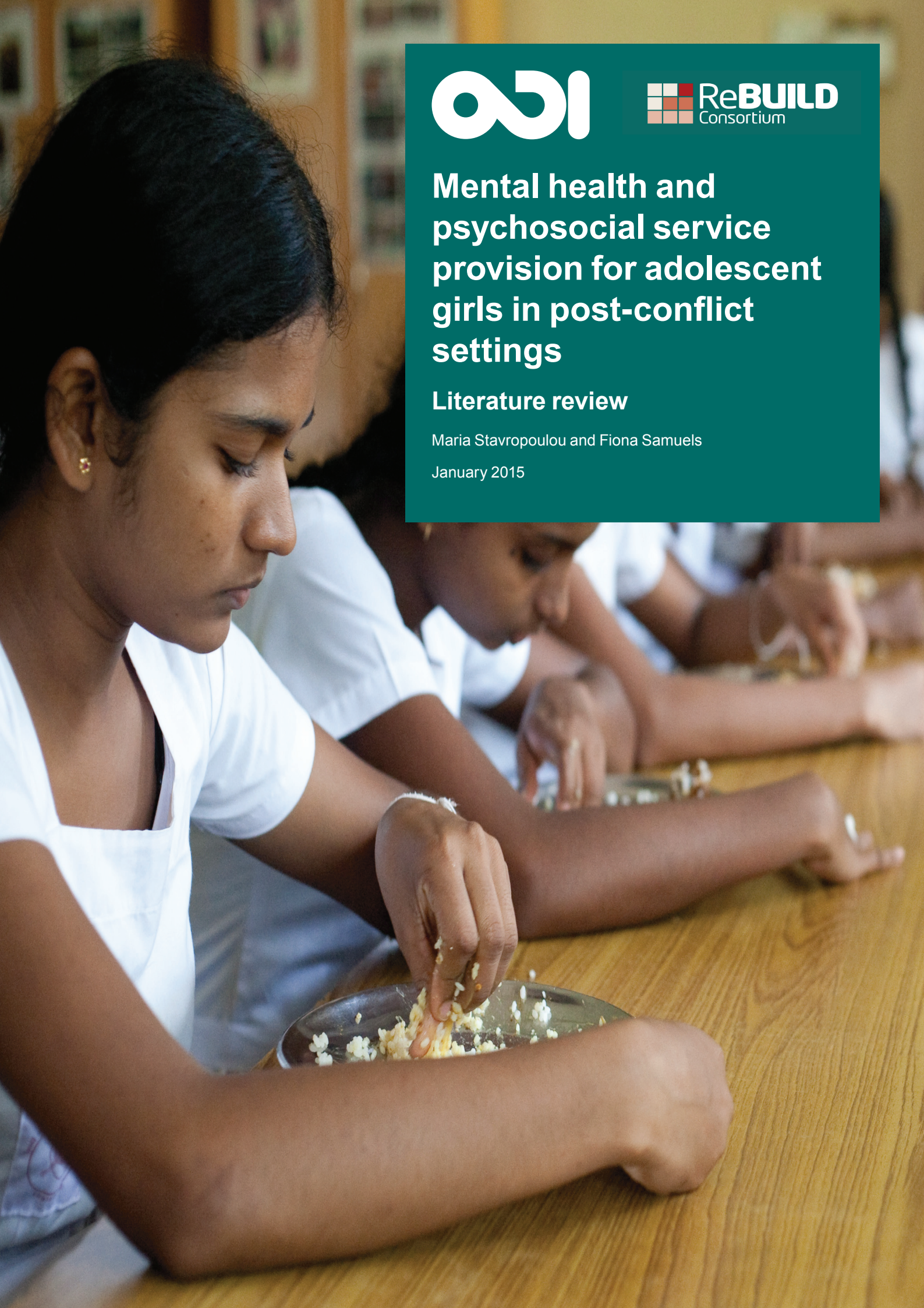# Mental health and psychosocial service provision for adolescent girls in post-conflict settings

Literature review

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1 Mental Health

1.1 Global mental health

The World Health Organization (WHO) definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' conceptualises health in a positive way and explicitly acknowledges mental health to be an integral part of wellbeing, as important as physical health (WHO, 2001).

Although a comprehensive cross-cultural definition of mental health is almost impossible, it is generally agreed that mental health is not equated with the absence of mental disorder but it includes subjective wellbeing, self-efficiency, autonomy, competence, and realization of one's potential: in WHO words, it is 'state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2001).

Despite its importance, it was not until the 2001 WHO flagship report that mental health started to attract some attention. This report was dedicated to mental health with the aim to raise awareness of the real burden of mental disorders and their costs, and to help dismantle the barriers which prevented millions of people from receiving treatment, including stigma, discrimination and inadequate services. The report recommended the integration of mental health services into primary care so that people can access easier and faster such services as well as the establishment of appropriate national legislation, policies and programmes. It also pointed out that in most parts of the world mental health was largely neglected or ignored and this neglect and treatment gap along with population ageing, worsening social problems and conflict were resulting to the increasing burden of mental disorder (WHO, 2001).

Indeed, evidence from both developed and developing countries indicates that mental illness is becoming increasingly common with one in four individuals expected to experience one or more mental disorders during their lifetime (WHO, 2001). Between 1990 and 2010 the burden of mental and substance use disorders actually increased by 37.6%, and this increase for the majority of these disorders was due to population growth and ageing. Moreover, this increase means that the global burden of mental illness is currently alarmingly high and mental illness and substance use disorders are the leading cause of disability, accounting for 22.9% of total Years Lived with Disability (YLDs) (Whiteford et al., 2013). Depressive disorders are the most prevalent type of mental illness and the major contributor to its burden as they affect 350 million people worldwide (Marcus et al., 2012), leading to productivity decline, increases in physical illness and health expenditures, and premature mortality. Alarmingly, their burden is predicted to increase more, and become second to ischaemic heart disease for both men and women worldwide by 2020 (WHO, 2001), and first by 2030 (WHO, 2008), posing considerable challenges to health systems in both developed and developing countries. Given their potential impact, their prevention and treatment have to become a public health priority (Whiteford et al., 2013). Yet so far governments spend on average less than US$2 per person annually on mental health care with the majority of funds allocated to psychiatric hospitals and institutionalised care (WHO, 2011).

Apart from human suffering, mental illness has negative effects on development and economic growth: it worsens poverty for affected individuals and families, increases inequality, reduces social capital, and hinders growth (WHO, 2010). Based on national mental health survey data from 10 developed and 9 developing countries, Levinson et al. (2010) estimated that between 0.3% and 0.8% of total national earnings are lost due to serious mental illness and related productivity loss. More recently, a report by the World Economic Forum and the Harvard School of Public Health predicted that over the next two decades mental illness will account for the largest proportion (35%) of global economic losses from non-communicable diseases (NCDs); in absolute terms, this means that the economic toll of mental illness will be over US$16 trillion, of which US$9 trillion in

developed and US$7.3 trillion in developing countries (Bloom et al., 2011). Given the negative development outcomes of mental health problems, some voices have supported the call for scaling up mental health care not only as a public health and human rights issue but also as a development priority (Lund et al., 2011).

1.2 Mental health in the developing world

Despite its significance for the overall wellbeing of individuals and societies, mental health has been largely neglected, or even ignored in many developing countries (WHO, 2001), while it has also been absent from the Millennium Development Goals (MDGs) and other development-related health agendas (Samman and Rodriguez-Takeuchi, 2013). Nevertheless, WHO has estimated that over 75% of the global burden of disability due to depressive disorders, occurs in developing countries (WHO, 2008).

Yet in many of these countries mental health issues tend to be of low policy priority, relevant legislation is either absent or outdated, funding is scarce, training of professional staff is inadequate, services are limited and provided through a few centralised institutions, public awareness and understanding is often low with rural communities resorting to traditional healers, and stigma and discrimination continue to be widespread and to contribute to poor outcomes[1] (WHO, 2001). Indicative of the situation is that only 36% of people living in low-income countries are covered by mental health legislation (compared to 92% in high-income countries), average annual mental health expenditure is less than 25 US cents per person (WHO, 2011), and that '…the number of psychiatrists serving the entire continent of Africa with a population of almost a billion is less than that practicing in the US state of Massachusetts with a population of less than 7 million' (Patel et al., 2013). In addition, there is a lack of scientific research on mental health issues in many developing countries (Sharan et al., 2007), despite the need for context-specific research and culturally appropriate tools in order to inform effective mental health policy, planning and interventions (WHO, 2001): a study of mental health research in 114 developing countries found that between 1999 and 2003, almost 58% of these countries contributed fewer than five articles to the international mental health indexed literature (Sharan et al, 2007).

The recent adoption of the latest 2013-2020 Global Mental Health Action Plan by the World Health Assembly built upon the saying 'no health without mental health' is an encouraging step towards developing national mental health policies, increasing funding, strengthening information systems and research, and integrating essential mental health services into primary health care structures in line with WHO vision (WHA, 2013).

1.3 Mental health and poverty

Research has established that mental disorder has a multifaceted causation: biological (age and sex), psychological (relationships with caregivers during childhood) and social factors (poverty, urbanisation, change, conflict and natural disasters) are all implicated in the development of mental disorder. Although quite often research focused on biological factors, the separation of biological from psychological and social factors is an artificial one and has actually become an obstacle hindering a complete understanding of mental disorders (WHO, 2001).

The relationship between mental health and poverty is rather complex and multidimensional. Poverty and associated conditions such as low education, unemployment and homelessness have been identified as risk factors for mental illness. This link is well established in developed countries and two mechanisms have been put forward to explain the higher prevalence of mental disorders among those with low socioeconomic status: the causation mechanism holds that deprivation produces high levels of personal and social stress and leads to disorder, while the drift theory argues that those who develop disorders may fall into impoverishment or fail to

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[1] WHO has supported the involvement of local communities through dissemination of information and use of community resources, including of traditional healers. In many cases, nongovernmental organizations (NGOs) have played an important role in the provision of mental health services. Another issue of critical importance is that despite similarities of mental health problems, given that they occur in diverse cultural contexts, interventions need to be culturally informed. Thus research tools and methods should be tested to ensure their reliability and validity. Accordingly WHO has developed several transcultural tools, such as the Self Reporting Questionnaire (SRQ) or the WHO Quality of Life Instrument (WHOQOL) (WHO, 2001).

rise out of it (WHO, 2001; Lund et al., 2011). A review of the effects of mental health interventions on individual and household economic outcomes in developing countries confirmed the positive link between mental health and economic status (Lund et al., 2011). Additional evidence suggests that the socioeconomic status plays a determinant role not only in the development but also in the course of the disorder, potentially due to service-related factors (WHO, 2001).

