



The Psychosocial Special Interest Group (SIG) aims to pursue didactic, research, policy, and operational excellence in international disaster preparedness, response, and recovery, including the prevention and mitigation of psychological stress, and the promotion of resilience.

PSYCHOSOCIAL SPECIAL INTEREST GROUP NEWSLETTER

Issue 3 - April 2018

Issue Theme: *Conflict Affected Populations*

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Introduction

This is the third newsletter issued by WADEM’s Psychosocial Special Interest Group. There will be two issues per year (April and September). It is being distributed, free of charge, to all WADEM members and to others known to us as having an interest or involvement in international psychosocial research and field work. Please feel free to forward this newsletter to other people who may be interested.

Purpose of the Psychosocial Newsletter

The Psychosocial SIG Newsletter has been developed as a medium to provide WADEM members and other interested academics, professionals, students, and organizations with useful information relevant to international psychosocial work. Each issue has a theme; this issue’s theme is that of ***Conflict Affected Populations***. Research and project abstracts and journal references are provided addressing this issue’s theme. In addition, each issue briefly identifies a different graduate school program or institute having a disaster mental health graduate level track, organizations providing a variety of psychosocial resource information, a journal with psychosocial emphasis articles, and upcoming conferences or events of likely interest.

Interview with Professor Frederick M. “Skip” Burkle, Jr.

In lieu of a guest editorial this issue we have included in our next section of the newsletter an in-depth interview with Professor Frederick “Skip” Burkle, Jr. the interview conducted by Erin Smith, PhD, who also obtained the other two articles listed below and is co-chair of WADEM’s SIG.

Interview conducted by Erin Smith, March 2018



Frederick M. “Skip” Burkle, Jr. is an American physician known for his work in disaster response and humanitarian assistance, public health preparedness, human rights, international diplomacy and peacekeeping.

The Washington Post called Professor Burkle "the single most talented and experienced post-conflict health specialist working for the United States government." His medical qualifications include pediatrics, emergency medicine, psychiatry, public health, and tropical medicine.

Drafted into the United States Navy during the Vietnam War, he served as a military physician with the Marines and completed combat tours in the Vietnam War (1968), the Persian Gulf War (1991) and Somalia (1992) with the 1st, 2nd and 3rd Marine Divisions, and with the United States Central Command in Somalia. He also served with the Red Cross in the Kurdish Refugee Crisis and as a negotiator for the Kurds in Baghdad. In 2002, Professor Burkle received a White House Appointment to serve as Deputy Assistant Administrator for the Bureau of Global Health at United States Agency for International Development (USAID), United States Department of State. In this capacity, he was appointed the first Interim Minister of Health in Iraq in 2003 during the planning and immediate crisis period.

In January 2017, WADEM (World Association for Disaster and Emergency Medicine) named its biennial Award for Global Leadership in Emergency Public Health in honor of Skip, recognizing his outstanding contributions to the science and practice of humanitarian relief efforts.

In this edition of the WADEM Psychosocial Special Interest Group’s Newsletter, Professor Burkle shares some of his thoughts on the psychosocial impact of war and conflict with the Co-Convener of the SIG, Dr. Erin Smith.

E: Skip, thank you so much for taking the time to share some of your thoughts and experiences on the psychological impact of conflict with the members of WADEM's Psychosocial Special Interest Group.

S: Erin, I'm honoured by your request. I want to say upfront that as a student of war-related psychological problems since the Vietnam War I have found the subject perplexing and unlike any other that we face in healthcare today. The interested audience, by and large, has been small and mostly limited to military psychiatrists and psychologists. Major operational and educational decisions have been made without benefit of good research or been overturned primarily through post-conflict evaluation research. Currently nothing has been more complex, and contentious, than the debate over the existence of and the impact of war on the development of PTSD. You will see that problems defining the nature of and response to psychological events witnessed in both the military and civilian war-related populations, while substantial, have not necessarily led to consensus in cause or response.

It remains an open book.

The subject is important enough to recommend that WADEM's Psychosocial Special Interest Group consider it a priority issue suitable for further study that might lead to educational and operational recommendations and competencies, especially as the WADEM membership become more involved in mental health decisions impacting war, armed conflicts and refugee populations. I have included at the end of my comments a listing of references I have found useful over the years and I speak to in the questions asked.

It is probably best to first explain how this topic led to occupy my mind for decades.

