For a detailed description see the supporting information

Study	Intervention	Design
Neuner et al., 2004 - North Uganda (2000, 2001)	NET	- n= 43 - Follow-up (4 months, one year)
Neuner et al., 2008 - South Uganda (2003, 2004)	- Flexible (intuition) Trauma Counselling. - NET	- n= 277 - Follow-up (3, 6, 9 months)
Farchi & Gidron, 2010 - Israel (2001- 2009)	- PI - Emotional Ventilation	- n= ?? - Follow-up (one month)
Yeomans et al., 2010 - Burundi (2007)	- Reconciliation intervention - Psycho-education, (including reconciliation)	- n= 124
Ayoughi, S et al., 2012 - Afghanistan (2009-2010)	- Manualised local developed counselling practice + medication - Medication only	- n= 61 women - Follow-up (3 months)

NET= Narrative Exposure Therapy, RCT= Randomized Control Trial, PTSD= Post Traumatic Stress Disorder, PI = Psychological Inoculation

All interventions except two (telephone [24]; Internet [25]) were conducted face to face. One intervention combined practical support (such as legal services provision) with the psychological intervention [11] and four studies included treatment with psychotropic drugs [26] [25] [15] [11].

Most interventions were brief (2-6 sessions; 4-day workshop). In three studies [12] [27] [25] there were an average of 10-15 sessions; one study evaluated an intervention of weekly sessions over an average of 8.5 months [10].

In four studies treatment was provided by local mental health professionals [24] [25] [11] [25]; and in four studies by expatriate mental health professionals [28] [16] [13] [15]. In seven studies treatment was provided by trained national (lay) counsellors receiving clinical supervision from non-national or local mental health professionals. One study was unclear on the professional level of the counsellors [9].

	Major findings
	PTSD: PTSD absent one year follow-up (71%). **Anxiety, Depression**, **Psychological Functioning**: No significant difference between cases and non-cases
	PTSD: NET, flexible counselling significant improved **Physical symptoms**: not significant indicating
	Mental Resilience: no changes
	PTSD : Significant improvement intervention groups (Reconciliation, Psycho-education) **PTSD + culture validated questionnaire**: Only significant Reconciliation group **Anxiety, Depression, Somatic symptoms**: no significant differences
	Anxiety: Counselling group significant reduction at 3 months follow-up **Depression**: Counselling group significant reduction at 3 months follow-up **Local Depression questionnaire**: significant reduction 3 months follow-up **Psychosocial Stressors**: Significant reduction of psychosocial stressors at 3 months follow-up. **Coping Mechanisms**: Significant improvement at 3 months follow-up.

Outcome measures used in studies

PTSD

All studies used questionnaires to measure coping with trauma and posttraumatic symptoms. Questionnaires included the Posttraumatic Diagnostic Scale (PDS), the Post Traumatic Stress Disorder Checklist (PCL-C) and the Harvard Trauma Questionnaire (HTQ). Mooren et al. [12] used the Impact of Event Scale (IES) to measure coping with trauma.

Anxiety, depression

Co-morbid disorders were assessed through checklists. The Self Reporting Questionnaire (SRQ 20), Hopkins Symptom Check List (HSCL 25) and anxiety/depression items of the Brief Psychiatric Rating Scale (BPRC) were used most frequently.

Table 2 Brief description of controlled trials meeting all inclusion criteria. For a detailed description see the supporting information

Study	Intervention	Design
Mooren et al., (2003) - Bosnia (Aug. 1994- Sept. 1999)	Brief trauma focused therapy	- Naturalistic comparative design: treatment (n= 5056), comparison group (n= 102)
Tol et al., 2009 - Nepal (Nov. 2003- Nov. 2004)	Problem solving & stress reducing counselling + psychotropics	- Naturalistic comparative design: treatment (n= 111) - Follow-up (5 months)
Sonderegger et al., 2010 - Uganda (September 2006)	Culturalized CBT intervention	- Controlled trial: experimental (n= 202) - Follow-up (3 months)
Bass et al., 2011 - Indonesia (2007)	Non-specific problem solving group counselling	- Controlled trial (n= 420)

PTSD= Post Traumatic Stress Disorder

Five studies [26] [16] [13] [14] [25] used the clinical interview as the Gold Standard. Three studies [26] [13] [14] applied standardized clinical interview instruments: the Composite International Diagnostic Interview [29] and the Mini-International Neuropsychiatric Interview [30].

Trauma related distress, maladaptive coping behaviour

Only four studies used questionnaires that had been validated for the local context: Neuner et al. (2008) used the PDS; Tol et al. [11] used the PCL-C and the WHO Disability Assessment Scale (WHO-DAS). Two studies used locally designed and validated outcome measures [27] [7].

Physical health

Somatic health was used as an outcome measure in five studies, mostly by means of self-designed questionnaires [7], [14], [8]; two studies [12], [11] applied structured questionnaires (General Health Questionnaire, Symptom Checklist 90: somatic part).

Functioning/ well being

Ten studies were using functioning outcome measures [7] [9] [24] [28] [16] [13] [27] [15] [11] [25]. All studies except three [26] [7] [27] used western-based instruments:

	Major findings
	General Health, Coping: - Clinically recovered: General Health 12.8%, Coping with Trauma 15.5% - Improved: General Health 54.5%, Coping with Trauma 23.1% - No improvement: General Health 32.7%, Coping with Trauma 61.4% - Deteriorated: General Health 8.7%, Coping with Trauma 9.7%
	PTSD: no clear improvements **Depression, Anxiety:** no clear improvements **Somatic symptom, Disability and Functioning:** significant decrease at follow-up
	Local Depression, Anxiety syndromes: Significant changes **Social functioning** **Pro-social behaviour:** significant changes **Unacceptable social behaviour:** No effect
	Anxiety/ Depression: no effect for intervention group **Somatic symptoms:** small effect size intervention group **Functioning: no significant difference** **Coping: Males:** significantly increased use of coping mechanisms

the social/psychological functioning scale (SF 12, SF 36), the DSM IV Global Assessment of Functioning (GAF), the Subjective Well Being Scale-4 (SW-4), Mental Health Inventory, the Disability Assessment Scale (WHO DIS), and EUROHIS- QOL (European Health Indicator System-Quality of Life).

Efficacy of interventions

PTSD

Three RCTs reported significant improvements of their clients using NET [13] and a reconciliation intervention without psycho-education [8]. The impact of trauma-focused counselling interventions differed substantially between studies. Neuner et al. [13] found no benefit for supportive counselling (without exposure), neither did Tol et al. [11]. Brief trauma-focused therapy (10-15 sessions) provided moderate results for coping with trauma [12]. However, Neuner et al. [14] reported significant results with flexible (intuition) trauma counselling (including exposure; for description see Table 1). Effect sizes merit careful examination as it is possible for interventions to produce significant improvements despite post-treatment symptoms remaining at pathological levels [12] [13]. In three non-experimental studies, psychotherapy combined with medication and psychodynamic therapy (Winnicott model [20]), or CBT based internet therapy, appeared to produce high improvement rates for PTSD [25] and complex PTSD [28].

Table 3 Brief description of non-experimental studies meeting all inclusion criteria

Study	Intervention	Design
Sanchez-Padilla et al., 2009 - Colombia (2005-2008)	Psychotherapy & Psychotropic medication	- Fixed clinic (n= 500) - Mobile Clinic: (n= 744) (adults) - No control group
Souza et al., 2009 - North Sudan (April-Nov. 2007)	Medication for epilepsy, psychosis, mood disorder Counselling: Problem solving approach for moderate/ mild depression	- n= 81 - Follow-up: 1 and 3 month - No control group
Hustache et al., 2009 - Republic of Congo (Jan. 2002- May 2003)	Psychological care	- n= 159 - Follow-up between 1-2 years after - No control group
Manneschmidt et al., 2009 - Afghanistan: (January 2006- May 2007)	Psychosocial group counselling	- Qualitative study (n= 137) - Post measurement only

Anxiety and depression

One RCT applying a locally developed counselling approach (for description see Table 1) described significant improvement of both anxiety and depression. Sonderegger et al. [27] using a group culturalized CBT intervention reported significant improvement on locally defined and validated depression and anxiety syndromes. None of the other interventions (NET, non-specific problem-solving group counselling, reconciliation, psycho-education, combined problem solving and stress-reduction counselling) gave statistically significant reductions in anxiety or depression symptoms. In three non-experimental studies, high improvement rates were found for depression and anxiety using psychotherapy (including psychodynamic interventions), problem-solving counselling and/or medication, and manualised internet therapy [28] [15] [25].

Physical health

A reconciliation intervention [8] did not lead to significant improvement of somatic symptoms. NET, flexible trauma counselling and non-specific problem-solving group counselling resulted in non-significant [14] or small improvement [7]. Tol et al. [11] showed a moderate benefit using problem-solving and stress-reduction counselling. Mooren et al. [6] found general health improved with brief trauma-focused therapy.

Functioning/well being outcomes

NET [13], psychological inoculation and emotional ventilation [24] did not result in significantly changed functioning or well being. However, locally developed counselling

	Major findings
	PTSD, Depression: - Fixed Clinic: 90.6% improved, 9.4% unchanged/ aggravated - Mobile clinic: 91.8% improved, 8.2% unchanged/ aggravated
	Disability: Significant decreased disability scores at 1 and 3 month
	Functioning: Low impairment on GAF score increased from 10.7% (pre-test) to 71.4% at post-test and maintained 71.4% at follow-up indicating a clear improvement
	Major reason for coming: physical, psychological problems symptoms **Most learned:** social (communication) skills **Life change:** improved social life **Next step:** find employment

methods based on problem solving approaches and positive psychology [26] as well as culturally-adapted CBT [27] did report significant improvement of psychosocial stressors, coping skills, pro-social behaviour, disability and functioning. Western problem-solving and stress-reduction counselling combined with minimum medical services, legal assistance and if necessary psychotropic drugs [11] showed similar improvements. Bass et al. [7] reported some functionality improvements with non-specific problem group counselling. In non-experimental studies substantial increase of functioning was reported [9] [16]. Souza et al. [15] report decreased disability of clients and improved functioning after visiting a primary (mental) health care clinic. A qualitative study of a long-term (8.5 months) group intervention helping women to improve their (functioning) skills and social networks, reported a substantial increase in social (communication) skills [10].

Quality of studies

Nearly one third of the studies applied the RCT methodology. One RCT, on the effectiveness of psychological inoculation [24], was difficult to evaluate because population samples and outcome measures (and their reliability scores) were not described. Four studies had a non-randomized, controlled design with large sample sizes. There was one qualitative study. The remaining six studies were observational studies.

Studies varied substantially with regard to participants, time since the potentially traumatic experience, treatment standardization, outcome measure, control groups,

treatment length and seriousness of disorder. Two studies applied locally constructed and validated outcome measures only, and another two studies validated measures locally, but did not construct them locally [14], [11]; the remaining twelve studies did not construct nor validate their outcome measures locally.

Discussion

A previous review evaluated psychosocial program outcomes unrelated to the stage of the conflict. We speculated that the effectiveness of typical psychosocial interventions such as counselling might differ because different set of problems and symptoms have to be addressed in different stages of the conflict. We aimed to complement the existing meta-analysis [1] with a review focused on (adult) studies of psychosocial interventions in the context of on-going man-made violence.

Effective interventions in areas of on-going violence

Our review of research on adults in areas of on-going violence did not reveal major difference between areas of violence and post-conflict settings [1]. Effective interventions for PTSD showed, in accordance to research conducted in western countries [31], the importance of exposure. Exposure techniques within PTSD interventions, such as NET (a variant of Cognitive Behaviour Therapy), were carried out according to strict protocols. Additionally, we found that less structured exposure methods such as relating the client's current problem to a past traumatic experience (flexible counselling, [14]) or encouraging to share war experiences (reconciliation intervention [8]) also provided substantial treatment results. We did not find evidence for the suggestion that strict manualization [11] enhances the effect of PTSD-focused interventions. The efficacy of different PTSD treatments is not surprising. A meta-analysis of studies comparing different PTSD treatments [32] concluded they were equally beneficial for PTSD patients. As with the previous review [1] the heterogeneity of the PTSD studies hindered us to do a comparison analysis.

An essential concern is the clinical implication of these outcomes. Statistically significant differences between pre-, post-treatment and follow-up indicated clear improvement. However, two studies reported statistically significant improvement but post-measurement scores still indicated pathology [6]. Similar to a previous review [1] we found that counselling approaches focused on PTSD did not have an effect on anxiety or depression co-morbidity (for instance [13] [14] [8]); probably, because they focused on PTSD and did not intend to treat co-morbidity [11].

We further found conflicting evidence for the impact of interventions on anxiety, depression, and physical symptoms. All interventions based on western counselling models that were not culturally adapted failed to establish an impact on anxiety or

depression or somatic health (except [6]). However, an RCT conducted in Afghanistan [26] applying a culturally sensitive counselling approach that drew on personal problem solving resources established significant improvements on anxiety and depression as well as improvement of coping skills and a reduction of locally defined psychosocial stressors. Another study conducted in Uganda using culturally-adapted CBT intervention [27] reported significant improvement on locally defined anxiety and depressive syndromes in a controlled trial.

These challenging outcomes might be explained by the lack of cultural adaptation of the intervention. The two interventions [26] [27] using locally developed intervention strategies reported substantial improvement on anxiety, depression, psychosocial stressors, coping skills and social functioning. However, another culturally adapted non-specific problem-solving counselling approach was reported to improve only coping skills and not anxiety or depression [7]. Maybe Bass et al. [7] were less successful in harmonizing the counselling approach with the explanatory model of the client's beliefs about causes of illness, assumptions about the time line, perceived consequences and what is acceptable as treatment [33] [34]. In a meta-analysis comparing outcomes of culturally-adapted and regular proven psychotherapies Benish et al. [33] concluded that differences in treatment outcome were related to successful adaptation of the intervention to the 'client's illness myth'. Thus for cultural adaptation not the changes in treatment elements are important but the adaptation of the therapist to the client's model of illness. Both Ayoughi et al. [26] and Sonderegger et al. [27] may have been more successful in this regard. Further research to clarify the impact of counselling on specific disorders such as anxiety and depression is needed.

In evaluating the client's changes in functioning, one RCT and most controlled studies reported significant improvement for interventions such as problem solving counselling [26], group culturally-adapted CBT [27] and problem and stress-reduction counselling [11]. No functional improvement was found for NET. The efficacy of these counselling interventions supports the proposition that in acute emergencies psychosocial programs should focus on the restoration of functioning [35] and the need for 'minimum responses in the midst of emergencies' ([5], p: 17). The next step needed is to confirm these findings through RCTs using locally validated concepts of functioning.