A growing body of literature examines the relationship between poverty and mental health particularly in developing countries. Using survey data from Brazil, Chile, India and Zimbabwe, Patel et al. (1999) found that common mental disorders are almost twice as frequent among the poor. A review of studies from Brazil, Chile, Indonesia, Lesotho, Pakistan and Zimbabwe, also confirmed an association between poverty and mental illness; the review tested several indicators of poverty (including insecurity, hopelessness, rapid social change and physical illness) and interestingly found that the most consistent relationship was with low education while only weak evidence emerged for the link between mental health and income, possibly due to data limitations (Patel and Kleinman, 2003). However, another often cited study using data from Bosnia and Herzegovina, Indonesia, Mexico, India and Tonga questioned the strong association between mental health and poverty as indicated by either education or household expenditure; instead it suggested that age, gender, marital status, physical health, cohabitation with people with poor mental health, and shocks such as physical illness or crisis are more strongly correlated with poor mental health, that is to say those who are older, female, widowed, and physically ill are more likely to report mental health problems (Das et al., 2007; 2008). What thus becomes evident is that mental health problems in the developing world are the outcome not of a single but of several contributory factors, and more research is needed to identify the causal pathways. It is perhaps not a coincidence that a review of the mental health effects of poverty alleviation interventions was also inconclusive with the exemption of some cash and asset transfer programmes that showed positive mental health impact (Lund et al., 2011).

1.4 Mental health and gender

Although the overall prevalence of mental disorders is about the same among men and women, anxiety and depressive disorders are more common among women, while substance use disorders are more common among men: thus reported depression rates are almost always twice as common in women than in men, while lifetime prevalence rates of alcohol dependence are 20% for men but 8% for women (WHO, nd). This difference is strongly age-related as it has not been reported in childhood (WHO, 2001), but appears among young people (Patel et al., 2007). Comorbidity, the co-occurrence of anxiety, depressive and somatoform disorders, is also more common among women. Women also report a higher number of symptoms, and have higher rates of help-seeking behaviour and of prescribed psychotropic medicines. However, men have higher suicide rates, while substance use disorders are rapidly increasing among women (WHO, 2001).

Several reasons have been put forward to explain these gender differences, and although the exact causal pathways are again still debated, the complex interaction of several biological and social factors is accepted (Patel and Kleinman, 2003). Initially under the influence of Freud and the emphasis on endogenous processes, research has largely focused on the individual and biological factors and particularly on the causal relationship between women's reproductive functions and their mental health; within this framework the premenstrual syndrome, postpartum depression and menopause disorders attracted most of the attention. Yet research has gradually turned to the social factors that shape women's lives and explored the negative contribution of gender inequality, unemployment or work overload, poverty, lack of social support, and limited power and personal control; it also highlighted the role of domestic and sexual violence that disproportionately affects women (Dennerstein et al., 1993; WHO, 2000).

Indeed studies identified low-income single mothers and elderly women in industrialised societies as vulnerable to high and persistent stress imposed by chronic conditions of deprivation and discrimination (Dennerstein et al., 1993; WHO, 2000). Analyses of data from a few developing countries also found strong linkages between women, low education, poverty and mental disorders (Patel et al., 1999).

Likewise, a systematic review of studies about perinatal mental disorders in low- and lower-middle income countries also concluded that contributory factors include poverty and poor physical health; poor relationship with partners and exposure to domestic violence; limited family support; lack of close relationships; limited control and participation in decision-making over financial and reproductive health issues; and several adverse

life events such as economic difficulties or unwanted pregnancy. It also found that the prevalence of such disorders was highest among women with the highest social and economic disadvantage, and particularly those living in crowded households in rural areas with unequal gender norms (Fisher et al., 2012).

One of the topics that increasingly attract attention is maternal mental health due to the established effects it has on child emotional development, intellectual competence, psychosocial functioning and mental morbidity. A number of studies from developing countries have found that the prevalence of maternal mental disorders is significantly higher in these countries, ranging between 18% and 25% of pregnant women and first-year mothers experiencing significant mental health problems, most often depression and anxiety; these studies also found that maternal mental disorders not only impact on infant psychosocial development but also result to low birth weight, reduced growth, malnutrition and lower immunisation (Rahman et al., 2013). This issue is also particularly important for adolescent girls, given high rates of adolescent pregnancies in many developing countries.

Moreover, research has also provided clear evidence of the association between female depression and violence: data from the WHO multi-country study on women's health and domestic violence against women, show that women who experienced such violence at least once in their life reported significantly more emotional distress and suicidal thoughts and attempts compared to non-abused women (Ellsberg et al., 2008); a recent systematic review of such studies has also concluded that intimate partner violence is strongly linked to depressive symptoms and suicidal behaviour for women in both developed and developing countries (Devries et al., 2013).

In addition, it has to be noted that women are also those who traditionally bear the brunt of care for family members with mental health problems (WHO, 2001), an issue whose consequences on women's mental health has not been adequately researched so far.

1.5 Mental health and adolescence

Adolescent mental health is a very important but rather neglected topic globally. It is important as young people represent the largest part of the global population (half is under the age of 25) and the majority of mental health problems begin during adolescence and continue into adulthood (WHO, 2007). It is also important as mental disorders are becoming common during adolescence with 10%-20% of children and adolescents experiencing mental health problems (Kieling et al., 2011), and as suicide rates are increasing with young people being now the group at highest risk of suicide in a third of countries, both developed and developing (WHO, 2007); suicide is actually a leading cause of death among young people in China and India (Patel et al., 2007). Apart from mortality, mental health problems have other negative consequences for young people such as lower educational achievements, substance abuse, violence, and poor reproductive and sexual health. However, adolescent mental health needs are neglected and unmet, particularly in developing countries, where the vast majority (nearly 90%) of the global population of children and adolescents live due to lack of government policy, inadequate funding, shortage of professionals, low capacity of non-specialist health workers, and the stigma attached to mental illness (Patel et al., 2007; Kieling et al., 2011). The 2005 WHO project Atlas with information for 66 countries encountered considerable difficulty to find relevant information largely due to lack of services, absence of a national focal point for child and adolescent mental health services, fragmentation in the service systems and lack of appropriate systems for data collection. Although in 18 countries there were beds designated for children and adolescents in paediatric hospitals, there was none in any of the low-income countries of the project. Interestingly in over 90% of all countries there was an NGO related to child and adolescent mental health with the majority of such NGOs focusing on advocacy and far fewer on treatment and prevention; yet their work was rarely connected to country level programmes and often lacked sustainability. Funding as part of the national budget for such services was rare and out of pocket expenditures for child mental health services was 71.4% in African countries compared to 12.5% in European countries (WHO, 2005). Yet, the WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide has included methods to assess and manage disorders in children and youth along with guidelines for family, teachers' training and community-based intervention (Kieling et al., 2011).

As with adult mental health problems, the cause for mental health problems in youth is multifactorial with several identified contributory biological, psychological and social factors, as shown in the following table:

Table 1: Selected risk and protective factors for child and adolescent mental health (Patel et al., 2007)

	Risk factors	Protective factors
Biological		
	Exposure to toxins (eg, tobacco, alcohol) in pregnancy Genetic tendency to psychiatric disorder Head trauma Hypoxia at birth and other birth complications HIV infection Malnutrition Substance abuse Other illnesses	Age-appropriate physical development Good physical health Good intellectual functioning
Psychological		
	Learning disorders Maladaptive personality traits Sexual, physical, emotional abuse and neglect Difficult temperament	Ability to learn from experiences Good self-esteem High level of problem-solving ability Social skills
Social		
Family	Inconsistent care-giving Family conflict Poor family discipline Poor family management Death of a family member	Family attachment Opportunities for positive involvement in family Rewards for involvement in family
School	Academic failure Failure of schools to provide appropriate environment to support attendance and learning Inadequate or inappropriate provision of education Bullying	Opportunities for involvement in school life Positive reinforcement from academic achievement Identity with school or need for educational attainment
Community	Transitions (eg, urbanisation) Community disorganisation Discrimination and marginalisation Exposure to violence	Connectedness to community Opportunities for leisure Positive cultural experiences Positive role models Rewards for community involvement Connection with community organisations

Particular identified social factors include: rapid social change, migration, social isolation, unemployment and poverty, increasing social pressures to perform well, peer pressure, individual and family crises, changes in traditional values and conflict with parents (Patel et al., 2007; WHO, 2010). An alternative lifecycle approach (see figure 1) has recognised as risk factors the genetic background, physical health and nutrition problems, maternal depression and lack of psychosocial stimulation, carer loss, deficiencies in the psychosocial environment, exposure to toxins, violence and conflict, migration or forced displacement, gender inequality, abuse or neglect (Kieling et al., 2011). Using a lifecycle approach, studies also found that behaviour problems at 7 years of age are related to poorer educational attainment at 16 and poorer employment outcomes at 22 and 33 years of age (WHO, 2010).

Figure 1: The lifecycle approach to risk factors for mental disorders (Kieling et al., 2011)
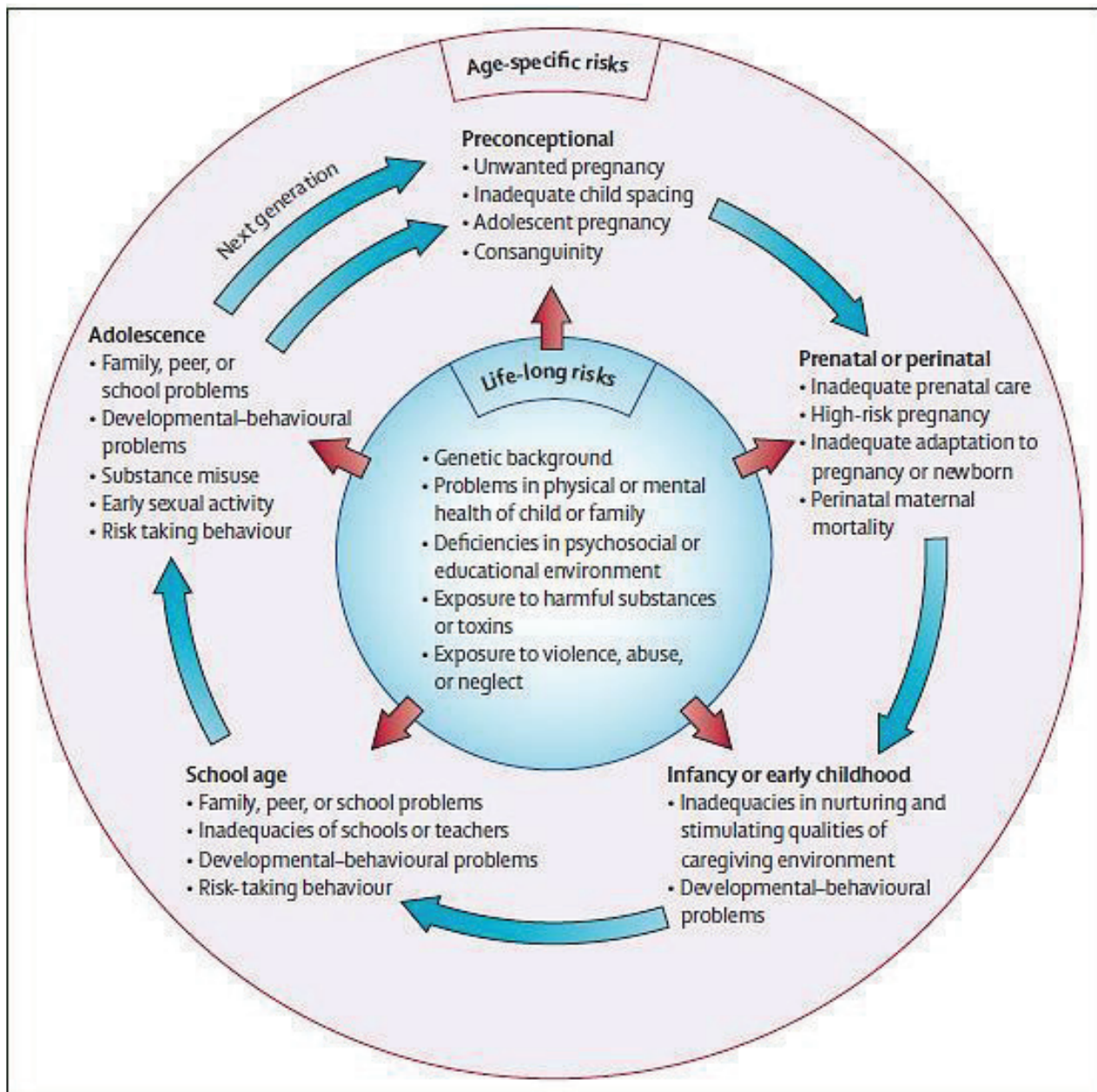
Research has also focused on protective factors. Longitudinal studies in various settings found that factors such as a sense of connection, low levels of conflict and an environment encouraging expression of emotions and providing support, do offer protection against development of mental disorders (Patel et al., 2007).