Honestly, Psychiatry was my least favorite subject in medical school, as I was singularly driven by a dream to be a paediatric surgeon practicing "global health" in rural Africa and Asia. My first Residency was in Paediatrics at the Yale University Medical Center, which in those days was required before one was accepted into the paediatric surgical training program. However, 3 years later when I completed this training I was drafted into the military. Within 20 days I found myself in Vietnam in a Marine Forward Casualty Receiving Facility (FCRF) a few miles south of the DMZ in 1968, an area of the country where most of the battles of that war took place. The area was unique in that the negotiate division of the country in 1952 established the 32 mile long DMZ which led to over 30,000 refugees fleeing from North Vietnam. They found themselves equally shunned by the regime in the South and were forced for decades to settle along the DMZ in unstructured refugee conclaves. Our triage-bunker casualties were often a mixture of Marines, Viet Cong, North and South Vietnamese soldiers, and civilians. No matter how well you think you have been trained every war becomes a daily learning experience.

As physicians we were all draftees except for the Commanding Officer. We knew little of the military culture and demands, and none of us had mental health expertise, which was first available at the next highest echelon of care. Despite the many demands for trauma triage and immediate casualty care it soon became obvious that war-related "psycho-social" problems were as pervasive as the trauma. Our lack of knowledge was tainted by our own ignorance, a language and culture we did not begin to understand, the mixed attitudes of the military over how to manage psychological casualties, and our own prejudices and unfamiliarity on how to diagnose and manage such challenges.

The trauma facility was frequently hit by artillery from north of the DMZ and was often coordinated by the NVA to hit just minutes after the helicopter arrival of casualties. Months later we became a dual functioned children's hospital and trauma facility that opened our eyes to the unattended suffering of children. These challenges included multiple infectious diseases, the largest bubonic plague epidemic of the last century, scurvy, severe

malnutrition and multiple weaponry related injuries. The massive civilian needs rapidly became evident to the otherwise unprepared military corpsmen and physicians alike and with success only resulted in more frequent threats from the Viet Cong and NVA who competed with us for the “hearts and minds” of the war weary civilian population.

In 1973 during a Grand Rounds presentation at the Uniformed Services University of Health Sciences in Bethesda, I discussed coping with stress in conflicts. I admitted that five of the 18 physicians with whom I worked in Viet Nam developed brief but debilitating emotional consequences. Two suffered from first-time acute asthmatic attacks with marked emotional overlay, one suffered catatonia on arrival of our own casualties, and one developed hyperactivity, depression, and transient psychosis. In this case sleep deprivation, alcohol consumption, and threats to his life from parents of children who died during emergency surgery possibly contributed to the development of symptoms. An additional physician developed a psychosis on returning home. Psychosomatic symptoms were common, especially where verbalization of anger and other feelings was not commonly perceived as being an acceptable outlet for a military officer. Literature from the Yom Kippur War describes differences in psychological reactions between members of elite combat units where there was considerable social support and reserve units and incoming draftees where members were total strangers to each other.

It was during the Vietnam War when I began to appreciate and plan for the population focused competencies I needed for my own future global health skill sets that I would encounter in wars, armed conflicts and refugee care in the decades that followed. I became qualified in adult and paediatric emergency medicine, paediatrics, completed my public health degree at UC Berkeley where I focused on population-based mental health, a psychiatry residency at Dartmouth, Fellowship in Adolescent Medicine & Psychiatry at Harvard, and diploma in tropical medicine. Today, reliable competency-based courses are readily available to an ever expanding and eager humanitarian audience. While I ended up doing all that any psychiatrist would be obliged to do in the individual treatment and therapy of patients, my interest and education was increasingly focused on population-based care and the challenge of how those individual-based care skills I learned could be translated to a suffering population such as refugees and other vulnerable populations of civilians. Since, I've been called back for 5 wars and multiple armed humanitarian crises on every continent I have used all these skills and acquired many more as the reasons for war and conflict and how the world responds to them changed dramatically every 10-15 years or sooner.

E: During World War One, soldiers exhibiting psychosomatic symptoms were given the label “shell shock.” The cause of their invalidity and, therefore, the appropriate form of management was the subject of considerable debate. Are shell shock and PTSD the same disorder by a different name?

S: First, I must emphasize that with every war, starting with WWI, the military leadership has always displayed strong ambivalence toward psychiatrists, psychologists and other mental health workers in the military affairs of war. Unfortunately there will always be a component of the military who will label psychological victims as “cowards, malingers, or lacking in moral fiber.” In WWI, they were not prepared for the large numbers of victims who, to them, posed serious concerns over maintaining the manpower needed to win battles. This was especially visible when publicity emphasized that the force was the “best trained and prepared warriors” that any country could produce.