We found one study, with a non-experimental design, on the efficacy of medication. It showed significant effects on symptom improvement [15]. However, Ayoughi et al. [26] found counselling significantly more effective when comparing counselling with medication only. The lack of studies on medication seems sensible as in unstable settings the priority is the improvement of access and adherence to medication. To lower risks of medication rupture and increase adherence, lessons can be learnt from other fields such as HIV/AIDS care [36]. The imperative to prioritize

delivery of medicines does not mean research on efficacy of medication should be neglected though.

We found a notable lack of studies on the preferred western, evidence-based interventions for PTSD such as CBT and Eye Movement Desensitization Reprocessing (EMDR). This disconnection between research and practice was also a major finding of Tol et al. [1]. Mental health and psychosocial interventions in areas of on-going violence should bridge the gap quickly. They can build on systematic reviews suggesting the effectiveness of western, evidence-based interventions in non-western populations living in the west, provided they are harmonized with the 'client's illness myth' as suggested [33] [37].

Quality of the evidence base

The reported studies varied substantially with regard to participants, outcome measures, time since the potentially traumatic experience, treatment standardization, outcome measure, control groups, treatment length and seriousness of disorder. This variation limits the generalization of conclusions.

The lack of cross cultural validity has been a major limitation in most studies. Our review showed that not validated western self-reporting questionnaires have been used in areas of on-going conflict mostly (12 studies). These instruments have several constraints, including their length, lack of cultural validity and reference to western mental health concepts. Also, their complexity may have hindered their application and their use by clients with low levels of formal education. Two studies used western instrument with outcome measures validated locally, but did not construct them locally [14], [11]. Only two studies ([7] [27], both controlled but non-randomized, used locally developed diagnostic labels and validated instruments for needs assessment and outcome evaluation. These studies showed the important differences in illness concepts and symptom clustering between western and non-western cultures.

The key challenge for research into the effectiveness of psychosocial interventions in areas of on-going violence did not differ substantially from those in other humanitarian settings [1]. Locally developed criteria and instruments have clear validity advantages but also shortcomings as their incomparability with other settings, is at least problematic. Some suggest this can be moderated by using the same protocols for different cultural settings and compare outcomes [38]. Furthermore, the clinical relevance is uncertain as the comparison of these instruments to an established clinical interview gold standard has been problematic. Unfortunately, the current frequently used Gold Standard to validate western instruments in non/western countries, such as the World Health Organization's Composite International Diagnostic [29], also had substantial cross-cultural validity limitations [39]. The application of these instruments to validate western-designed instruments in non-western settings (for instance [13], [14]) should be a point of further scientific discussion. The lack of cross

cultural validated gold standard instruments illustrates the complexity of conducting outcome research in non-western areas of on-going violence. The development of a gold standard should be a key priority in psychosocial intervention research.

Lastly, most of the non-experimental research was carried out by non-governmental organizations (NGOs). We question whether this is acceptable as strengthening of standard program monitoring may provide better information than non-experimental studies.

Design and methodological issues for future research

The American Psychological Association Division 12 is clear on their requirement for efficacious treatments: 'only RCTs and their logical equivalents afford strong causal inferences' [40]. We agree with this statement but question the inflexibility of this requirement for all contexts.

Such high standards may discourage research in conflict areas. The fast-changing and unpredictable circumstances of conflict settings may jeopardize outcomes. In Neuner et al. [14] over 80% of participants were lost to follow-up due to improved security conditions. Setting the RCT as a benchmark for evidence may push outcome research into the use of highly disputed (for instance [41]) western, medical Diagnostic System Manual- criteria [42] such as PTSD, anxiety and depression. This fear is realistic. Despite practical, time limited, scientific methods to create and validate locally developed criteria to identify important mental health issues [43] these methods have hardly been used in humanitarian settings.

RCT research models have methodological limitations too. Their use in outcome research gives insight about effects but leaves unaddressed the impact of important humanitarian motives such as compassion, empathy and a sense of justice [44]. Finally, in general the quality of most RCT studies is low. In two reviews of all RCTs available on PubMed it was concluded that the overall quality of RCT reporting remains below an acceptable level [45] [46]. Our review shows similar shortcomings in the RCTs we identified: poor study description (for instance [24]), lack of validation (for instance [8]) and small sample sizes (for instance [26] [13] [14]).

The importance of aiming for the highest quality scientific evidence is undisputed. However, it is questionable whether these standards are currently possible or necessary in areas of on-going violence. In addition, the alternative of controlled (but non-randomized) study design gives insight to the daily clinical realities of our clients, which is often lacking in RCTs [47].

We identified one qualitative study only. The lack of qualitative research leaves unanswered important questions such as what beneficiaries expect from an intervention. Other valuable domains of outcome research such as changes in skills (for instance communication), attitudes (for instance openness), relationships (for instance within the family), connectedness to community and functioning have not

been not explored [48]. Mixed-methods research capitalizes on the strengths of both qualitative and quantitative research methods and is recommended as practical and informative in this area [49].

Our review showed that the inclusion of beneficiary perspectives was limited. Future research projects should aim to include the local perspectives of recipients from start to evaluation to better understand whether the intervention is effective for them. This is in line with accepted research priorities [1]. On-going input of practitioners and beneficiaries in the design, execution and re-definition of the research protocol is vital if the clients' explanatory models are to be included. Joint ventures of local practitioners and universities with western-based academia have proven effective in this area (for instance [50] [51]).

Limitations of the review

We included only published studies and did not include grey literature publications. The limited number of studies (5 RCTs, 4 controlled trials) do not allow for strong conclusions. Different socio-cultural and health system environments in which these interventions were implemented might have contributed to heterogeneity in results. This has an effect on the generalizability of the conclusions. Likewise, differences in pre-morbid severity of symptoms, symptom duration, and the length of time since trauma exposure may also have influenced outcomes. The reporting of these variables was not consistent. For this reason we were unable to include in them in our review.

Conclusion

The small number of studies (16) identified in this review and their high heterogeneity does not justify strong conclusions. For different humanitarian contexts, conflict and post-conflict, we did not find important differences in treatment outcomes. In concord with a previous review [1] we found evidence for the effectiveness of psychosocial, mental health interventions focusing on PTSD symptoms in areas of on-going violence. Especially, NET which was considered part of CBT interventions proved to be effective. We also found that various methods of counselling enhanced the client's functioning [1]. In areas of on-going violence improved functioning may be essential for the survival of individuals and groups. Trained, clinically supervised, lay counsellors implemented most of the reviewed interventions. Their effectiveness is reassuring for the implementation of services in crisis areas in which often qualified, well trained staff is in shortage.

Our review showed the importance of culturally adapted counselling interventions. Non-culturally adapted counselling approaches did not affect anxiety and depression symptoms; those that were culturally adapted did have a significant effect on these symptoms next to the effects on posttraumatic symptoms.

Future trials should include multimodal intervention combining both trauma-focused therapies such as NET (for PTSD) and counselling /problem solving techniques (for anxiety-depression/functionality) given the fact that co-morbidity of mental disturbances and functional impairment often go together.

The knowledge base on psychosocial interventions adapted to the client's (cultural) illness model evaluated with locally-developed and culturally-validated concepts and instruments must increase. The development of a cross cultural validated gold standard is the most important challenge.

RCT methodologies and comparative evaluations should be encouraged for the assessment of future interventions, incorporating mixed-methods approaches to integrate qualitative evaluations. Establishing what works is important, but continuous input of practitioners and beneficiaries is the only way to start understanding why they work.

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Chapter 11

Client and counsellor perspectives on psychosocial intervention outcomes in settings with on-going violence

A retrospective data analysis from a regular monitoring feedback tool

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Submitted

Abstract

Background Existing tools for evaluating psychosocial interventions, such as unvalidated self-reporting questionnaires, are not ideal for use in non-Western conflict settings. We implement an alternative method of treatment evaluation. Client and counsellor feedback tools are implemented in 18 projects in non-Western humanitarian settings. The psychometric implications of our findings and suggestions for future research are discussed.

Methods and findings A retrospective analysis is executed using data gathered from psychosocial projects. Interventions aim to reduce psychosocial complaints and to improve clients' functioning. 7,058 adult counselling clients are eligible for analysis. Clients complete two (complaints and functioning) rating scales each session and counsellors rate the client's status at the end of treatment.

The client-completed pre- and post-intervention rating scales show substantial changes. Counsellor evaluation of the clients' status shows a similar trend in improvement. Univariate analysis of several variables with each scale separately demonstrates consistent results for the client and counsellor rating scales. All three multivariable models for each separate scale have similar associations between the scales and the investigated variables.

Limitations are: ratings give only a general impression and clinical risk factors are not measured. Potential ceiling effects may influence change of scales. The intra and inter-rater reliability of the counsellors' rating is not assessed.

Conclusions All three rating scales measure significant changes, no substantial differences are found between outcome ratings for different contexts and cultures. The validity is good. The focus on the client and counsellor perspective to evaluate treatment outcome seems a strong alternative for evaluation instruments frequently used in psychosocial programming.

The scales are useful to monitor client and programme progress. The session client rated scales helps client and counsellor to set mutual treatment objectives and reduce drop-out risk. Further research should test the scales against a cross-cultural valid gold standard to obtain insight into their clinical relevance.

Introduction

There is an urgent need for the assessment of the efficacy of psychosocial interventions in non-Western areas of on-going conflict. Are these interventions worth the efforts and do they really have effects on well-being and health? Although reviews show positive outcomes for certain psychosocial interventions [1], these reviews also point to substantial methodological constraints in current research designs [1] [2] [3]. A major dilemma concerns the frequent use of existing Western self-reporting questionnaires to evaluate intervention outcomes in areas of on-going conflict. Several of these instruments suffer from limitations, including their length, lack of cultural validity and reference to Western mental health concepts. Also, their complexity hinders their application and their use by clients with low levels of formal education.

Little is known about alternative methods to evaluate treatment outcomes from both client and therapist perspectives in non-Western humanitarian settings. In the West client and counsellor rating scales appear to be good psychometric alternatives for treatment evaluation tools such as self-reporting questionnaires [4]. Therefore, we set out to evaluate client and counsellor feedback tools (rating scales) implemented in 18 psychosocial programmes using retrospective data analysis.

The aim of the present study is to assess an alternative for Western self-reporting questionnaires as a method to evaluate client treatment progress and programme outcome in non-Western humanitarian settings. We investigate the psychometric qualities of the scales such as whether the client and counsellor feedback tools registered changes over the course of treatment, the degree of differences between the scales and major variables contributing to these differences. We discuss our findings from the perspective of validity.

Method

Data are gathered in 2009 from 18 psychosocial projects in eight countries. A detailed description of the projects is provided elsewhere [5]. The psychosocial projects are integrated in the services of Médecins Sans Frontières (MSF), a medical humanitarian organization operating in humanitarian contexts.

Data are included from six projects in a 'conflict' setting (having experienced active intra- or interstate conflict in the previous 12 months): Colombia (three locations), Democratic Republic of Congo (DRC) (two locations) and Iraq (one location). Three projects in a 'post-conflict' setting (a history of armed conflict but no active fighting for at least 12 months) are included: Central African Republic and DRC (two locations). Data from seven projects in an 'unstable' setting (political turmoil is present but has

not reached the stage of armed conflict) are used: India (three locations), Pakistan (two locations) and Russia (two locations). Lastly, two projects in a 'societal violence' setting (high levels of violence not linked to intra- or interstate conflict or political turmoil) are included in the assessment: Papua New Guinea.

The monitoring system of an earlier large-scale mental health project [6] is adapted and developed into the current system. A description of the monitoring system and the general outcomes is published in detail elsewhere [5].

The study population

All adult (≥18 years), newly enrolled clients in 2009, with more than one counselling session, at least one of three outcomes measures recorded and a closed file, are included in the study. Those included in the analysis receive individual counselling as part of a routine mental health programme in one of the 18 MSF psychosocial projects.

The intervention

The objective of the psychosocial programmes is to reduce psychosocial complaints and to improve (related) functioning [7] [8].

Brief counselling is used to normalise psychosocial reactions to war and disaster, to encourage appropriate expression and containment of emotions, and to mobilise personal resources through identifying resilience mechanisms, strengthening coping skills and activating new problem-solving approaches (see also [9] [10]). Counsellors adopt an empathic solution focused approach in sessions with their clients [11] [12]. Counsellors receive regular follow-up training and clinical supervision by a mental health professional [13].

Counsellors do not prescribe medication. Treatment of patients with serious mental health conditions (such as psychosis) is beyond the scope of the counselling programmes. In some projects referral to a local psychiatrist or primary health care physician to provide psychiatric medications is possible A detailed description of general set up of MSF psychosocial projects is given elsewhere [8].

Instruments

Complaint, functioning rating scales

The individual's explanatory model of illness, definition of problem, symptoms and/or functioning is used as reference to register intensity and change of the psychosocial problem. Clients present psychosocial problems such as complaints (nervousness), dysfunctioning (for example inability to care for the children) or a combination of both. Therefore, psychosocial problems do not necessarily relate to mental health symptoms (such as anxiety) or syndromes (such as depression). Client rating scales include both symptoms and functioning.

The rating is based on the intensity of the complaint and the client's related functioning at the beginning of each session (real-time monitoring). The measurement reflects outcome in terms of change experienced by the client since the previous session. Had the rating been done at the end of each session it would have functioned as an assessment of the current session.

The counsellor explains to every new client how to rate the symptom and the related level of functioning in daily life. It is also explained that the rating is done every session to see how the client is doing. The clients mark their rating on a scale, which usually is in the form of a line with bars at 1-cm intervals numbered 1–10 from left to right. A mark placed towards the right-hand end of the scale signifies a more positive judgment by the client of their symptoms or functioning. In populations with a high level of illiteracy or unfamiliarity with number ratings, the ends of the scale and various intermediate positions are illustrated with local, culturally equivalent symbols (see Figure 1).The scales and their interpretation are tested in the local context, and the explanation to the client standardised during counsellor training sessions. Most projects (13) have implemented and fine-tuned the scaling system to their populations the year(s) before the research.

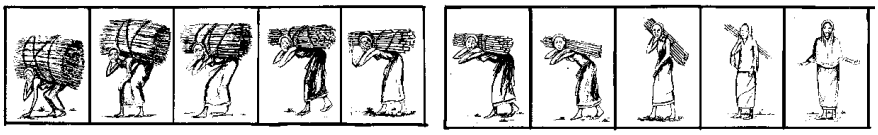

Figure 1 Example of culturally adjusted rating scale

Counsellor rating scale

'Status at last visit' is scored by the counsellor at the end of the treatment. The counsellor scale is rated in relation to the presenting problem for which the client receives treatment. The counsellor can rate the client's problem as being: completely resolved, improved, unchanged, or deteriorated in severity. The counsellor does not discuss his or her scoring with the client.