Over the past twenty-five years treatments for mental disorders in young people have improved and also include several forms of psychosocial interventions which either focus on the individual, family or group with encouraging results (Patel et al., 2007). Various school-based programmes to prevent mental health problems also seem to have positive outcomes (Kieling et al., 2011). Yet these interventions need to be evaluated with only 10% of randomised controlled mental health trials for children and adolescents coming from developing countries (Kieling et al., 2011). In addition, in many developing countries there are only a few child and adolescent mental health services available, particularly in rural or disadvantaged areas, while those at the middle and later stages of adolescence are directed either to child or adult services that focus on younger and older

patients respectively and are thus unable to effectively address their needs. Yet what is needed includes the provision of: psychosocial support services that promote mental health, reduce risk factors and strengthen protective factors in youth-friendly ways; training of primary care staff and associated workers to recognise such problems and deliver simple but effective services; and more systematic research on factors, interventions and care models that work (Patel et al., 2007).

1.6 Mental health and conflict

Conflict and disaster affect a large number of people, the majority of whom live in developing countries with often inadequate mental health infrastructure, and have negative consequences on their mental health. It is generally accepted that exposure to violence, death and stressful living conditions including food shortage, disease outbreaks, displacement, disrupted networks of support and weakened infrastructure, increase the risk for mental health problems. Indeed, mental health problems seem to be widespread in conflict-affected societies with between a third and a half of all affected people estimated to suffer from distress. The most frequent made diagnosis is post-traumatic stress disorder (PTSD), which is characterised by intrusive memories, avoidance of circumstances associated with the stressor, sleep disturbances, and lack of concentration (WHO, 2001). Large scale epidemiological surveys reported that PTSD and depression in conflict-affected populations can be up to seven or ten times the baseline in non-traumatized populations (World Bank, 2005 in Rockhold and McDonald, 2008). A systematic review of 181 studies of adults exposed to conflict and displacement found that more than 30% suffered from both depression and PTSD (Steel et al., 2007 in Reed et al., 2012). According to WHO (2013) between 15% and 20% of the adult population is predicted to develop a mild mental disorder such as moderate depression and PTSD compared to 10% before the emergency, and around 4% to suffer from severe disorder such as severe depression and psychosis compared to 2-3% before the emergency. Thus it has to be understood that although during an emergency the majority of the population experience some distress and pre-existing mental health problems are intensified, usually only a small proportion of people develop a mental health disorder in need of specialised care. Not all human distress is mental disorder and a depressed mood does not equal clinically diagnosed depression (WHO, 2001).

It has to be noted that conflict has significant consequences on the mental health of both combatants and civilians. Yet, despite the theory implying that increased exposure to violence increases symptoms of PTSD and depression, there is no agreement in the literature. Thus some studies reported high levels of post-traumatic stress among affected population, while others argued that the majority remained resilient. Nevertheless, there is agreement that social support is a significant protective factor (Annan et al., 2011). Another finding that is well established is that women and girls exposed to traumatic events are at greater risk of developing post-traumatic and depressive symptoms, despite the fact that men are more exposed to fighting and violence during the conflict. There is, however, no agreement on the reasons that this is happening; some focus on women's greater exposure to sexual violence and abuse, others on their greater exposure to stressors, while others prioritise biological factors (Annan et al., 2011).

Conflict does exacerbate sexual violence, largely directed against women and girls and used systematically as a weapon to terrorise and control civilian populations. In the post-conflict period, high levels of violence continue due to the normalisation of violence, availability of weapons and a culture of impunity. Another reason for the persistence of (both sexual and domestic) violence is related to male inability to live up to traditional gendered norms and subsequent frustration and aggression. In the aftermath of conflict the majority of men continue to face considerable difficulties in finding employment and regaining their status. Poverty, lack of jobs and infrastructure, displacement or urban migration and economic dependence on their spouses continue their disempowerment. Research conducted in post-conflict settings has documented competition between men and women in the informal sector, male demands to control women's income, substance abuse, mainly of alcohol and drugs, and increased levels of domestic violence (Baksh et al., 2005). As has been noted in the first part of this paper, gender inequality, stressful daily conditions and sexual violence are risk factors for mental illness among women.

Apart from women, children, the elderly and the disabled living in conflict-affected areas are particularly vulnerable to mental health problems (Murthy and Lakshminarayana, 2006). Apart from the traumatising impact of direct exposure to violence, the stressful conditions of their lives can compromise the psychological wellbeing of children and adolescents (Boyden and de Berry, 2004). The situation is particularly critical for adolescents.

Adolescence tends to be a stressful phase of human development in which people develop their personality and decide on their future as adults. In conflict-affected areas this transitional period becomes more difficult with serious mental health and emotional consequences changing the ways adolescents see themselves, relate to each other and think of their future. Not only do they miss education, economic and social opportunities, but they are also exposed to violence, may lose their parents and many are abused, abducted or forced to get involved into fighting. Girls and young women are particularly vulnerable to sexual violence and abuse. Some evidence even indicates that adolescent girls are up to six times more likely than their male counterparts to develop PTSD symptoms, despite the fact that the latter report more exposure to violence (Springer and Padgett, 2000).

While many studies of young people exposed to conflict indeed found high levels of depressive symptoms and emotional distress, research also confirmed child resilience and identified several protective factors even in the case of children involved in fighting. These factors include family support, community acceptance, relationships with peers, educational opportunities and restoring a sense of normality in child's life (Betancourt et al., 2013b; Kryger and Lindgren, 2011; Kalksma-Van Lith, 2007). Thus children cope best when they feel that they are cared about and supported by their parents (Bragin, 2005). A systematic review of protective factors in children and adolescents in conflict settings also confirmed the importance of positive parenting and support, although it remarked that resilience needs to be understood as a 'complex dynamic process driven by time- and context-dependent variables' (Tol et al., 2013).

Since 1996 when the ground-breaking Machel study on the needs of children affected by armed conflict recommended that psychosocial considerations should be taken into account at all phases of emergency and reconstruction assistance programmes, and that instead of separate mental health programmes, culturally relevant programmes should be established as part of relief and development programmes (Bragin, 2005), a range of clinical and psychosocial interventions have been used to address them, including the creation of child friendly spaces (de Winter, 2007), youth clubs, recreational activities, and even training of teachers on subjects such as the impact of loss and stress on children (Kalksma-Van Lith, 2007). A review of these interventions found that their majority are school-based, while only very few family and community-based programmes have been evaluated empirically (Betancourt et al., 2013a). Yet young people affected by conflict have several special needs that should be addressed in terms of psychological support, but also education and employment opportunities (Rockhold and McDonald, 2008).

The literature on children and conflict is growing and particular groups of children and adolescents have attracted the interest of researchers and practitioners. Such a group is refugee and displaced children and adolescents, who represent nearly half of the global refugee and internally displaced population. A systematic review of the impact of displacement on resettled children and adolescents pointed out that exposure to conflict violence and displacement threatens their physical, emotional and social development. Yet an acknowledged limitation of existing studies is their narrow focus on PTSD and neglect of the full range of psychological distress. The review found that depression was more prevalent among older children; emotional disorders and depression were more prevalent among girls in accordance with general population patterns; children were not only exposed to organised violence but in many conflict-affected settings they were also exposed to higher levels of domestic violence; good quality social support was again associated with lower levels of distress, although the pathways through which social support moderated the effects of stressors is still not fully understood (Reed et al., 2012).

Children formerly associated with armed groups and their reintegration into their communities, have also attracted attention. Abduction seems to increase the likelihood of mental disorder; assessing the nature and patterns of disorder among adolescents abducted during the war in Northern Uganda compared to non-abducted adolescents, a study found that over than 51% of abducted but just 18% of non-abducted adolescents had clinically significant distress levels. In particular, more abducted adolescents reported PTSD (26.8% compared to 12.7%), major depression (19.5% compared to 4.2%) and anxiety disorder (13.4% compared to 4.2%) compared to their non-abducted counterparts. Adolescents living under more stressful daily conditions with less perceived support also reported more psychological problems (Okello et al., 2007). Another study from Northern Uganda also found that abducted young women reported on average 20% more symptoms of distress than non-abducted women, and were 1.25 times more likely than non-abductees to be in the top quartile of the distress index. Some reported nightmares and visions that are associated with post-traumatic stress, but were attributed to the spirits of the dead haunting them. Exposure to violence appeared to be the key factor for distress symptoms with young women appearing to be far more sensitive to violent trauma than men (Annan et al., 2011).

Research has emphasised that successful family and community reintegration is a protective factor for former child soldiers. Apart from separate Disarmament, Demobilisation and Reintegration (DDR) processes for children that address the specific needs of boys and girls, reintegration processes also need to include education or vocational training opportunities, access to health care and supportive counselling, but often also traditional cleansing and healing ceremonies. A systematic review of relevant studies concluded that family and community support were crucial for their psychosocial wellbeing (Betancourt et al., 2013b). Thus Betancourt et al. (2010) found that family acceptance and community support were associated with lower depression and hostility and higher adaptive attitudes and behaviours among former child soldiers in Sierra Leone. Evidence from Northern Uganda based on life narratives of children and adolescents associated with armed groups also reported the importance of four factors: social support in terms of having a caring family, close friends and an approachable community; participation in terms of receiving education and training skills, and community acceptance; self-perception; and faith in God (Kryger and Lindgren, 2011). In her study again from Northern Uganda, Corbin (2008) also concluded that family provides the necessary supportive environment to develop relationships with others and protects children from community harassment.