The ignorance and unpreparedness for caring for both the military and civilian population’s psychosocial needs during war and conflict have remained a pervasive denial-driven subject that, quite honestly, has changed little since WWI. What these casualties are labelled as and how they are managed will always be “medicalized” and

“politicalized” in favour of one objective and operational priority, that of keeping the force “intact, eager and convinced of their invincibility.”

Shell shock was first coined to describe the physical reaction of over 80,000 cases that arose from the intensity of the bombardment that produced total helplessness when a soldier was unable to function and no other physical cause could be identified.” First evaluated by military physicians, it was seen as neurological in nature related to the direct effect of exploding shells. It was from Charles Myers and other civilian psychiatrists who convinced the British military to accept that shell shock was a “psychological reaction” to the “stresses of warfare rather than the expression of a predisposition to mental illness.” They introduced “psychotherapeutic interventions” for the first time, eventually incorporating into military operational thinking the deployment of psychiatrists placed “as near the front line as military exigency will permit.” While the acceptance of a psychological component was the earliest introduction of what PTSD would eventually become, researchers today feel “it bore little overt resemblance to the modern diagnosis of PTSD that includes psychological symptoms and signs.”

E: During World War Two, “breakdown” on the battlefield became a priority for the Allied democracies concerned that high casualties would undermine popular support for the conflict. Military psychiatry became an essential element of medical provision. With the direct involvement of the United States and its wealth of resources, attention was turned to evaluating the nature of breakdown and the effectiveness of treatments. What did we learn during this time?

S: Getting the soldier back to the front as quickly as possible remained the WWII priority in order to maintain operational efficiency. An emphasis was put on screening potential recruits before acceptance into the military. This proved unsuccessful, was eventually abolished and many of those initially rejected were then drafted. Unfortunately, initially in WWII and the Korean War military physicians continued to “medicalize” the signs and symptoms despite the fact that they were identical to those seen in WWI. For example, those with combat related psychoses were frequently evacuated with the diagnosis of “acute schizophrenia.” To the chagrin of the physicians, their reintegration and complete resolution of their psychotic behaviours resolved when they were taken out of combat yet their records often continued to show the diagnostic label of “schizophrenia.” Eventually, progress was made in “shifting attention from problems of the abnormal mind in normal times to problems of the normal mind in abnormal times” Yes, war is hell, or worse, but few wished to admit it!

The “forward psychiatry” component of WWI was continued and claimed to return up to 80% of “neuropsychiatric cases” to duty within a week. However, with post-WWII research these figures were adjusted downward to “very low.” Successes seen were probably best attributed to availability of extensive and well-equipped psychiatric services and the now committed belief that “all service personnel are potential stress casualties.” Unaware of similar initiatives in WWI, the WWII and Korean War “introduction of simple and straightforward treatments of rest, good food, hot showers, and sedation” were again claimed to be successful in returning men to the front line in a matter of days.” What appeared to matter the most was an increasing acceptance that they “were not cowards nor weaklings...but rather normal individuals who could no longer cope with the unremitting and horrendous stresses of war.”

E: Today, the recognition of post-traumatic stress disorder (PTSD) has established in the minds of the public, media and health professionals that conflict can produce long-term and severe psychological effects. However, is it the case that this was not always so?

S: The current view emerged, for the most part, from information that claimed that psychological effects were short-term, possibly influenced because time long-term studies on veterans were rare. Some components of PTSD, as we define it today, were certainly recognized in prior wars and conflict but under different names...that is one of the problems we've brought on for ourselves that has contributed to the confusion. Make one thing clear, PTSD is not unique to today's wars and conflicts. Before the Vietnam War consensus among therapists was that soldiers "who recovered from an episode of mental breakdown during combat would not suffer adverse long-term consequences...that disability commencing after the war was believed to be related to preexisting conditions." PTSD during and after Viet Nam deemphasized the role of the original traumatic event in the development of symptoms, "by highlighting the importance of a variety of contextual factors, among them the perception of social support, preexisting anxiety or depression, and a family history of anxiety." Additionally, both during and after the Vietnam war extensive and well-equipped mental health services became more available, visible and acceptable...but their impact has never been adequately researched.

E: The political crisis created by the Vietnam War, combined with significant cultural change, inspired a new interpretation of trauma psychiatry. Can you comment on this?