Client and program variables

The following variables related to the patient's condition are defined: age (per 10 years), gender, precipitating event, counsellor focus, number of sessions, and exit type. The precipitating event associated with the most important psychosocial problem is registered using 11 predefined categories adapted from Hollifield et al. [14]**.** The main precipitating events are re-categorized into six groups for multivariable modelling: psychological violence; physical violence; witnessing violence; sexual violence; displacement related problems; and other.

The counselling focus is classified as having inner problems, lack of (life, problem solving) skills, overwhelming feelings, practical problems, trauma-related symptoms, and need for psychiatric support [15].

The following variables, related to project characteristics, are defined: context setting, project size, work load, being professional counsellors, and age of the project.

Workload is defined by the number of clients supported by each counsellor in 2009 (<100, 100–200 or >200 clients per counsellor). The size of each project is defined by the number of counsellors in the programme (1–3, 4–6 or ≥7 counsellors).

Ethical approval

The study is a retrospective analysis of anonymous client information routinely collected as part of mental health services. It meets the standards set by the MSF Ethics Review Board, an independent international board, for retrospective analyses of routinely collected programmatic data.

Statistical methods

The difference between the first and last client ratings is used to calculate the overall change in the client's status with respect to their symptoms and functioning at the end of treatment. For clients who dropped out, the rating of the last one recorded is used.

Mean and standard deviations are used for continuous data. If data are skewed they are presented as median and interquartile range. Binary and categorical data are summarised as number and percentage.

Univariable and multivariable associations of outcomes are assessed using analysis of covariance, again with robust standard errors. Residual analysis is used to check the assumptions of the regression analysis. The two client rating scales are analysed using linear regression to estimate crude (unadjusted) associations for analysis of client rating scales), with robust standard errors to account for the heterogeneity induced by clients being clustered within different projects.

Counsellor assessment at the client's last visit is analysed using ordered logistic regression, the highest rating being full resolution of a patient's problem and the lowest a deterioration of the patient's problem to assess associations. In all cases the models are fitted using robust standard errors. We include exit type in the equations although exit type is not fully independent of the counsellors and client rating as both the client and counsellor can decide on terminating the treatment. We control for this in the multivariable model.

The total number of sessions is entered into the models as a log transformed variable. To control for the specific type of violence from projects in one country (Papua New Guinea: societal violence) a sensitivity analysis is performed on the data set. All data analysis is executed using STATA software, version 12.1.

Results

Baseline data

Less than half of the clients (7058 of 14,963) are eligible for analysis as shown in Figure 2. The majority of the clients included (55.5%, n=3,915) are located in settings of instability; one-fifth (20.8%, n=1,470) are living in a conflict zone; those in post-conflict and societal violence settings made up a smaller proportion (11.3%, n=800 and 12.4%, n=873, respectively). The study population is predominately female (72.3%, n=5101), with an average age of 37.5 years (SD=12.7).

One-third of the clients present anxiety-related problems as their main reason to seek counselling (33.3%, n=2,348). Other frequently mentioned problems are mood-related (16.3%, n=1,147), family-related (14.6%, n=1,032) or physical (12.3%, n=866). Most clients receive treatment from trained, supervised lay counsellors (69.1%, n=4,878, 11 projects). Counsellors choose as their main counselling focus most often: overwhelming feelings (36.0%, n=2,543), trauma-related symptoms (24.6%, n=1,735) and physical complaints (12.3%, n=866). The median number of sessions is five (inter-quartile range 3–7).

Client and counsellor treatment evaluation

On average, clients' rating of their symptoms post-treatment (complaint scale) show an improvement of 4.8 points compared to that before treatment (7.3 versus 2.5); a similar improvement of 4.3 points is noted for clients' functional status (7.6 versus 3.3). Comparing pre- and post-treatment ratings, these changes are significant (complaint: 95% CI: 3.8, 5.6; $p<0.001$; functional status: 95% CI: 3.5, 5.1; $p<0.001$; both n=7,007).

Comparing clients' assessment of their symptoms and of their function rating at their first visit, a significant difference between the scales is found; the client symptom rating is 0.83 points lower than the functional rating scale (3.34 versus 2.51; 95% CI: 0.52–1.14, $p<0.001$, n=7,024).

Counsellor evaluation of the status of the clients' psychosocial problem at the last session (n=7,039) shows a similar trend in improvement: condition resolved (35.0%, n=2,468), psychosocial problem improved (55.9%, n=3,945). A minority of the client's conditions are judged as unchanged or deteriorated (7.1% and 1.8% respectively).

Uni- and multivariable analysis of the change in rating scales separately

Univariable analysis of change within each scale separately shows consistent results for the client (complaint as well as functioning) and counsellor rating scales. The strongest associations of change in all three scales are with the following variables: the type of exit, the total number of sessions and the context setting.

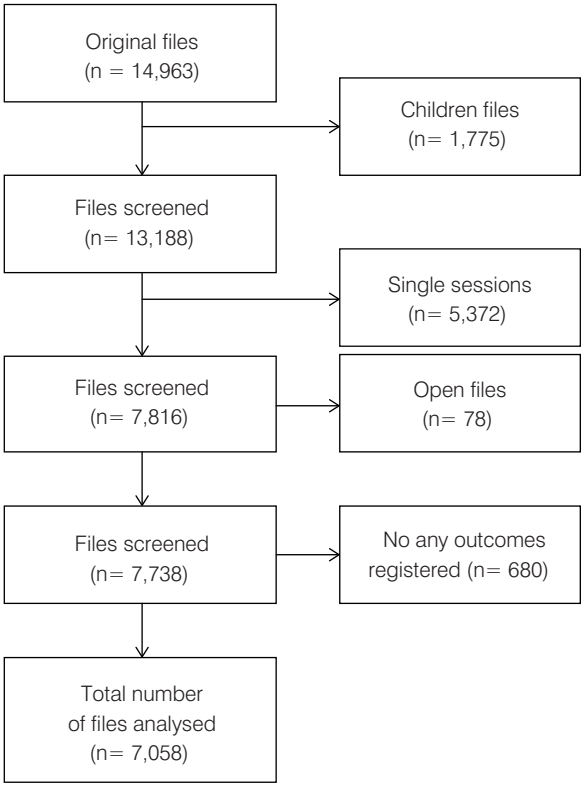

Figure 2 Diagram of files included in final analysis

All three multivariable models (see Table 1) of the change of each individual scale shows similar significant associations with the independent variables. The strongest association for the client scales (complaint, functioning) are: the value of the complaint or functional rating at the first visit, the total number of sessions and the exit type. The other independent variables (precipitating event, context setting, counselling focus, size of project) are statistically significant but the estimated parameters are small in absolute magnitude. The variable 'age' is statistically significant for the functional scale but not the complaint scale.

All the variables in the model, except complaint rating at first visit and client age show statistically significant associations for the counsellor rated scale. The strongest effect size is seen for type of exit and context. The counsellor rating scale has also a strong association, adjusted for the other model variables, with the client's functional status rating at the first visit.

The strength of associations is largely consistent across the three scales (see for an overview Table 1). The multivariable models of the client rating scales are strong in terms of explained variance of the variables (complaint: R^2= 0.585, n=6,390; functional status: R^2= 0.587, n=6,391). The explained variance of the counsellor's rating multivariable model is also acceptable (pseudo R^2=0.272, n=6,390).

Differences in change between client self-rating scales

On average clients' functioning improvement is 0.48 points higher than on the symptom rating scale (crude) (4.75 versus 4.27; 95% CI: 0.16, 0.80; p<0.001, n=7,004). After adjusting for rating-scale baseline differences, the functional rating scale change is 0.19 points higher (95% CI: –0.27, –0.11; p<0.001, n=7,004) than the symptom rating scale change.

Nearly half (46.0%, 3,219, n= 7,004) of the clients has the same change for both the symptom and the functional rating scales (See Figure 3). A small proportion (12.3%, 861, n=7,004) of clients has a functional rating change one point higher than their symptom rating change, and 19.5% (1,363, n=7,004) has a symptom rating change one point higher than their functional rating change. For most of the clients (77.8%), the change in rating scales differs by no more than one point between the complaints and functioning scale. Multivariable analysis reveals that the difference in change between the two client scales is related highly with the different ratings in scales at the first visit. Similar to changes in the separate client scales analysis, the total number of sessions, context setting and the size of the projects are associated (all p<0.001) but their effect is small. The multivariable model explains 61.5% of the variability of the differences in the changes of the rating scales.

Associations between client rating and counsellor assessed client status at last visit

More favourable counsellor-assessed outcomes are associated with larger improvements in each of the client rating scales (see Figure 4).

The association between counsellor-assessed status and the symptom rating improvement of the client shows a similar pattern. Resolved status is associated with a large improvement in client symptom rating (5.10; 95% CI: 4.25–5.92) and improved status links with a moderate improvement (3.04; 95% CI: 2.30–3.71). When the counsellor's assessed status is deteriorated, the mean change in client symptom rating is small (0.01; 95% CI: –0.93, 0.95).

Post hoc analysis shows a significant difference in the symptom rating scale change between counsellor-assessed status of 'resolved' and 'improved' (2.05 95% CI: 1.23–2.87, p<0.001), but there is no evidence of a difference between clients symptom rating whose problem remain unchanged and those who are worse off at the end of treatment (p=0.975).

Table 1 Associations of the individual rating scales and independent variables. Multivariable model: complaint rating difference (R^2 = 0.585, n=6390), functional rating difference (R^2 = 0.587, n=6391); Multivariable model: status at the last visit (pseudo R^2=0.272, n=6390)

Variable		Complaint estimate (95% CI)	P-value
Complaint rating at first visit		–0.67 (–0.77, –0.58)	<0.001
Functional rating at first visit			
Age (per 10 years)		–0.04 (–0.10, 0.01)	0.134
No. of sessions (log transformed)		1.43 (1.05, 1.80)	<0.001
Exit type			<0.001
Reference:	Drop out	0.00	
	Mutually agreed	1.80 (1.56, 2.03)	
Context setting			0.001
	Conflict	0.71 (0.36, 1.07)	
	Post-conflict	0.03 (–0.25, 0.32)	
	Unstable	0.37 (0.08, 0.66)	
Reference:	Societal violence	0.00	
Precipitating event			0.010
	Psychological violence	0.01 (–0.14, 0.16)	
Reference:	Physical violence	0.00	
	Witnessing violence	0.18 (0.04, 0.31)	
	Sexual violence	0.38 (0.07, 0.68)	
	Displacement problems	0.07 (–0.15, 0.29)	
	Other	0.22 (–0.11, 0.55)	
Counselling focus			
	Inner problems	–0.03 (–0.25, 0.18)	<0.001
	Lack of skills	0.19 (–0.08, 0.46)	
Reference:	Overwhelming feelings	0.00	
	Practical problems	–0.13 (–0.31, 0.04)	
	Trauma-related symptoms	–0.12 (–0.25, 0.01)	
	Psychiatric support treatment	–1.31 (–1.85, –0.76)	
Project size			
Reference:	1–3 counsellors	0.00	<0.001
	4–6 counsellors	–0.57 (–1.05, –0.09)	
	7+ counsellors	–1.04 (–1.42, –0.66)	

	Functional estimate (95% CI)	P-value	Counsellor rating Odds ratio (95% CI)	P-value
			0.97 (0.83, 1.14)	0.705
	−0.67 (−0.75, −0.59)	<0.001	1.14 (1.07, 1.22)	<0.001
	−0.06 (−0.10, −0.01)	0.015	1.00 (0.93, 1.07)	1.000
	1.24 (0.87, 1.60)	<0.001	1.94 (1.11, 3.38)	0.020
		<0.001		<0.001
	0.00		1.00	
	1.63 (1.41, 1.85)		13.65 (7.13, 26.12)	
		0.010		<0.001
	0.48 (0.09, 0.86)		8.31 (2.99, 23.13)	
	−0.08 (−0.38, 0.22)		7.05 (2.92, 17.05)	
	0.38 (0.10, 0.67)		2.23 (1.15, 4.31)	
	0.00		1.00	
		<0.001		<0.001
	0.03 (−0.08, 0.15)		0.84 (0.68, 1.03)	
	0.00		1.00	
	0.24 (0.13, 0.36)		1.29 (0.99, 1.69)	
	0.46 (0.14, 0.77)		2.16 (1.61, 2.90)	
	0.12 (−0.08, 0.31)		1.04 (0.74, 1.46)	
	0.27 (−0.06, 0.60)		2.39 (1.08, 5.30)	
	−0.10 (−0.33, 0.13)	<0.001	1.01 (0.73, 1.39)	<0.001
	0.14 (−0.05, 0.32)		1.41 (1.03, 1.92)	
	0.00		1.00	
	−0.20 (−0.39, −0.01)		0.70 (0.56, 0.88)	
	−0.10 (−0.27, 0.07)		0.58 (0.45, 0.75)	
	−1.34 (−1.90, −0.77)		0.29 (0.12, 0.72)	
	0.00	<0.001	1.00	<0.001
	−0.41 (−0.82, 0.00)		0.20 (0.08, 0.49)	
	−0.70 (−1.01, −0.39)		0.21 (0.10, 0.45)	

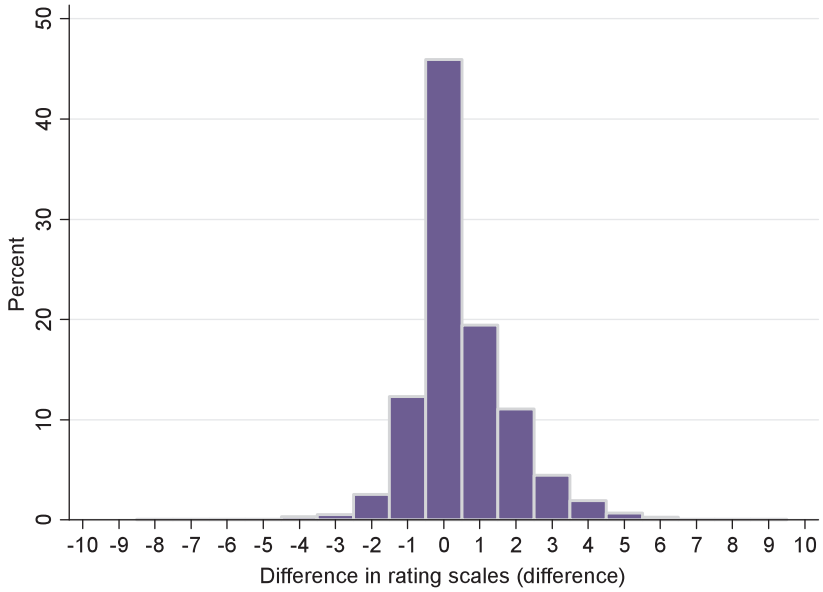

Figure 3 Efficacy in monitoring change of two client rating scales used to assess counselling outcome. Histogram shows difference in the changes in the complaint and functioning rating scales. Rating scale difference is defined as (complaint rating at client's last visit – complaint rating at the first visit) – (functioning rating at the client's last visit – functioning rating at the first visit); n=7004

The client functional rating improvement is 4.56 points when the counsellor assessed the client's problem as being resolved (95% CI: 3.85–5.27). A counsellor's assessment of the client's psychosocial problem as 'improved' is associated with a client functional rating improvement of 2.82 points (95% CI: 2.12–3.53). Clients assessed by the counsellors as deteriorated shows a small reduction in their functional rating: –0.09 (95% CI: –0.99–0.80).