Yet evidence from Sierra Leone and other sub-Saharan African post-conflict settings indicates that communities are sometimes reluctant to accept back children who participated in atrocities; thus even when parents welcome back these children and youth, some community members may abuse them verbally or physically and isolate them from social life. Research in sub-Saharan African post-conflict settings also shows that such a rejection has negative mental health consequences; rejected child combatants suffer from high levels of distress, including sleeplessness and nightmares, often experienced and expressed in a culturally specific way: in Northern Uganda these children said that they were haunted by the spirits of those they had killed (cen) that returned to take revenge in the form of visions, nightmares and sickness. Given that these revenging spirits are considered dangerous not only for child returnees but also for their families as they are believed to bring illness, misery or even death, traditional cleansing rituals had to be organised for the revenging spirits of the dead. In psychological terms, the exclusion and isolation communities impose on some former child soldiers lead to a second traumatization and worsen their mental health outcomes; evil spirits do not pollute all former combatants, at least not those who are able to find sources of social support (Akello et al., 2006). Traditional cleansing rituals enable an identity transformation from former child soldiers belonging to the bush into acceptable community members and thus contribute to a reduction of anxiety and depression levels as indicated by evidence from Sierra Leone, Mozambique and Angola (Williamson, 2006). In addition, several sources have supported the provision of skills training and micro-credit along with psycho-education as part of psychosocial interventions. Drama, games and sport can be used to teach young people how to relate with each other, improve self-esteem and build trust and confidence. Psycho-education, that is ways of coping with trauma, managing stress and conflict, should not only target youth involved in atrocities but also their community, including parents and community leaders (Amone-P'Olak, 2005).

Although it is now accepted that not all local cultural practices are helpful, traditional cleansing ceremonies are often considered as an integral part of psychosocial services for the reintegration of children associated with fighting forces. Stark (2006) studied traditional purification rituals for former girl soldiers in Sierra Leone. Having also experienced sexual violence and rape, these girls and young women had physical and emotional problems, and expressed feelings of hopelessness and despair; their families and communities regarded them as polluted due to having been sexually abused and involved in atrocities, and thus often stigmatized and isolated them. Their pollution or bad luck ('noro') was also believed to cause misfortune, sickness and even bad harvests, and affect the whole community. Through interviews with the girls and traditional healers, Stark explored how these rituals contributed to psychosocial healing and reintegration and concluded that they had two important aspects: they symbolised community reconciliation while they also allowed the spiritual transformation of girls who were purified and thus able to leave behind bad luck, negative social behaviour and negative self-perceptions that they had brought with them on their return to their communities. Reconciliation, community acceptance and improved relations had a positive impact on the psychosocial wellbeing of these girls. Yet Stark also noted that strengthening traditional systems such as cleansing rituals may have unintended consequences, such as strengthening the role of traditional healers within the community and allowing them to perform also harmful traditional ceremonies such as female genital mutilation. Moreover, as Amone-P'Olak (2005) notes, they should be performed only when girls and their carers believe in this practice.

Girls and young women involved with fighting forces have attracted considerable attention. Despite their increasing involvement in a wide range of roles in various conflicts, partly as a result of being cheap, obedient and effective fighters, these girls and women do not form a homogenous group. Their age, roles, ranks, type of fighting unit, gender of commander, type of association with the armed group and the length of their stay are all important factors that shape the different experiences girls have (Specht and Attree, 2006) and their impact on girls' wellbeing. Existing literature argues that they face considerable difficulty to reintegrate into their communities as not only they committed atrocities, but they challenged established gendered norms and attitudes. A study of abducted girls in Northern Uganda reported various signs of physical (malnourishment, infections, pains and fatigue), emotional (sadness, anxiety, fears, phobias, hopelessness and crying), cognitive (lack of concentration, confusion, intrusive thoughts, absent-mindedness and incoherent speech), and behavioural (nightmares, day dreaming, thumb sucking, suspicion, loss of interest and social withdrawal) ill-being (Amone-P'Olak, 2005). Participatory research with young women in Sierra Leone revealed that lack of income-generating activities, inability to marry and not being invited to women's secret society ('bondu') events, a key structure of social support for rural women, were the obvious signs of poor reintegration; on the contrary, participation in income-generating activities, marriage and education were indicators of successful reintegration into society (Stark et al., 2009)

Many early studies pointed out that returning girls and women face high rates of family and community rejection and stigmatization and are less likely to marry or benefit from economic opportunities. The most vulnerable ones are those returning with children fathered by a rebel, who may also be stigmatised as the children of killers and seen as an additional economic burden in an extremely difficult situation. Although many of these women would like to follow their partner to his own community, they were often regarded as abducted girls who had to reunite with their parental families. Yet this practice often failed with communities seeing these women as wives of rebels ('bush wives') and not as innocent abducted children (Akello et al., 2006).

However, more recent studies suggested that this is not always the case with women and girls accepted by their families in some settings. In the case of Northern Uganda, quantitative evidence based on a representative survey of young people (aged 14-35) and supported by qualitative in-depth interviews, showed that the majority of women had largely been recruited to forcibly become wives and mothers; and when they returned from the Lord Resistance Army (LRA), the majority seemed to be very resilient and able to gradually reintegrate after experiencing only temporary distress and social troubles; only a minority experienced serious problems due to greater exposure to violence or very little social support. Interestingly, women were 9 percentage points more likely than men to report family problems and 7 percentage points more likely to report community problems, often temporary. Only 7% of women and 3% of men reported persistent family troubles; those women who reported a family problem, were also found to be 26 percentage points less likely than men to see it improve. Those who returned to extended families and not their parents also faced more difficult relationships due to scarce resources, including food. Women returning with children to their families felt that they were welcomed and their children were taken cared by their grandparents, although they also faced some problems. The research also observed that men were more likely than women to go back to school after their return, partly as women in general were already less likely to continue their schooling. Again those least likely to return to school were girls returning with children; they were 45% less likely than any other groups to return to school (Annan et al., 2011).

Women and girls were neglected in early DDR programmes as they were not regarded to be a primary security threat. Without any material, medical or psychosocial support and facing high levels of stigma or rejection by their families or communities, many had to resort to negative coping strategies such as sex work or living with abusive partners in order to survive. Given that their education level was usually lower than that of their male counterparts, girls also had further difficulty to get employment, while patrilineal systems of inheritance and control of land and property increased their difficulty to provide for themselves and their dependents. In line with the aforementioned research in Uganda, evidence also shows that young women returning with children found it particularly difficult to improve their education and thus their lives, as they often lacked the time or the means to attend catch up education or vocational training courses. Even when official DDR processes integrated gender concerns, they often failed to consider the particular needs of adolescent girls and young women aged between 14 and 25 year old, as those below the age of 18 are considered to be child soldiers and are treated as children, while those over 18 are treated as adults and their education needs are often ignored (Specht and Attree, 2006).

Unfortunately, there is a lack of attention to children and youth with disabilities; they are often invisible and their needs overlooked in psychosocial programming (von der Assen et al., 2010).

Given acknowledged negative effects on the mental health of affected populations, mental health issues attract particular attention during emergencies. Yet it has been observed that PTSD tends to dominate assistance efforts at the expense of other mental health problems. Apart from the criticism of it being over-used, this diagnostic category has also been criticised as too culture-specific. Yet many studies in non-Western settings have confirmed its validity, while studies using locally derived measures of mental health and psychosocial functioning have also found a link between conflict-related exposure and distress. Thus it is generally established that exposure to traumatic events increase the likelihood of mental disorders, including what is described as depression and PTSD symptomatology (WHO, 2001). Likewise, provided treatments have also attracted criticism as culturally inappropriate and without robust assessments to ensure that they avoid harming people (WHO, 2013). However, in the post-conflict period mental health may be neglected and receive limited attention (and funding) in the development agenda as policy makers and the international community primarily focus on promoting economic development and stability, and thus implemented mental health interventions may not be sustainable.

Nevertheless, WHO considers emergencies as opportunities to build better metal health systems and suggests making best use of the short-term interest in mental health during humanitarian crises and conflicts and converting it into momentum for change and reform (WHO, 2013). The agency provides several case studies where despite challenging conditions, emergencies actually provided a window for the creation of better mental health systems. In Afghanistan, after the fall of the Taliban, mental health became a priority health issue for the government and was included in the Basic Package of Health Services, largely due to strong advocacy by the WHO and NGOs; thus in specific parts of the country mental health services have indeed been integrated into community care and scaled up; a national mental health strategy in place since 2010 has aimed to provide mental health services in 75% of all health facilities by 2014; yet the financial sustainability of these services continues to be uncertain as the health sector heavily depends on donors. In Aceh in response to the 2004 tsunami a basic mental health care system was introduced and the majority of districts developed specific budgets. Sri Lanka is also a good example; since the 2004 tsunami, the country rapidly developed basic mental health services in most parts of the country and a new national mental health policy was introduced for the provision of community-based care. Likewise, Timor-Leste rapidly built a community-based mental health system from scratch, introduced a national mental health strategy, and provided appropriate training to health workers. In some cases, such as in Iraq and Kosovo, reforms have also given some consideration to the needs of children and adolescents. A positive example from sub-Saharan Africa is Burundi: in 2000 mental health services did not actually exist in the country and only one psychiatrist and a psychiatric hospital existed with Burundians forced to rely on traditional healers, and understanding of mental health problems being limited with such problems often attributed to spirit possession. As the country began its transition from conflict to peace, an international NGO (HealthNet TPO) started providing such services at community level and trained social workers, nurses and community workers as psychosocial assistance providers. The latter became active agents of advocacy and change and five years later the NGO collaborated with the government for the integration of mental health services into the health system (WHO, 2013).

These country examples demonstrate that the short-term interest in mental health can indeed be effectively used for mental health system reform. The particular lessons that they offer include the importance of having a relevant policy framework developed through the participation of all stakeholders with a longer-term perspective for a sustainable system. The broad mental health needs of the population have to be considered, and focus should not be narrowed down to the problems triggered by the emergency. Irrespective of problems, the government has to play a central role in the reform and supervise all actors involved. Coordination across all those involved in the mental health reform is also crucial in order to enable them to complement one another in different areas and avoid duplication and waste of scarce resources. Mental health reform inevitably involves revision of national policies; when political will for reform is high, policy reform can be accelerated. The mental health system needs to be reviewed and assessed as a whole from institutional care to community level. Emphasis should also be placed on improving human resources and services rather than buildings. Good evidence from the first projects can help attract more funding for a longer-term reform; and advocacy by individuals and groups can also contribute to a broader mental health reform (WHO, 2013).

2 The psychosocial factor: the emergence of mental health and psychosocial support (MHPSS)

The mental health needs of populations affected by conflict and displacement attracted some attention for the first time in the aftermath of the Second World War when a clinical approach tried to solve the problems of resettled European refugees. Yet until the late 1980s humanitarian work focused on the provision of services to meet the basic material needs of people affected by emergencies. Issues of mental health and psychosocial problems were rather neglected. However, since then such issues started to attract increasing interest: reports revealed the mental health problems of Cambodian refugees in camps in Thailand, the media focused on the impact of the civil war in former Yugoslavia and an increasing number of studies revealed that conflict-affected populations had increased mental health needs. Accumulated evidence showed that conflict, displacement and associated conditions cause mental health problems such as anxiety, depression and PTSD, and exacerbate pre-existing ones. Neglecting them meant that interventions with livelihoods objectives could be undermined as people with mental health problems could not engage successfully. This recognition led to an increasing number of activities developed by humanitarian and international development organisations such as the International Federation of Red Cross (IFRC) and UNICEF, addressing individual mental distress but also psychosocial issues at community level (UNHCR, 2013).