S: Fifteen years after the Vietnam War, epidemiological studies concluded that 15% of Americans who served were suffering from PTSD and now appeared as a diagnostic category in the 1980 Diagnostic and Statistical Manual of the American Psychiatric Association. Furthermore, the varied incidence of PTSD that ranged from 3.5% to 50% among Vietnam veterans resulted in hotly debated discussions that continue today. Unfortunately, PTSD among veterans of the Persian Gulf and Iraq Wars that range from 15.6 to 17.1% renewed debate once again over "weakness of character or cowardice" as factors. Essentially the Gulf War has shown little attention to PTSD.

Pols and Oak suggest that since the Vietnam War long-term psychiatric disability best reflects individual factors that predated the war, such as familial predisposition for mental illness. Others claim that "no specific set of medical symptoms can be identified after each war, and because each war has given rise to an increase in unexplained medical symptoms it is argued that investigating the exact nature of postwar syndromes will not yield constructive results", a factor that has led to recommendations for integration of psychiatric approaches into primary health care settings for these veterans as well as for civilian migrants and refugees who were also caught up in current prolonged conflicts.

This being said, research on PTSD following deployment to Iraq and Afghanistan was reviewed in 2014. While the studies found a large variability in the prevalence rate, the PTSD rate was higher among Iraq-deployed compared to Afghan deployed and higher in combat deployed (Canadian, US, UK army or the navy/marines) compared to other services...but no difference was seen between active-duty or reserve/national guard. Interestingly, higher rates occurred in those with combat exposure and life and family disorders during deployment. Curiously, more post-conflict PTSD research seems to be originating from the UK and Canada than the US.

E: Women, children, the elderly and the disabled living in conflict-affected areas are particularly vulnerable to mental health problems. However, the traumatizing impact of direct exposure to violence and conflict can particularly compromise the psychological wellbeing of adolescents. What makes adolescents vulnerable?

S: As an adolescent psychiatrist, I would say that the impact of violence and deaths from war varies depending on exposure, effects on their parents, survival needs, their understanding of the conflict, direct threats of violence and whether they themselves engage in harming others. Yet, all adolescents have the potential to

suffer greater capacity for hopelessness, despair, disillusionment, aggression and antisocial behavior, risky and reckless behavior, disturbing images, depression and permanent learning problems.

Adolescence is the time in life when we first experience abstract reasoning and with it enhanced ability to both question, comprehend and deal with personal experiences and uncertainties such as guilt, anxiety, and shame in their actions as one's conscience is formed. We can feel many insecurities, false omnipotence and despair and depression for the first time. Unfortunately, in current conflicts it is not at all uncommon to find increased use of adolescent-child soldiers and sexual abuse and exploitation of adolescent girls. Historically, warring has been used as a 'right of passage' into adulthood. In crises, we have had reports of some young adolescents returning to more childlike behaviors in need for security while others have brazenly wanted to identify with adults and serve in that capacity during war and major natural crises. We briefly provided security for a Marine who was found to be only 16 years old and was awaiting return home. Gravely, he was killed in our compound while cleaning his weapon. We were never able to establish whether it was a suicide or an accident.

Militarily, Vietnam was very much a young person's war with 61 % of deaths under the age of 21. Twenty-six % of the Marine casualties, or 20,574 were between ages 17-19. Of all services there were 11,398 deaths of those aged 17-19 years among 58,220 total deaths of which 16,899 (the highest number of any year) occurred in 1968 alone, the year I served. The Marines were highly disciplined and characteristically, compared with other services, would silently lie on the stretcher "at attention" without a whimper despite terrible wounds. Yet, that façade was thin. One particularly crowded day of casualties in Triage a young Marine began to softly call out "Mother" ...only to be followed by most of the wounded Marines crying out the same name in unison. We worked in silence saying little but muted orders back and forth to corpsmen all of us dripping tears. We said nothing of that day.

E: What have more recent conflicts and complex humanitarian crises taught us about the psychosocial consequences of war, internal conflict and disrupting living conditions?

S: Those among displaced populations escaping from conflict, whether locally displaced, refugees or migrants, in need of psychosocial and mental health support represent several overlapping subpopulations of people with: (1) Disabling biological psychiatric illnesses; (2) severe psychological reactions to trauma, and (3) those individuals with significant problems who may be able to cope and adapt once peace and order are restored ...this latter group generally represents the majority of the population and clearly supports the decision not to jump to labeling anyone with a clinical "diagnosis."