Post-hoc analysis shows a significant difference between the functional rating change for clients with resolved versus improved condition according to the counsellors assessment (1.74 95% CI: 0.99–2.48, $p<0.001$). There is no evidence of a difference between patients whose problem remains the same versus those whose problem worsened ($p=0.836$).

The sensitivity analysis on the data set from Papua New Guinea reveals a slightly poorer fit in the prediction of the rating scales by the counsellor-assessed status, but the strength of associations remains very strong.

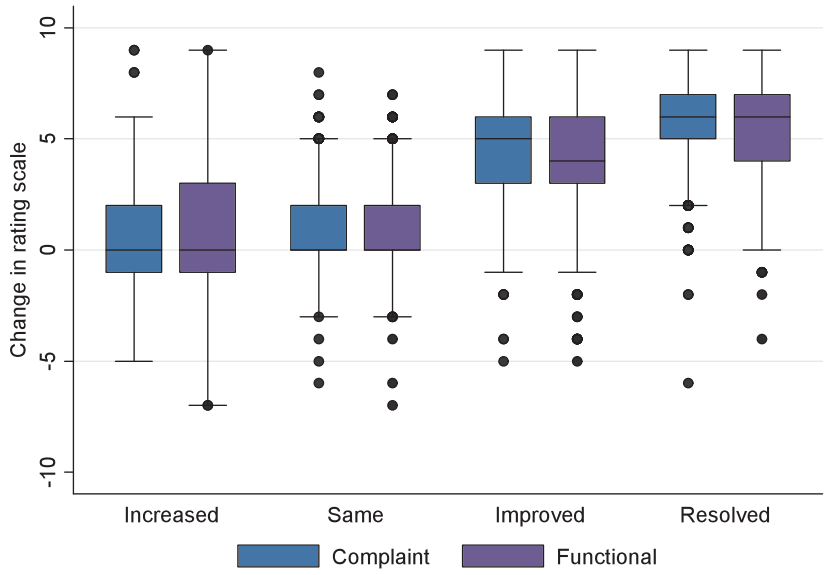

Figure 4 Association of the more favourable counsellor-assessed outcomes with changes in the client rating scales. Box-plot shows the distribution of change in rating scales (complaint, functioning) for each status (increased, same, improved, resolved) at client's last visit as assessed by the counsellor (n=6,988)

Discussion

Data from 18 psychosocial programmes in non-Western settings are used to assess two client and one counsellor treatment progress rating scale. No major differences between the different client scales and the client-counsellor rating scales are found. All scales show similar sensitivity to change. Also, variables associated with change (within the scales) are comparable. The discussion focuses on the implications of our findings for the convergent and construct validity of the scales and their usefulness for future psychosocial interventions.

Convergent validity

Various findings of our analysis point to good convergent validity. Firstly, treatment interventions are expected to result in changes in the clients' condition. The changes in all the scales are similar. Also, the underlying mechanisms of these changes are

similar. The multivariable models applied to all scales show similar associations between client and project characteristics.

It is also possible to interpret the client rating changes as an indication of client satisfaction. Also, from this perspective the similarity in change and association of the scales strengthen convergent validity. Several studies show that client satisfaction is associated with treatment gain [16] [17].

Thirdly, the expected number of sessions necessary to create change is consistent with other studies. The median number of sessions in our sample is five. Findings from other studies indicate that change is likely to occur after a minimum of three and a maximum of 10 sessions [18].

All three rating scales show the number of sessions are having an important association with the change in both client and counsellor ratings (more sessions= better results). This treatment dose–effect relationship supports the convergent validity of the scales. Howard et al. [19] found that 60–65% of people experience significant symptomatic relief within seven visits, figures that increased to 70–75% after 6 months, and 85% at 1 year.

An equally strong predictor for a positive outcome of counselling support is the type of exit being mutually agreed. A mutually agreed therapy termination is an indication of a good client–therapist relationship, which is known to be a solid predictor for positive treatment outcome [20]. In addition, the counsellor will normally only recommend discharge if the complaint is felt to be resolved or resolving.

Construct validity

The client rating scales register strong evidence of similar changes when pre- and post-counselling scores are compared. In practical terms this means scales may be interchangeable as the two scales essentially measure the same size of improvement as calculated by the pre and post scores. The change in the functional scale is 0.48 higher than the change in the symptom scale (4.3 versus 4.8 points). After adjustment for the significant difference at first visit, the symptom rating is 0.19 points higher than the functional scale. We conclude they are similar enough, as 0.19 points difference between the changes of the scales is essentially too small a difference to have practical, programmatic implications.

Interestingly, the significant worse complaint score compared to the functional score at first visit suggests that the most important motive for clients to seek counselling appears to be the alleviation of their symptoms, with their compromised functioning being a weaker driver. But when evaluating the benefit of the treatment: clients give still a better final rating to their functioning though their change in scale is a bit smaller than the change in complaint scale. This may be the result of the problem-solving approach adopted by our counsellors. It certainly shows that improved functioning is an important indicator of change next to psycho social complaint

improvement. More importantly, in areas of on-going violence, improvement of functioning may be even essential for survival of the clients.

Though for practical, programmatic reasons one client rating scale may be sufficient we suggest for future research into the validity of this method of client feedback to include both functional and symptom client rating by the client. A potential difference between the two types of client ratings should be investigated further.

To determine construct validity asks for comparison with an accepted standard. In the West clinician-rated measurements of improvement are an accepted standard [21]. Using our counsellors rating as standard we find similar changes in the client rating scales. More favourable counsellor-assessed outcomes are associated with larger changes in each of the client rating scales after adjusting for the baseline severity.

Some Western studies [22] dispute the clinician rated measurement as an accepted standard. They found low correlations between self-ratings and therapist ratings, concluding that clients' and therapists' assessment of the quality of the therapeutic alliance may differ considerably. Patients may overrate themselves relative to clinicians [23]. The large congruence in our study may be explained by the continuous monitoring we apply compared to two single pre- and post-measurements [24]. Longitudinal rating allows relationships, objectives and expectations to be adjusted over the course of the treatment leading to more congruent assessments. Active engagement of the client in his or her counselling process may also result in greater similarity between counsellor and client outcome ratings.

Importance

The relevance of this study is the development of an alternative for the Western, disorder-oriented self-reporting questionnaires often used for client evaluation in psychosocial programming in contexts of manmade violence and natural disasters. The tool that we evaluate is useful for both regular, on-going programme monitoring as well as for overall programme efficacy evaluation.

Client feedback tools should be simple and brief [25]. We find that our client rating scales are easy and quick to implement in different countries and cultures. Adaptation of the physical presentation of the scales for each context is simple. Although at the start counsellors have had difficulty explaining to clients the difference between symptoms and functioning, through training, clinical (group) supervision, and team meetings the best practices are shared and standardized. Involvement of local counsellors in the design ensures the scales' face validity with the clients. This feature is often missing in longer and more technical measures commonly used in psychosocial programmes, which are also more distant from the client's experience. We also observe treatment quality improvements linked to the client evaluation tool. The counsellors appreciate the use of the client rated scales, as it gives them an objective measure of the client's status at the start of each session, and helps them

keep the focus on the client's main concern. Western research shows that on-going client monitoring is relevant for the immediate quality improvement of the treatment intervention [20]. In line with other research [26] we observe that the continuous client feedback strengthens the therapeutic alliance between client and counsellor. The therapist's sensitivity to the client's subjective world is essential in cross-cultural settings. A recent meta-analysis has identified the therapist's ability to adapt his approach to the client's explanatory model of illness as the sole variable that explained superior outcome in culturally adapted psychotherapy [27].

The on-going monitoring helps our counsellor to predict early drop out. Our experiences are supported by research showing that a client's subjective experience of meaningful improvement in well-being after the first three sessions of therapy predicts successful treatment outcome [28] [29]. Furthermore, clients worse at the third visit are twice as likely to drop out of treatment [18]. Use of short client feedback instruments developed in Western countries for continuous measurement of the (changing) treatment process has been proven to enhance treatment outcome and reduce drop out [30] [31]. Our counsellors use the feedback of the client scales and discuss changes (or the lack thereof) with their clients. Challenging clients with no improvement of their condition are presented at the clinical supervision sessions to seek consultation from colleagues. Supervisors use the changes of the client scales to monitor quality of the counsellors. Counsellors having unusual changes (very high or very low) are invited to look into this phenomenon.

The positive findings of our study, implemented in 18 projects, may add a new important dimension to psychosocial programme evaluation in emergencies. Though our proposed method of monitoring does not inform on specific changes in pathology it adds the dimension on what may be equally important: whether it is perceived as useful for our beneficiaries.

Limitations of the study

Our analysis of project monitoring data has also limitations. We have to be careful with the interpretation of the positive treatment outcomes. The outcomes refer only to the client populations under treatment; a comparison population was not part of the analysis. It is outside the scope of this retrospective study that used regular programme data to compare against a reference population of waiting-list clients. Also, we have left out about half of the client population who has only one session (for an overall review see Shanks et al. [5].

As mentioned above the use of brief self-rating scales has shortcomings [32]. In the analysis of the treatment changes, a potential ceiling effect is present for clients with a high score on the pre-treatment scales. Furthermore, the assessment depends on accuracy of the client's self-rating and the counsellor's correctness regarding the accurate evaluation of the client's psychosocial problem at the end.

A limitation in determining construct validity is that we did not have a validated scale to compare with our rating tools. For future research we foresee this as the most problematic limitation to overcome. In most non-Western settings cross cultural validated gold standards do not exist; at best they are locally calibrated Western tools. Even the cross cultural validity of existing clinical interview methods are problematic [33]. A clinical gold standard is essential to get insight in the clinical relevance of scales. The scale ratings give a general impression. They do not contain different modalities or different perspectives. Neither do they measure clinical risk factors, or control for response sets such as social desirability.

The client's rating at the beginning of the last session may influence the counsellor's final assessment which is done at the end of the last session. In general we believe we have managed this limitation appropriately by including a very large number of clients and counsellors in our analysis. In future research it may be desirable to blind the counsellor for the client's final session rating.

The validity of the scales requires further research. The lack of a reference population masks the analysis of the scales' ability to discriminate between client and non-client. Furthermore, it hinders assessment of the ability to compare change between client and control groups over time. To assess this other (comparative) objective measurements is also necessary. Intra and inter-rater reliability of the counsellors' rating has been compared during training but not assessed formally, which limits the strength of the conclusions. Further research into the use of scales should address this through testing the intra- and inter- counsellor reliability.

Conclusion

The analysis of our regular treatment feedback tool in areas of conflict and disaster shows that it is possible to register in an easy way individual client changes without imposing Western, often non-validated, diagnostics and tools on the clients and counsellors. We find that rating scales measure significant changes over time. Analysis reveals both client and counsellor rating scales have good convergent and construct validity when compared to each other. The rating scales show counsellors and client perceive the usefulness of the treatment in identical positive ways.

Though these results are preliminary and need confirmation, we strongly suggest continuing to develop evaluation research that uses real-time, on-going client evaluation such as we described. The client, counsellor treatment feedback approach we describe seems a promising instrument to improve treatment evaluation for regular psychosocial, mental health programmes in humanitarian settings.

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Section V

Discussion and conclusions

Photo: Tom Stoddart

Chapter 12

Discussion and conclusions

Introduction

Awareness of the need to address psychological problems in the aftermath of mass violence in conflict areas started to develop in the 1990s. At that time, knowledge of the pervasiveness of violence-related psychological suffering came mostly from research among refugees in Western settings. The psychological consequences of mass violence among populations continuing to live in difficult circumstances such as on-going war or displacement were largely unknown. No theoretical framework existed for the assessment of needs or the organisation of a programme intervention model to address them. The effectiveness of such interventions was also unknown. Nowadays, in 2014, the knowledge on how to provide psychosocial support to populations in areas of mass violence, such as Syria and the Central African Republic, has grown substantially. We review here the scientific endeavour to answer the questions raised by the need to address the psychological problems in conflict areas. In the discussion reflections on our research outcomes and suggestions for the way forward are presented.

Question 1 What is the best methodology to assess violence and the related psychosocial needs in populations affected by on-going mass violence?

Four population surveys carried out in three conflict areas revealed high levels of exposure to traumatic events among the participants [1] [2] [3] [4] [5]]. Two surveys from the Northern Caucasus, using the same assessment instrument, found the greater part of the population to be experiencing psychological problems (Chechnya, Ingushetia: both around 80%). Assessments from Kashmir and Somalia indicated that approximately one-third of the population reported these problems (33% and 30% respectively).

Our findings, that at least one-third of the surveyed individuals had psychological problems, are in line with those of surveys done before 2000 (see Chapter 1, Table 2). The substantial distress that is found justifies an intervention to address the psychosocial consequences of violence. Our findings contribute to knowledge on the prevalence of psychosocial needs in areas subjected to acute, ongoing mass violence. These epidemiological data have contributed to the acceptance of mental services nowadays [6]. We also gave input to the development of alternative indicators that might identify psychosocial need in areas of violence.

Nevertheless, our surveys can be criticised with respect to 1) the methodology of psychosocial assessments used in areas of ongoing violence and 2) the wide variance in the reported prevalence of psychosocial problems (30% to 80%). In short: are there methodological flaws, are the results inflated?

Methodological concerns

Is the potentially traumatic experience a suitable indicator?