Thus over the past twenty years or so the impact of conflict or disaster on the mental health and wellbeing of affected populations has been increasingly acknowledged by the humanitarian community and has led to the emergence of the mental health (MH) and psychosocial support sector (PSS). The turning point for the establishment of the sector was the 2004 tsunami. More than any other emergency, this event actually brought to the global attention the 'enormity of suffering associated with psychological anguish, social disruptions and forced life transformations caused by the disaster' (Wessells and van Ommeren, 2008 in UNHCR, 2013), and corroborated the argument that mental health needs are equally important with basic needs and should also be addressed.

Exploring the pathways through which conflict and disaster affect wellbeing, a large number of studies revealed a range of risk but also protective factors: a review undertaken by Steel, a clinical psychologist with extensive experience on the mental health of refugees and asylum seekers, concluded that although torture is the strongest factor associated with PTSD, accumulative exposure to potentially traumatic events has the strongest association with depression. Displacement and life in refugee camps was also associated with increased mental disorder symptoms. A global synthesis of studies of displaced and non-displaced populations published between 1959 and 2002 found that post-displacement social conditions such as living in institutional accommodation, restricted economic opportunities and internal displacement were associated with poorer mental health outcomes (Porter and Haslam, 2005). Studies investigating protective factors, often context-specific, focused on religion, economic activity, community support and performance of traditional rituals such as mourning rituals, burials and community healing ceremonies. Thus a strong association has been established between exposure to conflict-related violence, loss, destruction and trauma and mental disorder. In addition, accumulating evidence from various settings indicated that conflict-related stressful conditions also pose considerable threats to the mental health of the broader population, sometimes even more significant than direct trauma exposure. Conflict creates or exacerbates stressful material and social conditions of daily life that affect the wellbeing not of some individuals but of the whole population: for example, it disrupts social networks through death or displacement leaving people without access to social support; destroys livelihoods and causes or worsens poverty and

associated conditions such as unsafe housing and lack of access to food and health care; and generates vulnerable groups such as widows, orphans, former child soldiers, survivors of sexual abuse and people with disabilities.

Research undertaken by Miller et al. in Sri Lanka (2009) and Afghanistan (2008) highlighted the negative impact of daily stressors such as poverty, unemployment, poor housing and domestic violence on the mental health of the population. A study of Darfur refugees in Chad also found that hardship due to displacement, particularly lack of access to basic resources such as money, firewood and food and safety concerns were more strongly linked to psychological distress than conflict-related traumatic events (Rasmussen et al., 2010). And a study of Palestinian youth exposed to the violence of Israeli occupation (Al-Krenawi et al., 2007) also concluded that family violence had a worst impact on their mental health than their exposure to political violence. Miller proposed a model (see figure 2) of how daily stressors impact on mental health according to which they actually mediate the relationship between conflict or disaster exposure to mental health and psychosocial status.

Figure 2: Daily stressors mediate the relationship between conflict and disaster exposure and mental health and psychosocial status (Miller et al., 2009)
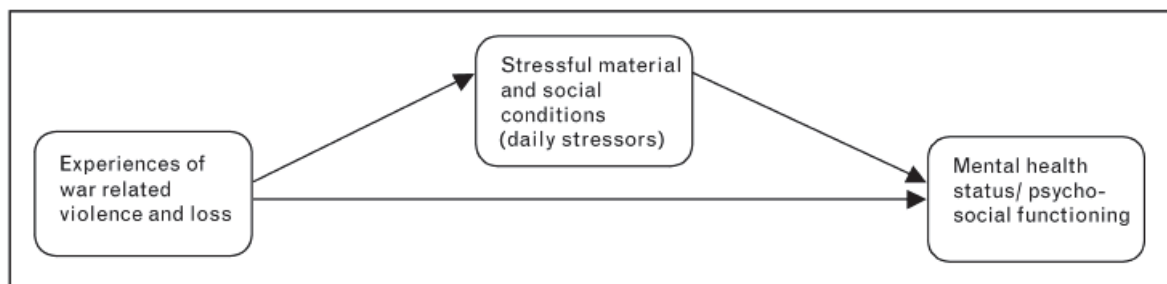
Proponents of the importance of daily stressors argued that only a minority of the population develop serious mental health problems in need of specialised care; these people may have already been suffering from serious mental health conditions such as schizophrenia, or developed such problems such as PTSD as a result of conflict-related traumatic events. On the other hand, the majority of the population require interventions to strengthen their resilience and cope with conflict-related daily stresses; with adequate social support and the passing of time even those exposed to a traumatic event have the capacity to function normally again.

Moreover, many voices argued that mental disorders are context and culture specific and thus not experienced in the same way: the validity of clinical diagnostic categories and particularly PTSD has been questioned along with its individual focus, instead of the collectivistic focus of non-Western societies. Summerfield (1999) is one of those that attacked the trauma discourse, the narrow emphasis on the PTSD, and the imposition of Western concepts on mental health issues among non-Western populations affected by conflict. He spoke of 'the discovery of trauma' and 'the medicalization of distress' by Western humanitarian agencies and criticised the reframing of social suffering as a technical problem to be addressed through short-term technical solutions. He also criticised the focus on vulnerable population groups as raped women and traumatised children (orphans, child soldiers and refugees) at the expense of larger child populations affected by conflict. In addition, Fernando (2004) argued that in collectivistic cultures clinical psychology and psychotherapy need to combine its Western individualistic focus with more collectivistic perspectives. Although Western assessment tools may be useful points of departure, professionals should be very cautious in using their translated versions; not only may the cultural setting be different, but people belonging to different socioeconomic groups and religions may experience and express psychological distress differently.

Thus two main approaches emerged: the trauma approach with a focus on individual clinical mental health problems and a treatment orientation, related to Western mental health concepts, particularly PTSD, and implemented by medical professionals; and the resilience approach that focuses on the majority of the population and less on their experiences of the past and more on challenges of the present, and aims to help affected communities cope with stressful situations through strengthening their protective factors and enabling local participation through activities implemented by non-mental health professionals. The focus on resilience is justified by the fact that in many cases, the majority of the population do not develop a psychiatric condition,

symptoms of distress reduce over time without clinical interventions, and community support was found to be important in the face of collective adversity.

Media's moving accounts, increased global and local awareness of the psychosocial effects of conflict and donors' interest led to the implementation of a wide and diverse range of interventions, indicative of the broadness and complexity of the field. Writing on the Sri Lankan situation, Galappatti (2003) mentions the provision of: explicitly psychological services such as counselling, art and drama therapy, and PTSD assessment and referral; awareness-raising and psycho-education such as information on trauma and strategies to cope with symptoms, or training of caregivers to help children manage stress; development of interpersonal skills at community level such as guidance for conflict resolution or problem solving; social activities supporting the expression of feelings and thoughts; mobilisation of existing community networks through establishing children's clubs or running workshops for traditional coping strategies; supportive practices for child development such as play activities; skills training to improve people's material situation such as vocational training for young people or skills development for widows; provision of material and other support to address structural threats to wellbeing such as provision of food, birth certificates for children to enable access to education and services, or microloans; activities strengthening the spiritual dimension; provision of psychological skills training for staff such as counsellors, teachers, social workers; provision of training on rights and conflict resolution; and improving links and collaboration between resources and support services.

Psychosocial was thus used as an umbrella term to describe such a wide range of interventions, yet there was ambiguity over what the term actually meant. Lack of consensus over goals, strategy and best practices resulted in calls for a clear definition to stop undermining the design and implementation of programmes and hindering their monitoring and evaluation. The difficulty to agree on a shared definition of psychosocial interventions was rooted in debates about the nature of the psychosocial effects of conflict, given several competing perspectives. The most influential of these perspectives have been derived from psychiatry, counselling, social or developmental psychology, medical anthropology and traditional folk knowledge. Each perspective has focused on particular concepts and theoretical assumptions that shape its distinct understanding of the psychosocial impacts of conflict (Galappatti, 2003). As has already been noted, the most debated example is the PTSD, 'the most frequently screened-for psychiatric diagnosis, as well as a concept utilised in the planning of many intervention programmes' (Ager, 1999 in Galappatti, 2003). And the greatest debates have taken place between psychiatry and medical anthropology, with the latter favouring culture-specific understandings of health problems and suffering and supporting the use of local healing practices; this opposition between psychiatry and anthropology has also taken the form of the opposition between the trauma and the resilience discourse. Thus projects were seen to be fundamentally different in terms of what constitutes a psychosocial problem, what comprises an appropriate intervention and what the successful outcomes are. Interestingly, though, these debates have largely taken place in the developed world with only a few contributions made by scholars and practitioners from the global South where actually most of the conflicts were taking place.

Since the beginning of the new millennium as interventions proliferated, efforts to end the dividing debate, establish a common conceptual framework and agree on best practices, intensified. The collaboration between academics and humanitarian agencies led to the formation of the Psychosocial Working Group (PWG) that did formulate a conceptual framework to understand psychosocial wellbeing and develop appropriate psychosocial interventions.

The PWG acknowledged the difficulty to define psychosocial and the subsequent confusion and ambiguity of the term. Its key members argued that the term has been used in three main ways: as a synonym for mental health with less stigmatising potential and a greater emphasis on the influence of social factors on wellbeing; as a term describing a wide and diverse range of programmes that in the past belonged more to community-development programmes; and as a term to describe the goal of enhancing the capacity of a community or individual to cope with adversity and mobilise effectively resources. The PWG embraced and focused on the third use (Ager et al., 2006).

According to the PWG, the term psychosocial 'emphasises the close connection between psychological aspects of our experience (our thoughts, emotions and behaviour) and our wider social experience (our relationships, traditions and our culture)'(Strang and Ager, 2003: 3) and thus 'psychosocial well-being is seen as the ability to deploy resources effectively to shape your own world' (ibid: 7). The key challenge for psychosocial

programming is to understand how a community has been affected by the conflict and how its members can be best supported. In order to do so, the PWG focuses on three key resource areas affected by conflict: human capacity (physical and mental health, knowledge and skills of an individual); social ecology (social relationships that enable people to function as a community, social capital); and culture and values of the community (see figure 3). Individuals and communities affected by conflict are perceived to be not passive victims but active actors responding to the challenges with the resources available to them. Thus psychosocial interventions need to identify how and why normal coping strategies fail to respond to conflict challenges and support people to do so by strengthening their normal coping strategies.