You don't generally hear much about displaced populations from the established mental health community because "mental health" care as we know it in society today and in the manner in which we are professionally trained as psychiatrists, psychologists and mental health workers is primarily focused on the individual patient who is more often viewed, evaluated and treated within the framework of a medically treated "biological illness." In refugee camps we often see new foreign mental health aid workers gravitating toward those refugees who appear most "mentally ill" ...and indeed may be greatly rewarded by successfully restarting them on their medication for bipolar disease, schizophrenia, severe biological depression that have been absent since their fleeing. But honestly, these "medical patients" make up a very small but highly visible percentage of those needing your attention and expertise; such as those threatening suicide or violence who may be found roaming and frightening others in the newly built refugee camp. Successful management of these problems by aid workers often lessens the fear of the refugee population and has the potential of resulting in other new refugees trusting the foreign aid workers in revealing their own problems...which in the long term will require most of

your attention and time. If successful you have practiced “population –based psychiatry and psychology “ that I talked about decades ago in Viet Nam!

Culturally, there are rarely many indigenous mental health workers; those duties are usually relegated to local nurses or family members. Psychiatrists and psychologists are rare. I have seen foreign aid workers arriving with stuffed pockets of psychiatric medications handing them out to local nurses. This is not good practice as the nurses are only familiar with psychiatric medications that are on the national formulary which vary greatly by country. The medications may be those last used in the West during the 1960s and 70s. Rather than bringing in new medications that cannot be found on the formularies of indigenous countries or be replaced, and which may have multiple side effects unfamiliar to the local health providers, it is imperative that humanitarian workers know the WHO guidelines for country-specific psychotropic medications in the Interagency Emergency Health Kit before deployment. If you can re-establish some sense of safety and spend time and patience supporting the local nurses in recovery then you have accomplished much.

E: *Do you think that the short-term interest in mental health following conflict can be effectively used to promote longer-term mental health system reform?*

S: Yes, definitely...but only if aid workers understand the culture and follow up with the UN, humanitarian and non-governmental organizations who work in these countries long term and desire both input and long term commitments to care. Changes are possible. We have seen improvements but the process is often disappointingly slow. Nationally and internationally we put resources into the “response” phase only. Mental health programs are only successful if they become part of preparedness, prevention, recovery and rehabilitation phases of the disaster cycle. In developed countries mental health programs are considered part of “essential public health infrastructure and protections” along with maternal and child health and vaccination programs. In the countries in conflict the described “essential infrastructure and protections” either never existed or were destroyed.

What is telling is this quote from Jan Egeland, the former UN Emergency Relief Coordinator who in 2004 stated, *“I often have to talk about “forgotten emergencies” and my responsibility is to alert the world to the emergencies it chooses to neglect. But the mental health crisis is not just neglected; it is also very much a hidden emergency. What we must do is bring it out of the shadows.”*

Lastly, I recently wrote that the nature of war has changed, not for the better. I must predict that psychological issues, especially among civilians will escalate. The combination of marked diversity of conflicts, the numerous parties in conflict, prolonged urban warfare, denial of applicability, political will and politicalization of protections under international humanitarian law (IHL) has increased since 2003. This has resulted in unprecedented “disproportionate attacks” or so called “Violations of Proportionality.” These cause under the IHL “incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated.” The total destruction by the Syrian government of east Aleppo and Western-based bombing campaigns that flattened Raqqa have been condemned by the UN as violations of proportionality risking a collapse of efforts to increase respect for IHL and to regulate the behavior of the parties to conflicts.

E: *Skip, thank you so much for taking the time to share some of your thoughts and reflections with our membership. Your insight is, as always, invaluable and much appreciated.*

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Conflict Affected Populations

Mental Health and Psychosocial Support in Conflict-Affected Populations

Kenneth E. Miller, PhD¹

¹ War Child Holland



There are currently more than 65 million people displaced from their homes and communities by armed conflict. This includes at least 40 million internal displaced people (IDPs), unable or unwilling to leave their homeland but also unable to return safely to their homes. It also includes roughly 22.5 million refugees, the great majority of whom live in refugee camps, informal settlements, or on the outskirts of cities in low and middle-income countries adjacent to their embattled homeland. Finally, it also includes 2.2 million asylum seekers, many of who have risked their lives to cross-seas and continents in the hopes of gaining safe haven in Europe and other higher-income regions.

The number of IDPs is at a 50-year high, while the number of refugees is the highest it's been in more than two decades ([UN, 2017](#)). The top three countries giving rise to refugee flows are Syria, Afghanistan, and South Sudan.

Interest among mental health professionals in the wellbeing of conflict-affected populations began in earnest in the wake of war and genocide in Latin America and Southeast Asia in the 1970s and early 1980s. Research and practice were initially guided by a narrow focus on assessing and treating war-related post-traumatic stress disorder (PTSD) and depression. The guiding assumption was that the high rates of distress seen among refugees from these regions were attributable primarily to the violence and loss they had experienced pre-migration.