The ongoing discussion on how to define a 'traumatic event' makes the assessment of prevalence complex. The DSM-IV TR definition [7] was used in all our assessments. To establish the prevalence of violent experiences among a population, self-report lists were adapted to capture the local violent events with the help of local staff. A potentially traumatic event could be experienced in one of three ways: exposed (heard but not seen), witnessed, or self-experienced. The lists differentiated between recent (with various periods) and life-time experience, and gave an overview of the population's overall encounters with violence. We identified several problems with using the traumatic event as indicator.

The reliability of self-reports to establish prevalence of traumatic experiences is disputed. Some authors (e.g. [8]) consider them as reliable, whereas others state that the fallibility of memory leads to substantial recall bias [9]. It is difficult to exactly verify traumatic exposure and to a certain degree one is reliant on the person's own account.

In most of our surveys we included lifetime experience of trauma events and found high rates of occurrence. However, in contexts of ongoing violence (Kashmir: 19 years; Chechnya: at least 10 years, Somalia: 20 years), recall of events that took place decades ago was potentially unreliable. Therefore, we limited the recall of traumatic experience to a specific recent period (e.g. since the last Ramadan). Nevertheless, numbers of respondents who had been 'exposed' (heard but not seen) to trauma remained high. We concluded that most of the population was exposed to serious potentially traumatic experiences. Consequently, the indicator 'exposed' was too general to allow differentiation between those in need of psychosocial support and those not. We omitted the 'exposed' indicator from the Somalia assessment and used just two indicators of experienced violence: witnessed and/or self-experienced traumatic events in a predefined time period.

The Somalia assessment showed the level of witnessed, self-experienced traumatic events to be unrelated to the prevalence of PTSD, increasing our doubts as to the relevance of the traumatic event as an indicator for psychosocial needs in areas of ongoing mass violence. Apparently people living in areas of mass violence perceive and report violent events as potentially traumatic only when the events are out of proportion to the context, even if such events would in other settings be classified as traumatizing [10],[11].

Findings by Miller et al. [12],[13] further increased our doubts on the relevance of the traumatic experience(s) as an indicator for mental health needs in areas of ongoing violence. Miller et al. [12],[13] concluded that in areas of ongoing violence, daily stress was a far more important source of mental health problems than the experience of potentially traumatic events, and stated that psychosocial needs were triggered mostly by the total breakdown of the social fabric in the community. These findings highlighted

an important potential confounder in our (and other) mental health assessments from areas of ongoing mass violence. Are the needs identified in our research caused by the extreme violence or the social breakdown? Both our findings and the findings of Miller et al. 's [12] [13] showed the importance of the contextual component in the identification and interpretation of mental health needs (e.g. [14]). This finding should deserve more attention in future assessments in areas of ongoing violence. Indeed, the contextual component has already been found to be of substantial importance in the interpretation of mental health needs following natural disasters [15].

Alternatives for the indicators

The struggle to define a traumatic event is illustrated by the evolving definitions in the DSM (Chapter 1, Table 1), and the creation of more strictly defined indicators is an attractive prospect. The call for reliable and valid assessment methods is echoed in other areas of disaster mental health (e.g. [16]).

Our research in Kashmir and Somalia looked into the use of alternative indicators to determine psychosocial, mental health vulnerability. These assessments included additional data on the daily life and functioning of beneficiaries. Its collection is a first step in recording how psychological suffering is related to the beneficiary's social context. We investigated the association between these variables and psychological suffering assessed by means of (symptom) questionnaires. We identified several alternative or proxy indicators connected with psychological vulnerability. Results from Kashmir (Chapter 4) showed that variables such as currently feeling safe, being forced to move, not being able to and cutting back on work (for women: daily activities) were associated with psychosocial vulnerability. The self-rated assessment of ill-health as an indicator of poor mental health has been demonstrated also in (non-conflict) developing countries [17]. In Somalia (Chapter 5) it was shown that the ability to describe a particularly traumatic event among a series of highly potentially traumatising events appeared to be a good proxy indicator for high mental health vulnerability.

Steel et al.'s review [18] identified several other proxy indicators for the prevalence of psychological problems in areas of ongoing mass violence. Increased prevalence of both PTSD and depression was related to the time passed since the beginning of the conflict (more time after the conflict lower prevalence). High depression prevalence was associated with a difficult recovery environment (e.g. ongoing conflict in resident areas, refugee/IDP camps). A high score on the Political Terror Scale (e.g. the pervasiveness of the violence in the region) was related to increased PTSD prevalence.

Western, self-report questionnaires

The second indicator used in our assessments was the incidence of psychosocial signs or symptoms among the participants. For most non-Western violent settings, no

validated tools assessing mental health and psychosocial problems are available. Hollifield et al. [19], reviewing 349 refugee assessment studies, concluded that most studies are only descriptive and do not use any standardized instruments to measure needs. On the basis of those that did, Hollifield concluded: 'Primary limitations to accurate measurement in refugee research are the lack of theoretical bases to instruments and inattention to using and reporting sound measurement principles' (p. 611. [19]).

To deal with the cross-cultural validity problem we used existing Western questionnaires that were validated in regions culturally close to the assessment region. The S-PDS we used in Somalia was validated in Somaliland. The GHQ (used in our Caucasus assessments) and the SRQ (Kashmir assessment) were validated respectively in Chernobyl and Pakistan and India. For some authors (e.g. [20]) this is acceptable, though it still would be necessary to recalibrate the questionnaire. For others, it is not. In their opinion only a locally constructed and validated checklist can address the validity and reliability limitations of most other assessment studies. Bolton and Tang [21] described a method to develop local psychological assessment questionnaires.

If time, resources and accessibility permit, cross-culturally validated instruments are indeed the preferred rather than recalibrating existing Western instruments. Nevertheless, for emergency settings it is more practical to look into proxy indicators. The alternative markers as described above can hint at psychosocial, mental health vulnerability and indicate the level of need without using potentially stigmatising mental health labels.

Survey design

Most psychosocial assessments, including ours, are based on similar principles [22]: population surveys, randomized, mixed or convenience sampling, self-report questionnaires and point prevalence (mostly: ≤1 month ago). Steel et al. [18] reviewed 161 assessment articles (covering 181 surveys from 40 source countries involving 81,866 participants) carried out in areas of mass conflict and displacement. 'Methodological factors' (such as sample size, sampling method, type of measure, time of diagnostic reference) were found to explain a substantial part of the differences between surveys[18].

Steel et al. [18] suggested that both large samples (>499 participants) and clinical interviews are required for population surveys, but this raises practical problems in the context of acute violence. Substantial time and human resources are required to implement this criterion, which in a high-risk, resource-poor area may be far too large a burden for organisations. Also, from a scientific perspective the fast-changing situation typical of contexts of ongoing violence may compromise a sample's validity. It is not unlikely that circumstances may change substantially in the course of gathering and processing data.

A final concern is related to an important criticism of overrated needs. The instrument used to assess mental health leads to different outcomes: questionnaires produce higher prevalence rates of PTSD than diagnostic interview [23] [18].

Overrated prevalence of psychosocial needs?

Population surveys from areas of violence have received much attention, regardless their focus [24] [25] [26] [27] [28]. The importance of measuring the impact of violence using indicators such as mortality or mental health issues increased. They became important media and advocacy tools. Mortality surveys showed the human loss attributable to conflict. The mental health surveys quantified the impact of the conflict's: the survivors' circumstances, the confrontation with violence and the resulting psychological suffering. The findings helped NGOs to advocate attention to the suffering in conflict areas. Furthermore, for the populations affected, the outcomes of need assessments were an acknowledgement of their suffering. For populations living in 'forgotten conflicts' such as those in Chechnya, Kashmir and Somalia, it was a sign of hope that at least someone cared. Lastly, these surveys contributed to increased attention to mental health in general and highlighted the mental health service gap in most countries.

However, there has been concern expressed that the poor validity and reliability of mental health surveys led to exaggerated outcomes, the main reason being the wide variation in prevalence rates. For instance, in our studies the prevalence of psychosocial problems ranged from 30% to 80%. This problem is not unique to psychosocial assessments. The results of population surveys using seemingly more straightforward indicators such as mortality also varied substantially, even within the same context. An Iraq study estimated the 2003 mortality from the UN-sanctioned US invasion at 650,000 [24], while another puts it at 151,000 [28]. In the Democratic Republic of Congo even larger differences were found: one study estimates the death toll since 1998 at 5.4 million [29], and another estimated it to be three times higher [30]!

An important caveat for mental health population surveys is their risk of overrating prevalence of disturbances. In Western settings surveys generate higher prevalence rates than do clinical interviews [23] [31]. The proportion of mild or transient symptoms that need no treatment may also contribute to overrated prevalence outcomes [32], as do other factors such as knowledge of compensation possibilities.

Some authors [e.g. 6] have stated that the inadequate methodology of most psychosocial needs assessments executed in areas of conflict has created prevalence rates for PTSD and depression that are too high. This raises the question: are the prevalence rates of our assessments studies exaggerated? To come to a conclusion on this, we compared our surveys with other psychological needs assessments in non-Western areas. Steel et al.'s review [18] enabled a comparison between our surveys and 181 others. Steel et al. [18] redefined all the instruments from the different

Table 1 Needs prevalence of Somalia, Chechnya, Ingushetia and Kashmir compared to the overall findings on inter-survey variance in the Steel et al.[18] review

Part 1

PTS Methodological Factors Total ISV 12.9%		
	MSF Survey	***Steel PTSD Prevalence rate***
Sample size	ISV 9.1%	
Somalia: N= 84	SPDS: 29.7%	39.4% (24.3-56.7)
Sampling Method	ISV 4.4%	
Somalia:	Mix sampling	37.2% (26.7-49.1)
Type of Measure	ISV 3.7%	
Somalia:	Questionnaire	34.6% (25.6-44.8)
Diagnostic Frame	ISV 5.9%	
Somalia:	Period Prevalence	17.0% (10.0-27.6)
PTSD Range	**Prevalence**	**Preferred method**
Lowest	13.2%	Diagnostic Interview, sample > 499
Highest	25%	Probability/ census> 499

Part 2

Depression Methodological Factors Total ISV 27.7%		
	MSF Survey	***Steel Depression Prevalence rate***
Sample size	ISV 14.6%	
Chechnya: N= 256	GHQ: 98.8%	34.6% (22.5-49.1)
Ingushetia: N= 283	GHQ: 98.2%	34.6% (22.5-49.1)
Kashmir (India): N= 510	SRQ: 33.3%	36.8% (22.0-54.7)
Sampling Method ISV 13.2%		
Chechnya:	Mix sampling	46.9% (35.0-59.2)
Ingushetia:	Mix sampling	46.9% (35.0-59.2)
Kashmir (India):	Mix sampling	46.9% (35.0-59.2)

	PTSD Substantive (Risk) Factors		
		MSF Survey	***Steel PTSD Prevalence estimate***
	PTE adversity ratio	ISV 10.8%	
	Somalia:	>.39	35.5% (20.8-53.5)
	Torture	ISV 23.6%	
	Somalia:	4.8%	17.6% (Reference)
	Political Terror Scale	ISV 3.5%	
	Somalia:	>4.0	38.5% (28.6-49.4)
	Time since conflict	ISV 10.0%	
	Somalia:	Ongoing	39.9% (Reference)
	Regional comparison ISV 5.7%		
	Somalia:	Africa	33.5% (14.2-60.7)

	Substantive (Risk) Factors Depression		
		MSF Survey	***Steel Depression Prevalence estimate***
	PTE adversity ratio ISV 22.0%		
	Chechnya	>.39	40.0% (28.4-52.9)
	Ingushetia	>.39	40.0% (28.4-52.9)
	Kashmir (India)	>.39	40.0% (28.4-52.9)
	Torture ISV 11.4%		
	Chechnya:	2.7%	28.1% (Reference)
	Ingushetia	3.9%	28.1% (Reference)
	Kashmir (India)	12.9%	28.1% (Reference)

Table 1 Continued

Part 2

Depression Methodological Factors Total ISV 27.7%		
	MSF Survey	***Steel Depression Prevalence rate***
Type of Measure ISV 7.0%		
Chechnya:	Questionnaire	36.7% (27.3-47.2)
Ingushetia:	Questionnaire	36.7% (27.3-47.2)
Kashmir (India):	Questionnaire	36.7% (27.3-47.2)
Diagnostic Time frame ISV 9.7%		
Chechnya:	Point prevalence	34.8% (reference)
Ingushetia:	Point prevalence	34.8% (reference)
Kashmir (India):	Point prevalence	34.8% (reference)
Depression Range (overall)	**Prevalence**	**Preferred method**
Lowest	8.1%	Diagnostic Interview, sample > 499
Highest	25.2%	Probability/ census > 499

Steel (2009) prevalence rate= weighted PTSD/ Depression prevalence for this factor of all surveys. E.g. all surveys with Sample size n< 100 had weighted PTSD prevalence of 39.4%. Inter-Survey Variance (ISV)= the percentage of explained variance between studies. E.g. ISV 14.6% means differences in sample size between studies explained 14.6% of difference in PTSD prevalence rates. Mixed sampling: partially representative, linkage, convenience sampling or volunteer samples. Point prevalence: current-1

research settings into PTSD or depression scores. Our assessment instruments were re-labelled as PTSD outcome (S-PDS, Somalia) or as depression score (General Health Questionnaire (GHQ), Chechnya/Ingushetia; Self-report Questionnaire (SRQ), Kashmir).

Steel et al. [18] introduced the categories 'Methodological Factors' and 'Substantive Risk Factors' to label methodological differences between surveys and the level of violence, and they corrected the survey prevalence rates for both these factors. Table 1 shows the comparison between our findings and the overall outcomes of Steel et al. [18].

	Substantive (Risk) Factors Depression		
		MSF Survey	***Steel Depression Prevalence estimate***
	Residency Status ISV 5.0%		
	Chechnya	Displaced	38.2% (27.2-50.5)
	Ingushetia	Displaced	38.2% (27.2-50.5)
	Kashmir (India)	Not Displaced	33.6% (23.7-45.2)
	Time since conflict ISV 21.9%		
	Chechnya	Ongoing	34.7% (27.2-50.5)
	Ingushetia	Ongoing	34.7% (27.2-50.5)
	Kashmir (India)	Ongoing	34.7% (27.2-50.5)
	Regional comparison ISV 6.8%		
	Chechnya:	Other	33.1% (19.1-50.9)
	Ingushetia :	Other	33.1% (19.1-50.9)
	Kashmir (India):	Other Asia	25.7% (14.5-41.3)

month ago as opposed to Period prevalence: 6-12 months ago/ life time. PTSD/Depression range: the range in all studies reviewed. Political Terror Scale: higher than 4.0, indicating that political violence and terror were pervasive affecting the majority of the population. Regional comparison: compared to other non-violence related studies in the region.