Figure 3: The PWG framework and factors influencing psychosocial wellbeing (Strang and Ager, 2003)
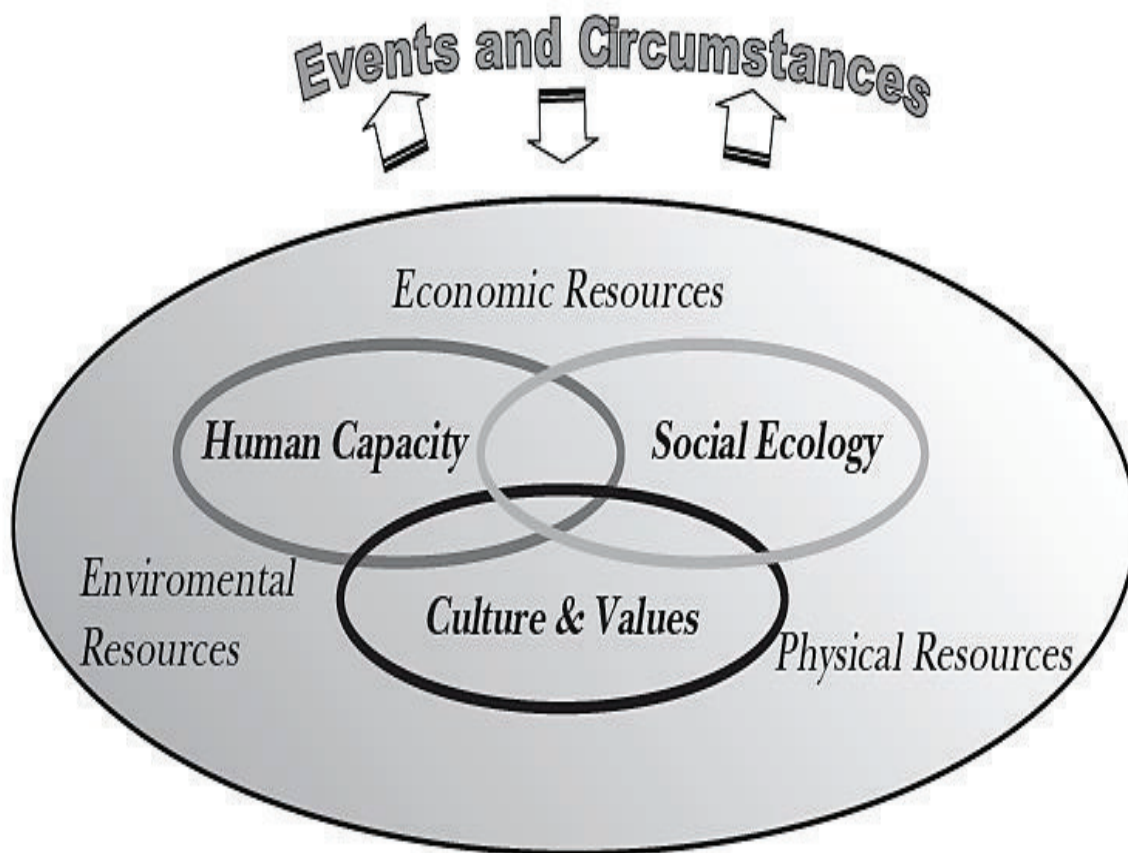
Apart from trying to provide a working definition of psychosocial wellbeing, the PWG stressed the need for interventions that are context-sensitive and build upon existing resources and support systems. Yet one of the limitations of its work was the emphasis on the psychosocial component and the neglect of clinical mental health and the provision of support to people with severe mental disorders (UNHCR, 2013), a limitation perhaps attributed to the prominence such interventions already enjoyed and the urgent need to define and establish psychosocial activities. Moreover, as Galappatti (2003) points out, many psychosocial workers felt that the PWG framework failed to consider material wellbeing which is a crucial component of overall wellbeing. Thus Galappatti proposed the integration of this fourth component:

Figure 4: The proposed adapted PWG psychosocial domains (Galappatti, 2003).
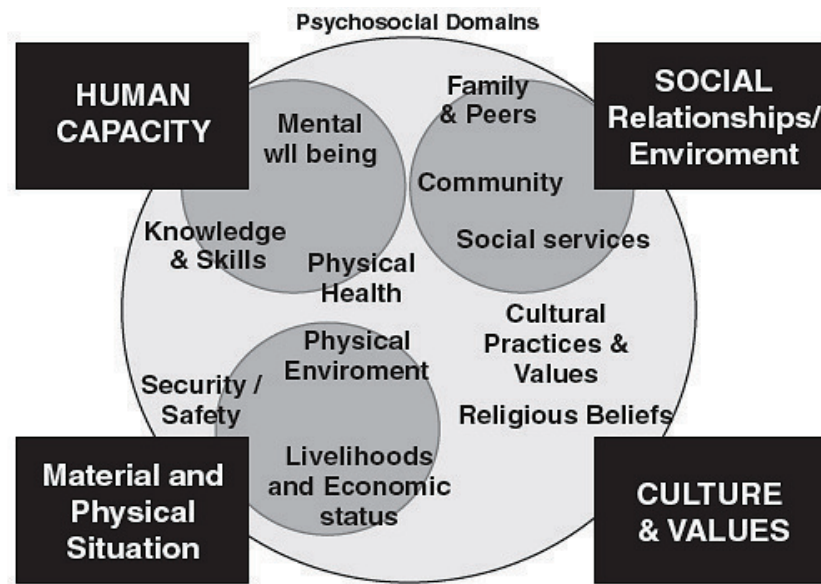
Based on their field experience in Sri Lanka, Salih and Galappatti (2006) pointed out that poverty was often found to mediate or even frame the suffering of people affected by conflict. In studies among conflict-affected populations, participants reported economic difficulties as the most common source of stress followed by displacement and lack of food; violence was reported as a far less common stressor. People stressed their inability to meet basic needs and their limited control over their lives, confirming that poverty and hardship are also a major threat to psychosocial wellbeing in conflict areas:

> *'By now we have consoled ourselves when thinking of the situation. Because we can't all afford to become mentally sick. We tell mother 'if you mention our house and cry, could you have borne the loss if you had lost one of us? Lands and houses you can earn if you are alive'. We scold her by saying this and try to quiet her, even though deep inside we also feel the loss. We try to act as if we are not interested in these things now. But we are also in pain when we think that we will have to get clothes from others'* (Displaced woman, Vanuniya in Salih and Galappatti, 2006)

> *'The financial needs are so many. Receiving financial aid brings a certain amount of mental relief'*
> (Informant, Moneragala in Salih and Galappatti, 2006)

In 2005 the Interagency Standing Committee (IASC)2 MHPSS Task Force was established to address these issues systematically and improve inter-agency collaboration and coordination. The composite term Mental Health and Psychosocial Support (MHPSS) was introduced by humanitarian practitioners 'to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'. As the IASC observed, aid agencies outside the health sector usually speak of psychosocial wellbeing, while health sector professionals focus on mental health and speak of psychosocial interventions to refer to non-biological treatments for people with mental disorders. Thus the two terms are closely related and overlap, but for many practitioners in the field they represented two complementary, albeit different, approaches (IASC, 2007). Thus, the composite term was chosen as it 'serves to unite as broad a group of actors as possible and underscores the need for diverse, complementary approaches in providing appropriate supports'. Two years later in an effort to reach a necessary consensus on minimum standards, IASC introduced specific operational guidelines under the MHPSS term (IASC, 2007).

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2 Established in 1992, the IASC is an inter-agency forum of UN agencies and non-UN partners on humanitarian issues.

The 2007 IASC Guidelines accept that the term psychosocial 'denotes the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other' (IASC, 2007). As has often been noted in the literature, the selection of this umbrella term was guided by the need to unite all practitioners and leave aside the theoretical debates that not only divided the field but had negative effects on programming and agency coordination. Thus the importance of the Guidelines lies in the fact that they provided a composite term and an integrated approach for mental health and wellbeing, combining activities to address individual cases of severe distress with interventions to build resilience and help the broader community cope with adversity and prevent the development of mental disorder. The Guidelines are based on six core principles: human rights and equity; participation of local populations; do not harm; building on available resources and capacities; integrated support systems; and multi-layered supports. Indeed, the Guidelines speak about the need 'to develop a layered system of complementary supports that meets the needs of different groups', and demonstrates that by the Intervention Pyramid (see figure 5).

Figure 5: The IASC Intervention Pyramid for mental health and psychosocial support in emergencies with examples (WHO, 2013)
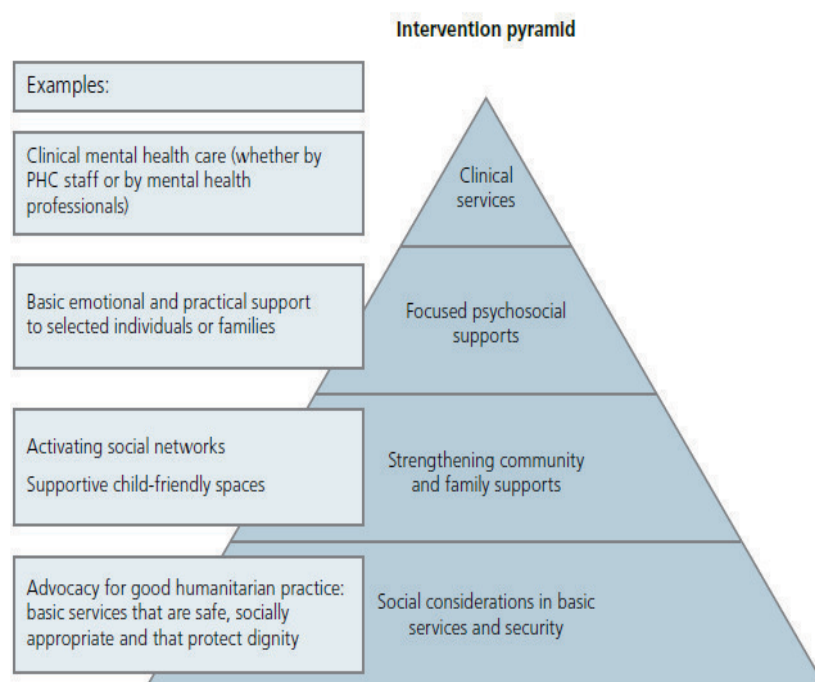
The Guidelines stress that all pyramid layers are important and interventions to address them should be implemented concurrently. Thus an MHPSS response should first establish adequate services to address the basic physical needs (food, shelter, water and health care) of the overall affected population and ensure that they are delivered in a way that promotes mental health and wellbeing. These services should be established in participatory, safe and socially appropriate ways to enable the reactivation and strengthening of family and community support systems, including women's groups and youth clubs. The third layer represents the supports that smaller number of people need through more focused interventions provided by trained and supervised community workers such as basic mental health care and psychological first aid to survivors of gender-based violence. Finally, the top layer of the pyramid represents the psychological or psychiatric support required for a small proportion of the population who suffer severe mental disorder and must be referred to specialised services if they exist.

The development of the IASC Guidelines is often regarded as the milestone to establish common minimum responses during emergencies (Aggarwal, 2011). Despite continuing disagreement, the IASC Guidelines established the necessary operational framework and the core principles of the field. The provision of MHPSS in humanitarian emergencies is now well established and takes place from the early stages of the humanitarian

response as was the case in the 2010 earthquake in Haiti, the 2011 emergency in Libya and the current refugee crisis in Syria, to help communities build their resilience and cope with adversities (UNHCR, 2013).