This assumption was adopted widely (and largely uncritically), leading to a narrow focus on healing war-trauma and treating depression presumed to stem from war-related separation and loss (for a review and critique, see Miller & Rasmussen, 2010).

The past 20 years have seen a marked shift in how we understand the mental health and psychosocial needs of war-affected communities. The simplistic war-exposure model that guided earlier work in this area has gradually given way to an ecological model, in which distress is understood to stem not only from war-related violence and loss, but also—and often more powerfully—from ongoing stressors caused or worsened by war and displacement (Miller, 2016; Miller & Rasmussen, 2016, 2010). A growing body of research has demonstrated that refugees' psychosocial wellbeing is powerfully affected by such factors as social isolation, poverty, the loss of valued social roles, poor quality housing, the inability to work, difficulties navigating the host setting, and various forms of family violence (spouse abuse, child abuse) that seem to increase as a result of chronic parental/family stress. Among non-refugee, war-affected communities, a similar set of daily stressors has been found to partially mediate or explain the link between armed conflict and mental health. War exposes people to terrifying and prolonged experiences of violence and loss, of course; however, it also destroys social networks, livelihoods, schools, and hopes for the future. It creates whole classes of stigmatized and marginalized individuals (orphans, survivors of sexual assault by combatants, people disabled by landmines), and generates chronic stress that has been linked to increased family violence and both physical and psychological vulnerability and illness (Miller & Jordans, 2016; Miller, Kulkarni, & Kushner, 2006; Miller & Rasco, 2004).

The ecological model expands our view beyond the effects of war exposure, to include ongoing stressors caused or exacerbated by armed conflict. In so doing, it holds great value as a roadmap for mental health and psychosocial interventions. Rather than focusing narrowly on assessing and healing war trauma, organizations should first assess the numerous factors causing and maintaining distress in their target communities. War-related trauma and loss may be salient; however, people may be more immediately concerned with, and affected by, stressful conditions of living that negatively impact their mental health, and that may impede healing from trauma and grief rooted in the past. A narrow focus on war-related PTSD can also lead us to inadvertently overlook current sources of traumatic stress (e.g., intimate partner violence, child abuse). Several studies have recently shown that trauma among war-affected children is at least as strongly related to family violence as it is to the violence of war (e.g., Fernando, Miller, & Berger, 2010; Panter-Brick et al., 2011); consequently, providing children with supportive or therapeutic group activities (a common intervention modality) is likely to have limited impact if support is not also provided to highly stressed parents and other caregivers, to help them make the home a more supportive, less stressful setting for their children (Miller & Jordans, 2016).

Kenneth E. Miller is a researcher at War Child Holland, and the author of War Torn: Stories of Courage, Love, and Resilience (Larson, 2016). He has worked with refugees and other war-affected populations since 1991, as a researcher, clinician, consultant, and filmmaker. He is currently a researcher at War Child Holland, where he develops and evaluates mental health interventions for conflict-affected children and families. Ken also writes about mindfulness and the science of helping relationships.

To hear Ken Miller reading excerpts from War Torn click here:

<https://soundcloud.com/popcorn-man/war-torn-reading>. Recorded live at Unity Temple in Oak Park, Illinois, August 7, 2017.

Exploring the Psychosocial Impact of Armed Conflict on Children: A Summary of the Works of Theresa Betancourt

Daniel Young, Katrina Keegan, and Sarah Klein



Theresa S. Betancourt, ScD, MA heads the Boston College School of Social Work's Research Program on Global Adversity. Betancourt, an international scholar in child trauma and human rights, has worked in communities around the world and has conducted innovative research exploring the trajectories of risk and resilience in children facing "compounded adversity," which she defines as multiple, concurrent risks, such as extreme poverty, armed conflict, displacement/refugee status, or chronic family illness/impairment. Betancourt's research aims to understand mechanisms to promote resilience for children facing compounded adversity through longitudinal and observational research, expand mixed methods research approaches for assessment of child mental health across diverse cultures and contexts, design and evaluate

behavioral interventions to promote resilient outcomes in youth and families facing adversity in low-resource settings, and develop innovative strategies to accelerate research translation and to advance the field of global mental health implementation science.