The PTSD prevalence from our Somalia assessment (29.7%) is lower compared to those outcomes adjusted for 'Methodological Factors' and 'Substantive Risk Factors' (33.5–39.9%). Regional rates represent area prevalence without differentiating between conflict or non-conflict areas. For Somalia, our assessment findings are also lower compared to the regional rates (33.5%). Also, the Kashmir's (redefined SRQ) depression score (33.3%) is lower compared to the adjusted scores.

Only the Chechen/Ingushetia outcomes (redefined according to the criteria of Steel et al.) appear substantially overrated. The (GHQ corrected) depression prevalence in our surveys from the Northern Caucasus are now considerably (and

probably unrealistically) higher (Chechnya/Ingushetia: 98.8%/98.2% (these were before 78.5%/81.3% respectively). There are several other possible interpretations of the difference between the Northern Caucasus survey outcomes and the reference scores. Another option is that the use of the Chernobyl questionnaire and cut-off scores is not appropriate. Lastly, it cannot be excluded that the needs in war-afflicted areas of Chechnya/ Ingushetia are indeed substantially higher. Overall, we are confident that most of our survey outcomes provide a good indication of psychosocial problems; they are comparable to other outcomes from the specific regions.

The way forward

Our research showed that mental health needs in areas of ongoing violence are substantial and justify implementing a psychosocial programme to address them. On the basis of our studies and other research developments, we suggest a two-part approach to obtain reliable data from assessments in areas of ongoing violence.

In areas of acute violence, fast-changing environments (e.g. refugee camps, camps for the displaced, etc.), and low-resource settings, non-intrusive proxy indicators associated with psychological vulnerability are practical to assess needs. We found several of such proxy indicators. Associated with psychological vulnerability in different settings were: currently feeling safe, being forced to move, not being able to and cutting back on work (for women: daily activities) and the ability to describe a particularly upsetting event. Steel et al. [18] also pointed to similar and related indicators. The use of vulnerability indicators rather than mental health diagnostic labels may also address the criticism that psychosocial assessments stigmatise whole populations as mentally ill [34]. The application of proxy indicators in areas of acute conflict provide agencies with sufficient information to justify and decide on a psychosocial intervention.

General indicators will help to identify vulnerable populations and at-risk groups, but they do not identify which individuals have developed psychological problems. Therefore, the concept of mental health pathology should not be excluded from assessments. In more stable settings and when security permits, more rigorous methods can be applied. Time constraints and lack of resources can no longer be used as an excuse for not applying rigorous methodologies. Two criteria for assessment in these areas are essential: cross-cultural validation of instruments and the use of validated clinical interviews to establish a mental health diagnose.

The first recommendation is a realistic minimum standard at this moment. Bolton and Tang [21] have applied [35] [36] [37] a method to define local concepts of psychological illness and syndromes, which can be used to construct and validate local mental health questionnaires. When this methodology is standardized over different cultural settings overall comparison of outcomes is possible [6].

The second suggestion requires more research. The cross-cultural validity of existing clinical interview methods is problematic [38] and must be improved, both to improve diagnosis and to establish a gold standard to test locally developed mental health instruments. This requires fundamental research, but this step is essential for improving knowledge on mental health disturbances in non-Western cultures. In the meantime, the 'Schedules for Clinical Assessment in Neuropsychiatry' (SCAN) diagnostic interview method is advised as alternative. The advantage of this method is that it allows for a specialist interpretation rather than relying on fixed-answer tick boxes [39] [40].

Question 2 What are the key components of a framework to address the psychosocial consequences of mass conflict?

The lack of consensus on goals, strategies, and methods has hindered development of psychosocial interventions in areas of ongoing violence. At the start of the 21st century attempts to draft psychosocial guidelines were made (e.g. [41][42]). Five international NGOs engaged in discussions with five universities and successfully created a framework for emergency interventions [43][44]. Over the following decade conflict-related psychosocial interventions evolved as a well-established domain in humanitarian aid. An array of guidelines for field practitioners has become available, both generally and NGO specifically (e.g. [45]). The Inter-Agency Standing Committee (IASC) psychosocial and mental health guidelines are widely accepted as the best practice intervention model [46]. Our own guidelines [45] were used frequently as reference. The World Health Organisation's clinical guidelines (2011) for first responders in an emergency [47] are the first clinical guidelines for dealing with different stress-related conditions associated with violence [48]. It is clearly an achievement that a highly disputed intervention such as psychosocial support in conflict areas has developed in such a relatively short time. Despite this progress an important omission from these international materials is guidance on how to adapt the intervention to the local culture.

We have defined explicitly the essential components of a psychosocial programme to address violence-related psychosocial and mental health problems in areas of mass violence. These are: an individual approach to address serious mental health symptoms in the onset of an emergency with a growing emphasis over time on the social community context: the psychosocial problems that hamper people's ability to cope with the extreme stress and to adapt to their new situation come at the forefront. If the events of Rwanda 1994 happen again, we now know how to intervene. In the remainder of this section we reflect on our contributions to the development of a framework for psychosocial programmes in areas of mass violence and on the different perspectives toward interventions.

Who knows best: mental health experts or the local beneficiary?

Training of local staff has been a vital element of our intervention model from the beginning. The training aimed to create a mix of Western mental health concepts and local beliefs, traditional support mechanisms and local concepts of suffering [49] [50]. Western and local experts in dealing with people affected by violence discussed and adapted concepts with local trainees and future counsellors [51] [52] [53] [54] [55] [56]. This interaction and its implicit message of respect for local expertise are important to improve understanding of local needs, enhance knowledge on the meaning of suffering and to create services addressing them. Involvement of the local population in the design and execution of the intervention enhances self-control of the beneficiaries. Recruiting staff from the beneficiary population and training them to support their own people creates a sense of dignity and a sense of future perspective [57].

The intervention model is not explicit on the choice between the expert or the beneficiary perspective, as discussed in Chapter 1. Both options – sending mental health professionals *or* providing communities with resources to 'help themselves' – [58] remain open. Our model is a pragmatic mix with a clear but shared control with the local beneficiary population of what is important in their experiences, how the negative consequences should be addressed and which interventions are most appropriate.

Some argue that the local beneficiary perspective is the most relevant. Control should be moved from experts that know best to the beneficiaries (e.g. [34]). However, experiences in the field demonstrate that the issue is not clear cut. In non-Western cultures mental health and psychological problems are often associated with chronic, severe pathology that requires hospital admission and medication. Non-medication approaches are rarely available or even known, and local perspectives on mental health will leave many needs unaddressed. Potential clients of a psychosocial support programme do not want to be associated with people who are severely mentally ill. Even if mental illness is less stigmatised, the risk that beneficiaries may not recognise themselves as in need of support is substantial. An approach focusing on improved coping skills together with non-medication and brief therapy interventions is complimentary to local beneficiary input and should not be dismissed because it is Western. An appropriate balance between local, beneficiary perspectives and Western approaches is essential to ensure locally acceptable, quality services for those in need.

While implementing the mix of expert and local beneficiary perspectives in the field, it became clear that the inclusion of local workers per se did not guarantee representation of the local beneficiary perspective. Sometimes the cultural competence and sensitivity of national staff themselves was an issue. Even if recruited from the affected populations, an individual might lack the understanding of their own

cultural groups in their society or might be engaged in local power dynamics [59]. Already during the Rwandese intervention this became clear, when the trainers identified former perpetrators among counselling recruits. In certain interventions, the presence of outside experts ensures a balanced approach.

Collective, social context versus Individual, trauma approach?

Controversy regarding psychosocial programming in emergencies has been centred on the influence of Western models of intervention. In essence, the discussion is about how best to approach the individual affected beneficiary. The collective (social context) approach promotes community interventions to support beneficiary groups in dealing with the adversity of violence (e.g. [60] [61] [62]). Violence is considered as a community experience. Community interventions provide a range of opportunities such as practical support, stimulating community ties, promoting community support mechanisms, helping local groups to support their community, etc. Community strengthening and interventions are used to heal at a collective level and to reduce the need for individual psychological interventions.

The question of whether community interventions affect individual mental health outcomes is crucial for the discussion. De Silva et al. [63] found only a weak association between social networks and individual mental health. Some (e.g. [64]) state that it is time to provide empirical evidence for the impact of resources in the community on individual mental health. In (post-) war settings, and after natural disasters, some evidence is emerging for the effectiveness of community interventions. It has been shown that organizing community meetings [65] and school-based interventions [66], and implementing socio-therapeutic interventions in the community [67] often improve the individual member's functioning. Wind et al. [68] are among the first to describe the cross-level interplay between social community factors and individual psychosocial resources.

Those who advocate the individual perspective do not necessarily disagree with the importance of the collective experience and community approach. They doubt, however, whether community interventions are the best way to deal with the affected individuals in contexts of ongoing violence (e.g.[12]). Therefore, a focus on individual suffering is used as point of departure for planning and acting; individual care is provided for specific problems such as PTSD and other disorders through counselling and psychotherapy.

Our initial intervention model [69] [50] took the individual perspective as point of departure. Disturbance of the social ecology was recognized as an important element in the suffering of beneficiaries but no specific interventions were geared to improve it. The programme model included community activities to educate the population on the recognition of violence-related psychological problems, and to raise awareness of potential solutions and of where to get support if self-help mechanisms.

Nevertheless, our initial perspective cannot be labelled as trauma focussed. Despite the widespread tendency at the end of the 20th century to label post-trauma psychological signs as pathological disturbance (e.g. PTSD), the core philosophy of our intervention model [45] has been the view that mental stresses in contexts of violence are to be considered as normal reactions to abnormal circumstances. In our intervention model [45], the focus of early intervention is on supporting *coping* with extreme stress rather than on PTSD *treatment*. Reinforcing coping mechanisms included facilitating problem-solving skills, supporting emotional understanding of the situation, sharing of traumatic experiences, normalisation of reactions and experiences and helping beneficiaries to find their own solutions. The usefulness of this strategy was later acknowledged [70].

Changes over time: The growing importance of the social context approach

Our experiences in the field of humanitarian psychological interventions have not resulted in a radical change with regard to our initial intervention model. The overall objective 'to support the individual to reconnect, re-integrate into the environment *and* to create an environment that facilitates the individual, or rather groups of individuals, to re-integrate' (p. 33 [45]), covered both individual and collective perspectives. Our intervention model is not fixed in the dichotomy of being '*either* individual level *or* the community level'. We adhere to an intervention model that covers both within a multilevel framework [71]. The back-up safety net for those beneficiaries suffering from severe mental disorders remains crucial. The individual mental health approach justifies itself through the suffering of the most affected, if necessary 'at the expense' of the focus on the collective experience – the shattered social context. Clearly, a combined approach is preferable.

We learned to deal better with the concept that war-affected people may not form a homogenous category: they can differ substantially and require a multilayered approach [72]. The intervention model improved with respect to the input of local. Our initial focus of (psycho-) educational approaches shifted from (traumatic) stress-related problems to general community problems such as living with different ethnicities, living with perpetrators, prostitution, and substance abuse. Community mobilisation was improved by giving more impetus on the (re)activation of (pre-) existing community support mechanisms. This approach is in line with the findings of Benight [73] [74], who noted that the more affected individuals are empowered to act themselves, the more quickly they will overcome their mental health problems. Both the collective experience of the violence, as well as the beneficiary control over the support given to their people, gained importance in our model.

The psychosocial needs of violence-affected populations change over time. The intervention model evolved into a programme approach that addressed the over time

changing needs in an emergency better. A step-wise approach was promoted. In *acute emergencies* mental health projects applied a medical, vertical approach that focussed on those mental disturbances causing immediate danger to physical survival. The prevalence of severe mental disorders, such as psychosis [75] [76] seems substantial in emergencies [77] . In accordance with the WHO guidelines [78] they are treated in the primary care system. Meanwhile, in *chronic crises* the intervention model addresses psychosocial problems that hamper people's ability to cope with the extreme stress and to adapt to their new situation come at the forefront [45] [49].

The framing of what helps survivors of violence to cope with their experience has changed. Initially, the question 'What do people do to make them feel better?' is answered in terms of 'protective factors' (p. 1616, [69]). In the final versions of our intervention model [45] [50] [45] [79] the concept of 'resilience' replaces 'protective factors'. This change marks a change in the locus of control. An external shield against the suffering is changed into an inner strength that makes people continue (e.g. [80] [81]). Resilience is mobilised in various individual, and/or collective domains: physical, mental, social, spiritual and moral [79] [45] [79]. The concept of resilience strengthens further the importance of self-control and self-help [64] [82] [64] [83].

The way forward

The most important finding of our research is that we know which psychosocial programme components can be implemented at different stages of an emergency. We know now better how to provide psychosocial support in mass violence situations such as Rwanda (1994). In the field of psychosocial programming, the two perspectives mentioned in Chapter 1 (PTSD as a theoretical framework and the criticism on this) have merged into a common approach.

This does not mean that academic debate has ceased. A recent fierce debate between Neuner [12] and Miller [60] on the importance of the social ecology in psychosocial programming was reminiscent of the past. Miller and Rasmussen, despite their intention to bridge the gap between individual, trauma-focused interventions and social ecology approaches, only widened the gap. The fundamental point of controversy remained: what has priority in the provision of psychosocial support in violence-affected populations? However, an important difference between this debate and earlier discussions is that the recent disagreement was based on empirical research outcomes rather than on unsubstantiated opinions (p. 1381 [12]). Miller et al. [60] propose, in an emergency, initial addressing of daily stressors (e.g., social, community problems), letting specialist, individual interventions wait till later. Neuner [12] favours interventions focussing on the individual affected by a mental health problem or disorder related to experiences with violence. Our intervention model [45] advocates a combined approach from the start, with a changing balance

between 'psycho' and 'social' interventions at different stages of the emergency. At the start of an emergency, survival for the majority depends on securing food, shelter and water, whereas those severely affected by psychosocial disorders need mental health intervention, because they cannot survive by themselves. When violence continues, the larger groups require substantial attention, not so much for their disorders but more to help them adapt to their changed environment. In spite of these promising developments, research is needed to clarify the complex interplay between the social context and individuals' mental health.

Question 3 In areas of ongoing conflict, how effective are interventions to address psychosocial consequences of mass violence?

The Bosnia study included in this thesis [57] has been a frontier study on the effectiveness of mental health interventions in areas of ongoing mass conflict. The literature review (Chapter 10) indicated that it was the first study that presented outcomes of a mental health intervention for adults in a context of ongoing violence. Most other studies, except the one by Neuner et al. [84], were published in or after 2008.