However, problems continue to exist. The exact meaning of psychosocial continues to be contested and each agency involved tends to have its own definition. For example, UNICEF describes the psychosocial framework as the one that aims to 'reinforce well-being, dignity and resilience' at both individual and community level. Terre des Hommes describes it more broadly in terms of 'the well-being of individuals in relation to their environment' (UNHCR, 2013).

A recent UNHCR review of MHPSS services globally found limited provision of clinical mental health services for displaced persons, including gaps in referral systems to specialised assistance. It also found that data on mental health and psychosocial problems, availability of services and MHPSS activities in humanitarian settings are actually severely lacking. Furthermore, the monitoring and evaluation of MHPSS activities is also weak. Indeed several sources stress that there is a lack of monitoring and evaluation of MHPSS humanitarian interventions due to a number of factors. As practitioners in the field argue, mental health and psychosocial wellbeing outcomes are far more difficult to measure compared to physical health outcomes. Baseline data rarely exist and evaluations can only reach limited conclusions, while they are also unable to identify whether any changes observed are due to the time lapsed from the emergency, other factors such as improved social conditions, or the intervention itself. Moreover, there are serious methodological issues in terms of availability of appropriate and effective research methods and indicators to measure mental health and psychosocial wellbeing. As has already been noted, Western psychiatry has developed and used several diagnostic tools particularly for children and adults to assess common mental disorders. Yet it is largely accepted that the use of these measures in non-Western settings without any adaptations has considerable limitations. Thus a growing body of literature focuses on adaptation and development of pilot measures that are context-specific. Indeed, despite the challenges involved in selecting and adapting such measures, mental health researchers increasingly develop methodologies to efficiently measure mental health. Some have even conducted randomised controlled trials (RCTs) to evaluate specialised interventions with positive results in terms of showing that such research is feasible and that these interventions deliver results. Yet according to the UNHCR review methods to evaluate common MHPSS interventions are still inadequate; one of the difficulties is that often such interventions are broad with several complementary components, and it is thus difficult for evaluation methods and indicators to capture all of them instead of focusing on a single activity (UNHCR, 2013). Preliminary findings of a review on health in humanitarian emergencies which included among health interventions those focusing on mental and psychosocial health show that largely such interventions focus on PTSD, yet there are gaps in terms of their effectiveness, the feasibility of scaling-up, their linkages to other interventions and their assessment (Blanchet et al., 2013). However, positive developments are already taking place: having secured funding for such activities and in collaboration with an academic institution, the UNHCR MHPSS programme in Syria has integrated a strong evaluation component from the early stages of the programme consisting of quantitative methodology to assess specific symptoms, an assessment survey of MHPSS impact, and in-depth interviews to identify positive and negative coping strategies at community level (UNHCR, 2013).

Moreover, existing literature provides evidence that the understanding and framing of mental health and psychosocial issues need to be improved. Although many agencies have adopted and integrated psychosocial principles and activities within their core programmes, more needs to be done to improve understanding, and more resources to be invested in building appropriate skills for such activities. Another issue of critical importance is that psychosocial interventions are often implemented in response to an emergency humanitarian situation, but are not sustainable in the transition from the post-conflict to the development context. However, there are projects providing MHPSS services in post-conflict settings with the aim of assisting people and communities cope with long term conflict consequences and chronic adversities.

Related to that is another debate within the MHPSS field. The main issue is whether MHPSS programmes should be distinctive interventions or integrated within already existing programmes. Thus Williamson and Robinson (2006) argued against a distinct psychosocial sector and in favour of an integrated psychosocial approach in emergency settings, as the 'material, biological and psychological aspects of well-being are integrally related, and it is not helpful to try to separate them into separate areas of programming'; what is needed is 'that all interventions with populations affected by armed conflict should be informed by and incorporate a working understanding of the relevance of psychosocial issues'.

This means that apart from a psychosocial intervention, there can be a psychosocial approach. While the former is a programme with the primary objective to improve psychosocial wellbeing, the latter is an approach, which based on the IASC principles can be integrated into existing programmes with other objectives (shelter, nutrition, education, health, water and sanitation) in order to ensure that issues of psychosocial wellbeing are explicitly considered, and to maximise programme impact. In particular, psychosocial activities can be integrated into sexual and gender-based violence, child protection, education, and community development programmes. In practice, both psychosocial interventions and approaches currently exist. Although the emphasis is still placed on MHPSS programmes in humanitarian emergencies and guidance for MHPSS programmes in urban and non-emergency settings is largely lacking, such activities also occur in various non-humanitarian contexts. An increasing number of programmes with poverty reduction objectives also include psychosocial support services within their usually microcredit and income-generating activities This is being done in two main ways: by employing counsellors to provide assistance should it be required, and by training field workers through skills building in counselling and supportive listening (Salih and Galappatti, 2006). Some agencies have also linked psychosocial activities to their particular mandate with, for example, UNICEF and Save the Children integrating psychosocial principles into their child health and protection programmes, and UNICEF finding that such activities within nutrition programmes improve their outcomes.

However, a growing body of evidence indicates that people's subjective perceptions of wellbeing within each cultural context should inform the design, implementation and evaluation of such interventions. A recent qualitative and participatory study among conflict-affected, vulnerable women in Burundi, Nepal and Northern Uganda aimed to understand what psychosocial wellbeing means for them. The authors noted that the term psychosocial brings together the psycho and the social as they constantly influence each other and are inseparable. Thus 'psycho' refers to 'the psychological dimension of the individual', that is 'the inner world of thoughts, feeling, desires, beliefs, values, cognitions and ways in which people perceive themselves and others'. On the other hand, 'social' refers to 'the relationships and environment of the individual', and 'includes the material as well as the social and cultural context in which people live, ranging from the network of their relationships to cultural manifestations, to the community and the state'. Interestingly, the study found that previous studies focused on women's suffering and emphasised their identity as victims of violence and abuse with thus psychosocial wellbeing used as a metaphor for surviving this violence. Yet participants defined psychosocial wellbeing not as an absence of suffering and violence, but as a positive and aspirational state of being. Women actually identified several domains that according to them comprise psychosocial wellbeing; these domains are inseparable and interlinked and work together to create a condition in which women feel well in heart, mind and body. While some domains were country specific (e.g. freedom of movement in Nepal, or religion and spirituality in Burundi and Uganda), five common domains emerged: education; access to resources; love and harmony in the family; friends and social support outside the family; and voice in home and community (Bragin et al., 2013).

Finally, it has to be noted that outside the MHPSS, the concept of wellbeing has been attracting increasing attention in development policy and practice. Given the acknowledged difficulty to define it, it has been used in several different ways with economists focusing on happiness as its proxy and psychologists speaking of subjective wellbeing and people's ability to meet basic psychological needs. Combining scholarship in international development and psychological wellbeing and based on field research in developing countries, researchers at the University of Bath have developed their own psychosocial wellbeing approach, built around the concept of Inner Wellbeing. Defined as 'what people feel and think they can do and be', this 'encompassing and holistic' concept, is comprised of seven distinct but interrelated domains: economic resources, agency and participation, social connections, close relationships, competence and self-worth, physical and mental health, and values and meaning. Contrary to other wellbeing approaches focusing on the individual and internal psychological processes, this one emphasises the importance of relations, local context and politics (White, 2013).

3 Good research methodologies

Many studies investigating the mental health of populations affected by armed conflict or natural disaster have measured their mental health status based on aggregation of individual responses to questionnaires administered in the agreed survey settings. In general, these survey questionnaires were developed in Western clinical settings and for that reason when they are used in a culturally different setting, they have to be adapted and their validity has to be tested.

The survey instruments often used to screen psychiatric disorder among adults is the General Health Questionnaire (GHQ) (see figure 6), and the 20-item Self-Report Questionnaire (SRQ-20). These questionnaires have been translated into many languages and their validity tested in many developing countries. In the case of studies that focus on children and adolescents, a questionnaire often used to assess disorder and social functioning is the Strengths and Difficulties Questionnaire (SDQ).

Figure 6: The short version (with 12 items) of the General Health Questionnaire (GHQ-12)

How have you been feeling, in general, over the past few weeks?

Have you recently?

	A	B	C	D
1. Been able to concentrate on what you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2. Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. Felt you were playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4. Felt capable of making decisions about things?	More so than usual	Same as usual	Less than usual	Much less capable
5. Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. Felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less than usual	Much less than usual
8. Been able to face up to your problems?	More so than usual	Same as usual	Less than usual	Much less able
9. Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. Been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11. Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. Been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less than usual	Much less than usual

Thus in an assessment of the nature and patterns of psychiatric disorders among war-abducted adolescents in Northern Uganda, Okello et al. used the SDQ and the Mini International Neural-Psychiatric Interview for Children and Adolescents (M.I.N.I-KID). The SDQ is a brief tool for use in 11-16 year olds; it has 25 items and five sub-scales on emotional, conduct, hyperactivity, pro-social and peer problems. On the other hand, the M.I.N.I-KID is the child and adolescent version of the M.I.N.I., a well-established psychiatric diagnostic tool based on the fourth version of the DSM, the Diagnostic and Statistical Manual of Mental Disorders published

by the American Psychiatric Association which aims to provide a common language for the classification of mental disorders; the M.I.N.I-KID has been used in non-Western settings to determine the specific nature of child psychiatric disorders (Okello et al., 2007).

Another study on abducted adolescent girls again in Northern Uganda, used the Impact of Events Scale-Revised (IES-R), a 22-item checklist, widely used to measure the psychological impact of exposure to trauma and particularly PTSD symptomatology worldwide; an additional tool to measure adolescent girls' war experiences, the 46-item War Experiences Checklist (WEC), was specifically designed for the study to provide information about the girls' experiences and their links to PTSD symptomatology (Amone-P'Olak, 2005).

As Kohrt et al. (2011) note, lack of culturally appropriate tools for mental health and psychosocial support is a barrier to assessing the prevalence of mental health problems and evaluating relevant interventions. The translation of instruments developed and validated within Western cultural settings and their uncritical application, as is often the case, is inadequate. Such instruments may be unable to capture what they are intended to measure in a different cultural context as the meaning, clustering and experience of symptoms may be different. Moreover, as such instruments can be used to generate data to inform interventions, un-validated instruments can lead to potentially harmful interventions. A number of cross-cultural validation techniques are now available for mental health research with adults but also children and adolescents.

In their study, the authors chose to explore the Western psychiatric categories of PTSD and depression among Nepali youth affected by the conflict for the purpose of developing and adapting instruments to screen children for enrolment in NGO-led psychosocial interventions. Although ethnographic research in Nepal did not find concepts synonymous with clinical depression and PTSD, some of the symptoms were observable, and terms capturing specific elements of the disorders existed.

For the adaptation and validation of instruments developed within Western clinical settings in cross-cultural child MHPSS research, the authors proposed six evaluation questions/criteria: what the purpose of the selected instrument (often a questionnaire) is; what the construct to be measured (a Western mental health problem, a local idiom of distress or a cross-cultural construct) is; what the contents of the construct (social relations, behaviours, exposures, personal characteristics) are; what the local idioms employed (local terms and their meaning) are; how should questions be asked and responses structured (e.g. a true and false statements, a categorical yes/no, severity levels on the so-called Likert scale from rarely to often, or illustrations); and what a score on the instrument means.