Betancourt's 15-year intergenerational study of war-affected youth in Sierra Leone is considered one of the most extensive examinations of post-war relationships and a pioneering approach to investigating mental health, child development, family functioning and resilience. This study, which began in 2002 and is now in its' fourth wave, has illuminated critical insight into how war-related and post-conflict experiences affect the long-term mental health and psychosocial adjustment of former child soldiers. As the first prospective study to investigate psychosocial adjustment in male and female former child soldiers, it was designed to examine both risk and protective factors in psychosocial adjustment. The role of stigma emerged a major risk factor and potential mediator between war-related experiences and problems with post-conflict psychosocial adjustment and adaptive behaviors. In her research, stigma has shown significant relationships with increases in depression, anxiety and hostility over time. In addition to risk factors, Betancourt places heavy importance on protective factors. Some of the major findings from her research center around community acceptance, social support, and educational/ economic opportunities. Overall, these factors—both initially and over time—emerged as an important predictor of reduced depression over time as well as improvements in prosocial attitudes and confidence. Thus, her research shows that even young people who experienced extreme trauma can successfully reintegrate if they have strong family and community support.

A longitudinal and life-course approach underlies Betancourt's research, with an approach to developing targeted interventions that are grounded in child development theory. Using mixed quantitative and qualitative research methods, she investigates key mechanisms shaping child development and mental health; a perspective crucial to understanding the interrelated and compounded effects of multiple forms of adversity on the health, well-being, and life trajectories of children. Her research also draws from a social ecological perspective to consider the many socially mediated factors and resources at the family, peer, and community levels that influence child development and mental health in vulnerable populations. Betancourt's research seeks to illuminate malleable risk and protective factors that contribute to better than expected outcomes despite exposure to extreme forms of risk and while advancing an ecological model of resilience. She highlights that in low-resource settings, it is often neither productive nor appropriate for interventions to focus on single vulnerability groups, since children face multiple forms of risk. Consequently, the concept of compounded adversity is a central tenet in her research on developing integrated and holistic approaches to child protection,

featuring transdiagnostic mental health interventions that target broad domains of symptoms and functional impairments rather than singular mental health diagnoses.

Betancourt often cites gap between research and practice, calling for more research backing the most frequently implemented psychosocial interventions. She argues that many critical themes are often understudied within interventions including prevention and maintenance, differential effects and comorbidity, and measurement tools for cross-cultural use. To address these deficits, Betancourt advocates for effective and ethically responsible research in this field. Notably, she calls on investigators to prioritize ethical conduct and safety of children, highlighting the importance of local research staff and ensuring that interventions are developmentally and ecologically contextualized with investment in participatory approaches, locally defined research priorities, and collateral respondents. She encourages mixed-methods approaches to select and validate measures, strong sampling designs and comparison groups, and longitudinal designs.

Betancourt also champions that treatments should integrate individual, family, peer, and community components and carefully consider sustainability and cost-effectiveness, including mental health systems strengthening. For example, preventive transdiagnostic interventions offer great promise as innovative and cost-effective components of stepped care models in low-resource settings, wherein broad-based interventions can be a first line of defense in countries and communities with limited funds, infrastructure, and human resources. Individuals who do not benefit from participation in preventive or broad-based interventions can be identified and referred to a higher level of care for targeted and disorder-specific interventions. Using this tiered approach in her research, with prevention as its foundation, helps maximize limited healthcare resources. Additionally, Betancourt seeks to ensure that interventions can be brought to scale and be implemented and sustained with a high degree of fidelity by government entities, global development partners, and local non-governmental agencies (NGOs). A deployment focus critical to implementation science underlies her approach and ensures interventions developed for children and families in low-resource settings are responsive to political, financial, environmental, and human resources limitations.

Looking towards the future, Betancourt's objectives are threefold. First, she hopes to demonstrate that it is possible to develop evidence-based, preventive, trans-diagnostic interventions to support positive life outcomes for vulnerable children who face compounded adversity. Secondly, she aims to provide evidence that implementation of these evidence-based practices is feasible and cost effective. And thirdly, she'll advocate that such interventions should be a critical element of investments in child health, social services, and the economic development agendas in low-resource settings. By prompting these agendas, Betancourt seeks to advance child welfare and protection systems by building and strengthening integrated models to promote the best interests of the child and to promote effective planning and implementation of evidence-based to assist the most vulnerable children.

Theresa S. Betancourt, ScD, MA heads the Boston College School of Social Work's Research Program on Global Adversity. Betancourt, an international scholar in child trauma and human rights, has worked in communities around the world and has conducted innovative research exploring the trajectories of risk and resilience in children facing compounded adversity.