We find evidence for the effectiveness of psychosocial interventions (Chapter 10) but the small number of studies (16) identified in this review did not justify strong conclusions. Research in areas of ongoing violence showed that PTSD-focused approaches have been studied the most. Approaches that include exposure as a key ingredient of the intervention (e.g. Narrative Exposure Therapy [85]) were found to be the most effective interventions for PTSD for specific groups. Furthermore, various forms of lay counselling enhanced the client's functioning. These outcomes confirm the importance of psychosocial interventions in areas of ongoing violence. Symptom reduction and improvement of the individual's ability to function are crucial for the survival of both the individual and the group.

Our chapter (11) on the evaluation of intervention effectiveness showed alternative methods for evaluating effectiveness. The scaling monitoring method successfully implemented in eight non-Western countries enables to measure the improvement of symptoms and functioning from both client and therapist perspective. Though further research is needed, the method may be another way to investigate the effectiveness of intervention programmes without Western diagnostic tools.

NGOs such as Médecins sans Frontières are at a crossroads with regard to deciding to commit to further research. The body of knowledge on research methodologies has grown substantially. The usefulness of small studies with non-validated questionnaires is more and more questioned [6]. NGOs not interested in applying high-quality research designs or with no means to do so, should focus on implementing solid program monitoring systems instead of relying on low-level research methodology.

The way forward

The challenge for psychosocial, mental health interventionists in areas of ongoing violence is to strengthen their knowledge base – preferably but not necessarily by implementing randomized controlled trial (RCT) methodologies. Once again, a minimum requirement (and top priority) for all study designs is the inclusion of cross-culturally valid and locally developed psychological ill health concepts and instruments to measure them. These standards are unlikely to be met in emerging emergencies, but may be more feasible in contexts of chronic ongoing violence. For emergencies alternative methods to evaluate intervention effectiveness, such as our scaling monitoring method using both client and counsellor perspectives, should be examined further.

A positive finding, for the development of treatment interventions and future research, is the importance of tailoring the intervention to the client's explanatory model. This adaptation is more important than changing the overall therapy ingredients [86][87]. In a meta-analysis comparing outcomes of culturally-adapted and regularly proven psychotherapies, Benish et al. [87] concluded that differences in treatment outcome were related to successful adaptation of the intervention to the client's explanatory model.

Continuous input from practitioners and beneficiaries on evaluation research is important. A combination of quantitative and qualitative research methods (e.g. mixed method research) is necessary to improve knowledge on what works best, and also to start understanding why the interventions work [36].

Conclusion

Practitioners and researchers have struggled with the question of how to provide psychological support to survivors in areas of ongoing violence. What are their needs, how can they be addressed and are the interventions effective? The answers to these fundamental questions are important if resource allocation for psychosocial interventions in contexts of mass violence is to be justified. First, contrary to popular belief, most people in contexts of mass violence do not suffer serious violence-related problems. Nevertheless, our research shows that approximately one-third of a population in a context of mass, ongoing violence experiences substantial psychological distress, and this prevalence is high enough to justify psychosocial interventions. Through our studies we have collected knowledge gained at the heart of areas subjected to acute or ongoing mass violence of the prevalence of psychosocial needs. We have proposed alternative indicators to assess those needs. Moreover, we have shown the suffering and ongoing violence associated with forgotten conflicts in Chechnya, Kashmir (India), and Somalia.

An intervention model that works in the field has been developed. The framework mobilises strengths from both local and Western perspectives. Beneficiaries can influence the intervention and tailor it to their needs and priorities. Initial outcome research shows that, in particular, trauma related symptomatology decreases and that counselling including exposure approaches is effective in improving functioning and therefore survival. We developed a way to measure, session by session, the effectiveness of individual interventions.

The first psychosocial programs were a step in the dark. Nowadays, we know much better how to effectively approach psychological problems in areas of ongoing violence. It was courageous of humanitarian organisations such as MSF to start addressing needs and to substantiate learning through research in the 1990s. Currently, many NGOs run psychosocial, mental health programs as part of their activities. In 2013, the Dutch section of MSF operated 24 mental health, psychosocial programs in 16 countries. All activities are integrated in existing services, primary health care units, or hospital programmes in community or camp settings. These developments are enabled through successful (operational) research while providing services for those in need.

The outcomes of this dissertation demonstrate that one of the largest humanitarian disasters in modern times, the Rwandan crisis of 1994, led over time to the improvement of care for those suffering from the psychological consequences of violence. If only we were equally successful in preventing violence.

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Photo: Jorge Nyari

Summary

Summary

Problem definition

Major wars in Europe (Bosnia-Hercegovina, Kosovo) and genocides such as in Rwanda and Burundi challenged the humanitarian community to provide adequate psychological support to survivors of mass violence. This thesis deals with psychosocial humanitarian research carried out from 1999 until 2013. Central questions are: how to assess needs in terms of psychosocial health, how to adequately address those needs, and what is the effectiveness of these mental health interventions?

The dominance of PTSD and alternative criticism

The diagnosis Post-Traumatic Stress Disorder (PTSD) has dominated the thinking and the design of psychosocial support programmes for war-affected populations. A consensus exists on the signs and symptoms of PTSD; these are assumed to be universal. However, less agreement exists on the precondition to develop PTSD: a traumatic experience. The definition of a traumatic experience differs in each consecutive version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Non-Governmental Organisations (NGOs) have adopted the (assumed) universality of PTSD in their intervention models to address psychosocial needs in areas of mass conflict. Also, exposure to violence and the development of PTSD are considered as causally related leading to a widely held belief that after mass exposure to violence whole populations will suffer from PTSD.

Criticisms are raised against the assumptions of universality, the 'causal' relationship and the central notion of PTSD. Research has shown that PTSD is not the only possible psychological consequence after traumatic exposure. Even if PTSD is universal, it does not imply that the subjective interpretation of the experience or the meaning given to it is universal. Moreover: are the negative responses to mass violence not normal, adaptive reactions that most people will recover from? According to this adaptation perspective the impact of mass conflict is conceptualised as a collective experience, which should not be reduced to individual mental health or medical abstractions related to medical disorders. Therefore, it is vital to focus in psychosocial programming on the social ecology that addresses the changed social world of survivors.

Thesis questions

Instruments and methods for assessing psychosocial and mental health needs in contexts of ongoing violence are scarce at the start of the 21st century. How to assess the experienced violence and related psychosocial needs is the *first research*

question of this thesis. Based on the critical comments mentioned above, mental health symptoms rather than diagnostic labels such as depression or PTSD were used to assess the psychosocial impact of violence on populations.

The focus of intervention as well as the prioritisation of services to address the suffering in areas of mass conflict was rather unidentified in the 1990s. Two perspectives may be distinguished. In the expert perspective experts use bio-psycho-social models (such as PTSD) to look at suffering and interventions; the beneficiary is a patient. The opposing viewpoint using a local perspective, states that not experts but beneficiaries know best: the recipients of aid decide on their own priorities. Each perspective has its credibility. Which perspective is the most useful is discussed in our *second research question*: What are the key components of a framework to address the psychosocial consequences of mass conflict?

Resources allocation in emergencies is justified when psychosocial interventions in war areas are effective. Our *third question* addresses this issue: what is the effectiveness of interventions to address psychosocial consequences of mass violence in areas of ongoing conflict?

Findings and discussion

Question 1: What is the best methodology to assess violence and the related psychosocial needs in populations affected by on-going mass violence?

Population surveys executed in Chechnya, Ingushetia, Kashmir and Somalia revealed that nearly all respondents had been confronted with various potentially traumatic events. We found that at least one third of the respondents reported substantial psychosocial health difficulties (in Chechnya: 80%; in Ingushetia: 67%; in Kashmir: 33%; in Somalia: 30%). The use of empirically reported epidemiological data contributed to the acceptance of psychosocial services in these areas of conflict.

Psychosocial population surveys are often criticised for their methodological shortcomings. One of these shortcomings is the small sample size of the surveys. The sample size in our surveys was substantial (varying between N= 250 and N= 510) with the exception of Somalia due to security circumstances (80). The use of instruments that are not validated for non-Western settings is another point of criticism. Both points of critics may lead to overrated prevalence of psychosocial needs in assessment areas. However, comparison of our survey outcomes with data from other population assessments in the same region leads to the conclusion that our findings are not overrated.

The use of the occurrence of traumatic experiences as indicator of psychosocial suffering is problematic according to our research findings. Firstly, the general exposure to violence did not differentiate sufficiently. Also, specific indicators such as the level of witnessed, self-experienced traumatic events failed to show a relationship with PTSD prevalence; as was shown in our Somalia research. Respondents reported an

average of 5 potential traumatic experiences, although 'only' 30% had substantial PTSD symptoms. Apparently, people living in areas of mass violence perceive violent events as potentially traumatic only when the events are out of proportion to the context.

Our research gives input to the development of alternative indicators to identify psychosocial health care needs in conflict areas. We have found proxy indicators for psychosocial vulnerability such as: currently feeling safe, being forced to move, not being able to and cutting back on work (for women: daily activities).

Our research also showed the importance of using contextually adapted indicators and methods. Therefore, a differentiation of psychosocial indicators in different stages of the violent context is proposed. For emergency settings it is more practical to apply proxy indicators. These alternative markers can signal psychosocial vulnerability (in risk groups) and indicate the level of need without using potentially stigmatising mental health labels. However, they do not identify which individuals have developed psychological disturbances. Therefore, the concept of mental health pathology should not be excluded from assessments. In less violent settings and when security permits, locally defined concepts of illness and cross-culturally, validated instruments to measure these are the preferred minimum assessment standard. This includes the development of a 'gold standard' clinical interview that can meet cross-cultural validity requirements as well.

Question 2: What are the key components of a framework to address the psychosocial consequences of mass conflict?

Currently, a consensus among NGOs exists on goals, strategies, and methods of psychosocial support delivery in areas of mass violence. The Inter-Agency Standing Committee psychosocial and mental health guidelines developed by representatives of NGOs and the World Health Organisation, are nowadays widely accepted as the best practice intervention model. Our research has given substantial input to the making of these guidelines.

In our program model the recruitment, the training of national staff as well as their involvement in program design are considered as essential. However, no explicit choice is made between the expert and the beneficiary perspective in our program model. An appropriate balance between local, beneficiary perspectives and expert input is recommended. Experts are often needed to guarantee an appropriate quality level, beneficiary input is essential to translate interventions to locally acceptable support.

How to support the individual beneficiary best: by community interventions to improve the social ecology or by applying an individual, trauma oriented perspective? Psychosocial programs generally aim to support both individuals and communities to create an environment that facilitates the individual, or rather groups of individuals

to cope with ongoing violence and its aftermath. Our initial psychosocial intervention model took the individual perspective as point of departure. Community interventions were included to promote self-help and to improve service access. Early individual interventions focussed on the stimulation of own one's coping mechanisms rather than in the treatment of disorders (such as PTSD). In the course of applying intervention models in several conflict areas we have learned to deal better with the notion that war-affected people form a heterogeneous group. The collective experience of the violence, as well as the beneficiary control on what they need has gained importance in our model. A 'strict' coping with trauma approach gave way to a methodology that added general community problems associated with living in areas of violence as an important component. The importance of the strength of the beneficiary (resilience) has grown in our program model.

A step-wise approach is nowadays used to improve contextual relevance. In *acute emergencies* psychosocial programs focus on a 'strict' medical, vertical approach to ensure survival of the most vulnerable. When a *chronic crisis* develops more emphasis is given to people's ability to cope with and adapt to their new situation.

Question 3: In areas of ongoing conflict, how effective are interventions to address psychosocial consequences of mass violence?

Our study on the evaluation of a comprehensive mental health counselling program in Bosnia-Hercegovina showed a marked improvement in two third of our 5056 clients. Recently we reviewed all other evaluation research (until 2013) executed in areas of ongoing violence. The most effective interventions for mental health disturbances were Narrative Exposure Therapy (improvements of 71% of the clients) and a form of flexible and reconciliation counselling. Both included exposure as a key ingredient. Culturally adapted problem focused counselling and cognitive behavioural interventions showed important improvement of general anxiety and depression. For example, both in Uganda and Afghanistan significant symptom improvement post therapy were reported; for Afghanistan even at three months follow-up. Various forms of lay counselling, such as problem solving and stress reduction counselling (e.g. in Nepal significant improvement was reported at five months follow-up) were found to enhance the client's functioning. These outcomes confirmed the importance of psychosocial interventions in areas of ongoing violence. Symptom reduction and improvement of the individual's ability to function are crucial for the survival of both the individual and the group.

The difficulty to conduct scientifically sound research in areas of ongoing violence as well as the major cross-cultural limitations in this research challenged us to look for alternative evaluation methods. We experimented with the scaling monitoring method using both client and beneficiary for evaluation. It showed good

validity and may be an alternative for existing methods using Western diagnostic tools to investigate the effectiveness.

Further research into the effectiveness of psychosocial interventions is needed. Preferably randomised controlled trials should be conducted, but the top priority is the application of cross-culturally valid and locally developed concepts and instruments assessing health issues and adjustment. More research is needed into alternative measurement methods such as the scaling monitoring method. Nevertheless, our research contributed substantially to the knowledge on assessment, implementation and effectiveness of psychosocial interventions in areas of mass, ongoing violence experiences.

Photo: Sarah Elliott

Samenvatting

Samenvatting

Oorlogen zoals die in Bosnië-Herzegovina, Kosovo en de genocides in Rwanda en Burundi stellen de humanitaire gemeenschap voor de uitdaging psychologische ondersteuning te geven aan de getroffenen. Dit proefschrift beschouwt het psychosociaal onderzoek uitgevoerd in verschillende humanitaire conflicten tussen 1999 en 2013. De centrale vragen zijn: hoe moet de omvang van psychosociale gezondheidsproblemen gemeten worden, hoe kan de hulpverlening georganiseerd worden en zijn deze psychosociale interventies effectief?

Dominantie van het PTSS diagnose, kritieken en alternatieven

Het denken over en het ontwerpen van psychosociale hulpverlening tijdens of na grootschalige geweldsgebeurtenissen is sterk gedomineerd door het 'universele' Post Traumatisch Stress Stoornis (PTSS) concept. Er lijkt consensus te bestaan over de symptomen en de universaliteit van PTSS. Echter, over de definitie van de aanleiding voor het ontwikkelen van een PTSS, een traumatische ervaring, bestaat onduidelijkheid. Elke nieuwe versie van het handboek voor diagnostiek van mentale aandoeningen (DSM) hanteert een verschillende definitie voor een traumatische ervaring.

Veel Niet-Gouvernementele Organisaties (NGOs) nemen de veronderstelde universaliteit van PTSS over bij de ontwikkeling van een programmatisch model voor interventies in gebieden van grootschalig geweld. Daarbij wordt ook een causaal verband verondersteld tussen de blootstelling aan geweld en het zich voordoen van PTSS. Dit leidt tot de algemeen gangbare gedachte dat in gebieden van grootschalig geweld hele bevolkingsgroepen aan PTSS kunnen lijden.

Er is veel kritiek op deze vooronderstellingen. Zelfs indien PTSS universeel voorkomt dan impliceert dat nog niet dat het ervaren van geweld en het toekennen van betekenis aan dit geweld voor een ieder hetzelfde is. Ook de veronderstelde causale relatie tussen blootstelling aan geweld en het voorkomen van PTSS is twijfelachtig. PTSS is immers niet de enige mentale aandoening waaraan geweld ten grondslag ligt. Daarnaast: moet het optreden van klachten niet gezien worden als een normale aanpassingsreactie waarvan de meeste mensen op eigen kracht herstellen? De critici zien de impact van geweld als een collectieve ervaring welke niet gereduceerd moet worden tot een individueel mentaal gezondheidsprobleem of een medische aandoening.

Vraagstellingen in het proefschrift

Aan het begin van de 21-ste eeuw bestonden er weinig instrumenten om de behoefte aan psychosociale hulp in geweldsgebieden te meten. De *eerste vraag* richt zich dan ook hierop: Wat is een goede manier om de mate van het door de bevolking ervaren

geweld en de psychosociale gevolgen hiervan te meten? De gevolgen van geweld worden in de in dit proefschrift beschreven onderzoeken zoveel mogelijk gemeten door middel van symptomen. Het gebruik van diagnostische etiketten, zoals PTSS en depressie, wordt vermeden.

Hoe wordt ondersteuning geboden, welke diensten hebben voorrang, welke praktische interventies zijn nodig in gebieden met massaal geweld? Dit alles was onbekend ten tijde van de uitvoering van onze studies. Er zijn twee perspectieven in de beantwoording van deze vragen te onderscheiden. Enerzijds zijn er de experts die bio-psycho-sociale modellen en perspectieven (zoals PTSS) gebruiken bij het ontwerp van een psychosociaal interventiemodel. De getroffenen worden gedefinieerd als patiënten die door experts behandeld worden. Daar tegenover staat de lokale benadering. In dit gedachtegoed spelen de getroffenen een centrale rol. Zij weten het beste wat er nodig is en moeten daarom de aard en prioriteiten van de hulpverlening bepalen. Beide perspectieven worden gebruikt bij de *tweede centrale vraag*: Wat zijn de kerncomponenten van een interventiemodel dat tot doel heeft ondersteuning te bieden bij de psychosociale gevolgen van grootschalig geweld?

Toewijzing van middelen aan psychosociale interventies ten tijde van noodsituaties zoals oorlog en geweld, is gerechtvaardigd wanneer deze interventies effectief zijn. De *derde en laatste vraag* gaat hierover: Wat zijn de effecten van psychosociale interventies in gebieden van grootschalig geweld?

Bevindingen en discussie

Onderzoeksvraag 1: Hoe kan in gebieden van voortdurend grootschalig geweld vastgesteld worden in welke mate mensen met geweld geconfronteerd zijn en wat de gerelateerde psychosociale behoeften zijn?

Onze bevolkingsonderzoeken in Ingoesjetië, Kasjmir en Somalië tonen aan dat bijna iedereen (meerdere) ernstige geweldservaringen heeft meegemaakt. Wij vonden bij tenminste een derde van de respondenten substantiële psychosociale klachten (Tsjetsjenië: 80%, Ingoesjetië : 67%, Kasjmir: 33% en Somalië: 30%). Het gebruik van onder meer deze wetenschappelijk onderbouwde epidemiologische bevindingen heeft bijgedragen aan de acceptatie van psychosociale interventies in deze crisisgebieden.

Veel psychosociaal bevolkingsonderzoek wordt bekritiseerd vanwege de kleine steekproefgrootte. Onze steekproefgrootten waren evenwel voldoende substantieel om representativiteit en statistische 'power' te garanderen (variërend van 250 tot 510); de steekproefgrootte in Somalië (80) was een uitzondering vanwege de slechte veiligheidssituatie). Een ander kritiekpunt is het gebruik van instrumenten die niet gevalideerd zijn voor niet-westerse regio's. Beide kritiekpunten kunnen leiden tot een

te hoge inschatting van psychosociale behoeften. Vergelijking met de uitkomsten van andere, in de regio uitgevoerde, bevolkingsonderzoeken leidt tot de conclusie dat onze onderzoeken geen overdreven prevalentie waarden weergeven.

Uit onze onderzoeken blijkt dat het beleefde geweld geen goede indicator van psychosociaal lijden is. Het begrip 'algemene blootstelling aan geweld' differentieert onvoldoende. Maar ook specificaties zoals het 'zelf zien of ervaren van geweld' blijken problematisch. In ons onderzoek in Somalië vinden wij geen relatie tussen de hoeveelheid ervaren geweld en PTSS: respondenten hebben gemiddeld vijf ernstige geweldservaringen terwijl 'slechts' 30% substantiële PTSS symptomen hebben. Blijkbaar ervaren mensen die leven in gebieden waar veel chronisch geweld plaatsvindt, gewelddadige gebeurtenissen alleen als traumatisch wanneer deze afwijken van het 'gewone' dagelijkse geweld. De context speelt een belangrijke rol bij de beleving van geweld.

De onderzoeken in dit proefschrift dragen bij aan het denken over alternatieve indicatoren voor het bepalen van geweld gerelateerd psychosociaal lijden. We vonden alternatieve indicatoren zoals: het huidig gevoel van veiligheid, gedwongen verhuizing, totaal of gedeeltelijk onvermogen om te werken/ functioneren. Deze bleken in bijna alle situaties goede indicatoren te zijn van psychosociale kwetsbaarheid.

Op basis van onze onderzoeken raden wij aan om in toekomstig psychosociaal bevolkingsonderzoek indicatoren en methodologie te gebruiken die beter bij de context passen. In *noodhulp* situaties is het gebruik van alternatieve indicatoren zinvol en praktisch. Deze indicatoren tonen psychosociale kwetsbaarheid aan. Bovendien geven deze een behoefte aan die niet direct gerelateerd is aan pathologie. Dit voorkomt onnodige stigmatisatie. Nadeel is dat er geen precieze vaststelling is van de heersende pathologie. In contexten met *gestabiliseerd geweld* waarin het veiligheidsniveau het toelaat om uitgebreider onderzoek te doen, moet het gebruik van lokaal ontworpen en gevalideerde instrumenten welke (lokale) pathologie meten de nieuwe standaard worden. Dit houdt in dat het klinisch interview, de 'gouden standaard' in de psychiatrie, ook cultureel aangepast wordt.

Onderzoeksvraag 2: Wat zijn de belangrijkste bestanddelen van een psychosociaal interventie model in gebieden van grootschalig geweld?

Tegenwoordig is er een consensus bij NGOs over de doelstellingen, strategieën en methoden bij het verlenen van psychosociale hulp in gebieden geteisterd door grootschalig geweld. Richtlijnen voor psychosociale en geestelijke gezondheidsinterventies in geweldsgebieden, uitgegeven door het overkoepelende orgaan van Europese NGOs, zijn algemeen geaccepteerd als 'best practice'. Onze inbreng, gebaseerd op onderzoek uit dit proefschrift, is belangrijk geweest bij het tot stand komen van deze richtlijnen.

In het door ons beschreven programmatische model zijn de werving en training van nationale staf en hun invloed op de ontwikkeling van het programma cruciaal. Echter, een expliciete keuze tussen de 'expert' of 'getroffene' benadering wordt niet gemaakt. Ons model gaat uit van een pragmatische mix met een goede balans tussen de visie van experts en getroffenen. Experts zijn veelal nodig om de kwaliteit te garanderen maar de getroffenen zijn essentieel om de interventies te vertalen naar lokaal acceptabele hulpverlening.

De hulpverlening kan zich richten op het individu of op het verbeteren van de sociale ecologie van de gemeenschap. De kerndoelstelling van psychosociale programma's is niet veranderd: het creëren van een omgeving voor zowel het individu als de gemeenschap, die helpt bij de omgang met de door geweld veroorzaakte psychosociale problemen. Echter, in het beginstadium van de ontwikkeling van ons psychosociale model lag het accent meer op de individuele benadering. Interventies in de gemeenschap beperkten zich voornamelijk tot het stimuleren van zelfhulp en het bekendmaken met de dienstverlening.

Over de tijd hebben we geleerd om beter om te gaan met de diversiteit van de groep oorlogsgetroffenen en de context. Een 'strikte' benadering gericht op het omgaan met de herinneringen aan geweldservaringen verbreedde zich tot een methodologie waarin ook het omgaan met andere, algemene problemen van de gemeenschap aandacht krijgen. Een stapsgewijze aanpak maakt de interventie relevanter voor de context. In *acute noodsituaties* hanteert de dienstverlening een medische, verticale benadering gericht op de overleving van de meest kwetsbaren. Ontwikkeld zich hierna een *chronische crisis* dan kan de dienstverlening zich dan richten op het omgaan met de geweldservaringen *en* het aanpassen aan de nieuwe situatie. Het aansluiten bij de eigen kracht van getroffenen (veerkracht) wordt steeds belangrijker bij onze psychosociale hulpverlening voor oorlogsgetroffenen.

Onderzoeksvraag 3: Hoe effectief zijn psychosociale interventies in gebieden van grootschalig geweld?

Naast de door ons uitgevoerde effectstudie in Bosnië-Herzegovina welke een belangrijke verbetering van klachten bij twee derde van 5066 cliënten aantoonde, is in het proefschrift een overzicht van al het, in contexten van massaal geweld, uitgevoerde effectonderzoek opgenomen (tot januari 2013). Voor getroffenen lijdend aan PTSS werden duidelijke effecten aangetoond voor Narratieve Exposure Therapie: 71% van de cliënten verbeterde significant. Maar ook voor varianten van counseling zoals flexibele en verzoeningscounseling, werd een significante verbetering van klachten aangetoond. Het belangrijkste was dat de behandeling een component had waarbij de cliënt in gedachten op gecontroleerde wijze blootgesteld wordt aan zijn traumatische ervaring (exposure). Cultureel aangepaste behandelvormen gebaseerd

op oplossingsgerichte en cognitieve gedragstherapie leidden tot duidelijke verbetering van angst- en depressieklachten. Tevens bleken verschillende vormen van counseling (zoals oplossingsgericht, stress reducerend) het functioneren van cliënten te verbeteren. Deze uitkomsten bevestigen het belang van psychosociale interventies in gebieden van grootschalig geweld. Zowel symptoomvermindering als de verbetering van het functioneren zijn beide cruciaal bij het overleven in gebieden van doorlopend, massaal geweld.

De moeilijkheid om onderzoek te doen in geweldsgebieden maar ook de complexiteit van cultureel verantwoord onderzoek, nodigen uit tot het ontwikkelen van alternatieve evaluatiemethodieken. We hebben geëxperimenteerd met 'waarderingsschalen' ingevuld door zowel de getroffene als de hulpverlener. Deze methode heeft een goede validiteit en vooralsnog lijkt het een goed alternatief voor de gangbare, westerse, niet gevalideerde instrumenten.

Meer onderzoek naar de effectiviteit van psychosociale interventies in gebieden waar zich grootschalig geweld voordoet is nodig. Bij voorkeur gerandomiseerd, gecontroleerd onderzoek. Echter, van groter belang is dat het onderzoek cultureel valide is en gebruik maakt van lokaal ontwikkelde, psychologische ziektebegrippen en daarop gebaseerde instrumenten.

Photo: Andre Francois

Acknowledgements | Dankwoord

Acknowledgements | Dankwoord

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Many - including me - wondered how I combined intense field work with conducting elaborate research and writing the articles (in my free time). It took me 15 years to complete this thesis. I felt it as a compelling moral necessity to the beneficiaries, Médecins Sans Frontières, and myself to provide the best possible mental health service. I discovered research to be a perfect tool to create some order in the madness of war; research became for me an essential coping mechanism.

My parents provided me with the basic feeling of safety which has been essential for me to work in areas of violence. It proofed a solid background for my wanders into the unknown. It is to my late mother to whom I dedicate this thesis.

Finally, the most important backbone for this thesis is my family. Stella and Issa, my daughters who cushioned the rough edges of my work. My para-nymph and my nymph for life, Moniek, dealt with my frequent absence in the field or study room while raising two children and pursuing a career in documentary making. You taught me to take time to smell the roses.

Photo: Robin Hammond

About the author

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Kaz de Jong was born on August 17th 1961 in Amsterdam. He completed a study in Physiotherapy and worked as physiotherapist several years in a private practice. He also holds two academic Masters: in Clinical Psychology with a minor in Organisational Psychology, and in the Psychology of Movement with a minor in human Exercise Physiology, both at the Free University of Amsterdam.

He worked for several years in the Amsterdam Free University Clinic as clinical psychologist. He started his own enterprise specialized in the provision of organisational advice and training on topics such as absenteeism, safe-security behaviour, and transition of organisation culture.

In 1994 Médecines sans Frontières sent him to Bosnia-Hercegovina to establish a mental health program in Sarajevo. This program received several years later the prestigious "Clinical Excellence" award of the International Society of Traumatic Stress Studies (1999). For Médecines Sans Frontières he implemented mental and psychosocial programs in many countries, on four continents, both as field worker and as mental health advisor. Most of these interventions addressed the consequences of natural or man-made violence. Others dealt with the consequences of chronic diseases such as HIV/AIDS and Tuberculosis. In the capacity of mental health advisor (1996-2008) he was responsible for the implementation of psychosocial programs, quality control and evaluation. Most of the research described in this thesis originates from this period. At the end of 2008 he returned to the direct client care when accepting the position of the coordinator of the psychosocial staff care unit of Médecines Sans Frontières.

Kaz is regular guest lecturer at the Harbour Clinic (Rotterdam), the Hoge School in Leiden, the Erasmus University (Rotterdam), the Academic Medical Centre Amsterdam, the Liverpool School of Tropical Medicine and Hygiene, and the Geneva University. He is president of the board of the Dutch Charity 'Lifeboat' (www.lifeboatfilms.org) which fights the stigma on HIV. He shares his life time with Moniek his wife, his two daughters Stella and Issa and the (male) dog.

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