Selected studies for further reading:

Betancourt, T.S., Agnew-Blais, J., Gilman, S.E., & Ellis, B.H. (2010). Past horrors, present struggles: The role of stigma in the association between war experiences and psychosocial adjustment among former child soldiers in Sierra Leone. *Social Science & Medicine*, 70(1):17-26.

Betancourt, T.S., Borisova, I.I., Williams, T.P., Whitfield, T.H., de la Soudiere, M., Williamson, J., & Gilman, S.E. (2010). Sierra Leone's former child soldiers: A follow-up study of psychosocial adjustment and community reintegration. *Child Development*, 81(4):1077-1095.

Betancourt, T.S., McBain, R., Newnham, E. A., Akinsulure-Smith, A. M., Brennan, R. T., Weisz, J. R., & Hansen, N.B. (2014). A Behavioral Intervention for War-Affected Youth in Sierra Leone: A Randomized Controlled Trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 53(12), 1288-1297.

Betancourt, T.S., McBain, R., Newnham, E., & Brennan, R.T. (2014). Context matters: Community characteristics and mental health among war-affected youth in Sierra Leone. *Journal of Child Psychology and Psychiatry*, 55(3):217-226.

Betancourt, T.S., Borisova, I., Williams, T.P., Meyers-Ohki, S. E., Rubin-Smith, J.E., Annan, J., & Kohrt, B.A. (2013). Research Review: Psychosocial adjustment and mental health in former child soldiers – a systematic review of the literature and recommendations for future research. *Journal of Child Psychology and Psychiatry*, 54(1), 17-36.

Brown, F.L., de Graaff, A.M., Annan, J., & Betancourt, T.S. (2016). Annual Research Review: Breaking cycles of violence - a systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. *Journal of Child Psychology and Psychiatry*.

Featured Graduate Program

University of Denver - International Disaster Psychology Master's Program



Through academic coursework and practical experiences students develop a solid foundation for knowledge and skills in the mental health field and unique and specific approaches in the field of international disaster psychology. Students receive essential opportunities to integrate knowledge with practice in contextually relevant and culturally competent ways. Internship experiences domestically and abroad, disaster simulation exercises, and classroom case studies support an integrated training experience helping students bring a "best practice" model to their work in a variety of psychosocial and mental health contexts internationally and in the US.

Instruction is provided in diverse areas including international disaster psychology, trauma intervention, disaster mental health, gender-based violence, crisis intervention, group dynamics, loss and grief, the effects of trauma on life-span development, psychotherapeutic models, program evaluation and research, global health, and cross-cultural foundations. Faculty expertise addresses the full span of mental health and psychosocial work that is necessary for effective work in this innovative field.

Graduates work in a variety of professional settings providing direct services to populations affected by trauma, training and consulting with community, non-governmental and government agencies to promote psychosocial wellness of affected populations, developing emergency preparedness and response plans, and monitoring and evaluating psychosocial interventions. With comprehensive and specialized training in this emerging fields of international disaster psychology and global mental health, students are prepared to make a difference in the world.

Featured Journal

This issue's featured journal is the [*International Journal of Mental Health*](#), published by Taylor and Francis Inc. The publisher's website description is: "Features in-depth articles on research, clinical practices, and the organization and delivery of mental health services around the world. Covering both developed and developing countries it provides vital information on important new ideas and trends in community mental health, social

psychiatry, psychiatric epidemiology, prevention, treatment, and psychosocial rehabilitation.”

N.B. Readers are encouraged to submit mental health and psychosocial support article manuscripts for review and possible publication in WADEM’s journal *Prehospital and Disaster Medicine*. For further information please see the journal’s submission instructions.

Upcoming Events

- [International Mental Health Conference](#), 8-10 August 2018, Gold Coast, Australia
- [Promoting Social Change](#), I.S.T.S.S, 8-10 November, Washington DC, USA
- [WADEM Congress on Disaster and Emergency Medicine](#), 7-10, May, 2019 Brisbane, Australia

Organizational and Informational Resources

This issue’s featured informational resources that have free publications for academic, professional, and lay persons interested in disaster psychosocial matters are:

- National Child Traumatic Stress Network - www.nctsn.org
- Substance Abuse and Mental Health Publications - www.samhsa.gov/publications-resources
- National Center for PTSD - www.ptsd.va.gov

Reader Comment

Comment from our newsletter readers is welcomed. The primary purpose of reader comment is to briefly address the issue’s theme writings (guest editorial and abstracts). Please include your name and email address.

Disclaimer

Please note: All views expressed in this newsletter are those of the authors of their respective writings, and do not necessarily reflect those of the editor of the newsletter or of WADEM.

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