The instrument chosen was the Depression Self-Rating Scale (DSRS), an 18-item self-report measure for children, which has been used in various cross-cultural contexts to record symptoms over the past week. Items appear as statements: e.g. 'I sleep very well' and responses range from 0 (mostly), 1 (sometimes), to 2 (never). They also used the Child PTSD Symptom Scale (CPSS), which has 17-items corresponding to PTSD diagnostic criteria in the 4rth version of the DSM. Items again appear as statements, and responses are given on a 0-3 scale with 0 meaning not at all or only once and 3 meaning many times. Both instruments were translated in Nepali and each item validated and reviewed by experts. Then, focus group discussions (FGDs) were conducted with Nepali children (boys and girls) whose age, ethnic and residential demographics were comparable to the children who would later participate in the quantitative studies; instruments were modified in line with children's recommendations.

Children also evaluated three visual 'pictographic' response scales created by a Nepali artist: water glasses, an abacus, and a basket scale, which have often been used in mental health research. Each item had to be endorsed by at least two children from each focus group as having a connection to sadness ('dukkha'), and indeed it was in most cases apart from a few items. Contrary to Western children, Nepali children did not associate appetite loss and stomach-aches with sadness or depression in line with findings from previous studies among Nepali adults who also did not associate depression with gastrointestinal or somatic complaints. Nepali children also identified two items as common responses to trauma that were not, though, linked to distress: avoiding activities and people related to a bad stressful event, and less interest in activities. Children said that in conflict settings is better to avoid places where an attack occurred or where people in uniform were present; and they added their common cultural explanation that places where bad events happened should be avoided as ghosts and spirits haunt them. Thus avoidance and changing activities were not signs of pathology within the Nepali context.

Children said that forgetting a bad event led to feeling better, so their goal was to intentionally forget; forgetting in the Nepalese culture means not having intrusive memories and again this was in line with research among adult trauma survivors who said that they remembered every detail of the traumatic event but wished they could not.

In addition, children were asked to comment on the statements and scales used. What was rather interesting and revealing of the importance of culture is children's views on the three pictographic scales: water, abacus and basket ('dhoko') scale. The basket scale was developed as a modification of previous research (by Bolton and Tang, 2002), which used a non-verbal response card depicting people carrying bags with different weights. Thus the basket scale ranged from a man with no bricks in his basket standing upright to a man straining under the weight of a basket full of bricks. Researchers explained to children that the basket represented their heart-mind and the bricks an emotion such as sadness, anger or fear. Then children had to describe how much their heart-mind was full of a specific emotion by choosing a basket with a specific quantity of bricks; the assumption was that children would associate an empty basket with a positive symptom-free condition and a full basket with a negative condition of heavy symptom burden. However, in every focus group children tended to associate a full basket with lack of sadness and an empty basket with extreme sadness: a full basket meant happiness, because more bricks were linked to a higher earning potential; in contrast, the man with the empty basket was described as lazy and as he was not going to make any money, the saddest of all. Thus the basket scale was discarded from the quantitative part of the study. The easiest picture scale to translate proved to be the water glasses (see figure 7).

Figure 7: Picture-based response sets tested in Nepal (Kohrt et al., 2011)
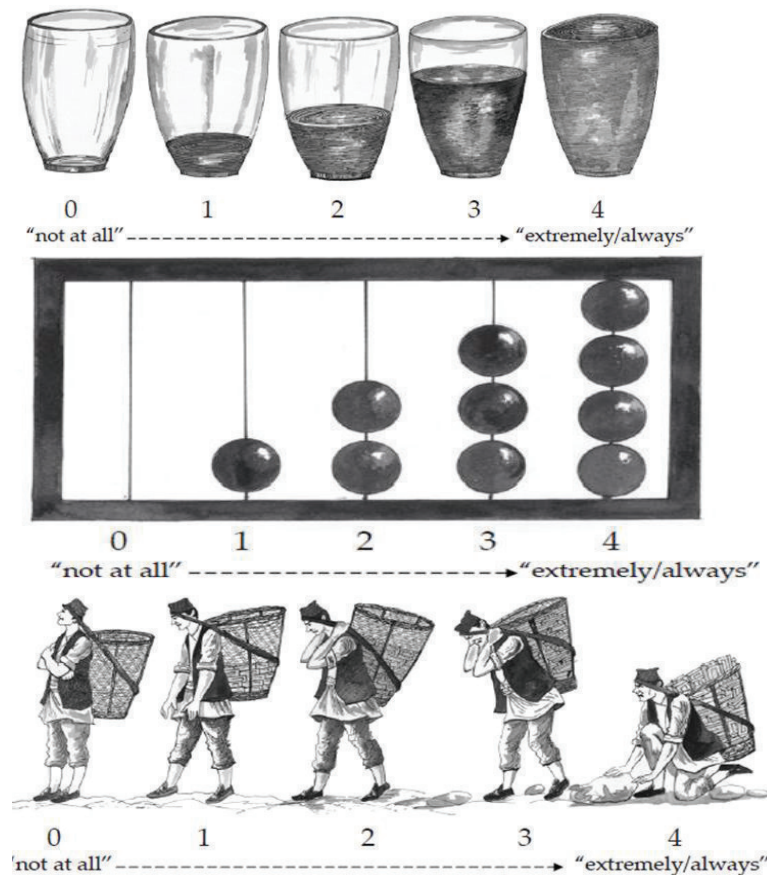
The modifications made by both mental health experts and children were then integrated into the original documents. The authors particularly stressed the importance of using focus groups to assess not only the validity of locally developed items and response sets, but also of Western developed tools. One school was randomly selected in the targeted district and a sample of children was selected and interviewed by research assistants trained in the administration of the DSRS and the CPSS. Results of this quantitative study were then analysed statistically and although both selected instruments were found to perform well, they were inappropriate as screening tools as they would include a large number of children without any psychosocial disorder.

The use of Western instruments in different cultural settings has attracted a lot of criticism, particularly from medical anthropologists. They have particularly emphasised the critical role of culture in experiencing and expressing mental health problems; for example, in some cultures illness is perceived to be the outcome of troubled social relationships and is not situated in the individual body or mind. Given that idioms of distress are culture-specific, indicators measuring them in one setting may not be applicable in a different cultural setting. Otherwise, according to A. Kleinman, a leading psychiatrist and medical anthropologist, we commit 'categorical fallacy', that is 'the reification of a nosological category developed for a particular group… then applied to members of another culture from whom it lacks coherence, and its validity has not been established (Kleinman, 1987 in Jayawickreme et al., 2009). The collection of qualitative data is often promoted as the best way to increase understanding of illness and wellbeing in each context, allow the validation of measures used and improve the interpretability of results.

A growing body of literature supports the use of mixed methods as the best choice to explore mental health and psychosocial wellbeing in non-Western settings. Thus in the research model put forward by De Jong and Van Ommeren (2002), they included both qualitative and quantitative techniques such as FDGs and in-depth interviews, but also snowball sampling and population surveys. Qualitative methods are deemed important as they offer valuable information about the illness experience. This background information is needed 'to shape research questions, to modify instruments for local situations, and to interpret collected epidemiological data'. The authors argue that important concepts to consider are: the combined emic-etic approach, the disease-illness approach and the explanatory model approach. Thus in the first approach the researcher chooses a scientific (etic) construct and then develops local (emic) ways of measuring it, thus instruments are constructed locally. The second approach involves distinguishing the sufferer's view based on culturally shaped accounts of sickness from the professional concept of sickness. Sickness in patient's terms is called illness, while in terms of the health professional's view is called disease (the illness/disease dichotomy is a matter of the vantage point of the speaker: illness is the subjective personal experience of sickness, while those who professionally study it and it is their object speak of disease). Finally, the explanatory model concept, developed by Kleinman, has been applied in three ways: to specify semantic networks linking the experience of patients, healers, and other concerned parties; to refer to perceived causes of illness; and to look at the 'cognitive distance' between patients and practitioners.

The first stage of the model involves organising focus groups to identify problems, risks and protective factors at population level; participants may be selected on the basis of gender, ethnic group, status, trust, community residence and knowledge of the community. Focus groups are indeed helpful to explore topics of interest, identify concepts and develop research questions, and thus they can help decide what variables to measure. They can also offer help to interpret findings after completion of the quantitative study. The second stage includes in-depth interviews which offer insights into subjective experiences. They are extremely useful to confirm what issues the local population consider important so as to ensure that the study has relevant research questions (De Jong and Van Ommeren, 2002).

An approach often used and cited is the one pioneered by Bolton and Tang (2002). Working in rural areas of Uganda and Rwanda, they used free-listing to develop local measures of psychological functioning. Free-listing is a qualitative technique in which respondents are asked to generate a list of items in response to a specific question. Bolton and Tang asked three questions (tasks people do for themselves, their family and their community) and respondents had to give as many tasks as they could think. Then they had to provide a short description of each. All completed interviews were then combined into six composite free lists, referring to self, family and community tasks separately for men and women. The lists were reviewed and the nine most frequently mentioned items – at least one from each of the three lists - created two new lists, one for men and one for women. An additional 'other tasks' category was inserted as ten categories are thought to be sufficient

and do not make a questionnaire too long. The questionnaire was then used in community-based surveys and their properties (reliability, validity and factor structure) were evaluated through conventional data analysis techniques.

In another often cited study, Miller et al. (2009) also used a mixed methods approach to develop a measure of daily stressors affecting the mental health and psychosocial wellbeing of young people in eastern Sri Lanka; the Sri Lanka Children's Daily Stressor Scale (CDSS) is 'a contextually sound measure' implemented in the Ampara district, an area very much affected by the conflict and the 2004 tsunami. Researchers first used qualitative methods, including free-listing, to identify a list of context-specific daily stressors and then quantitative methods to assess the properties of this measure and its application in a survey of factors affecting youth mental health and wellbeing on the island. Participants in focus groups, both girls and boys aged 13 to 19 years representing each of the three ethnic groups (Sinhalese, Tamils and Muslims), were asked to provide items reflecting positive psychological functioning through free-listing. The most frequent items identified along with a few more emerged in previous research in the country, were used to develop the 29-item CDSS which was then used along with other measures to assess factors related to the mental health of students from all three ethnic groups. Miller et al. emphasise the importance of using qualitative methods such as FGDs, Key Informant Interviews (KIIs) and free-listing, at the beginning of the research so that community members identify locally significant variables that might otherwise be overlooked. A similar methodology was used by Miller et al. (2006; 2008) in Afghanistan to provide indicators of positive and negative mental health and then generate items for the development of the Afghan Symptom Checklist (ASCL), a brief assessment tool; again the validity of this tool was tested and established in a survey of adult mental health.

Another pilot project in eastern Sri Lanka (Hart et al., 2007) aimed to develop a range of participatory tools and methods to monitor and evaluate psychosocial interventions targeting children affected by the armed conflict. The project chose not to use the diagnostic category of PTSD and instead explored local understandings of psychosocial wellbeing, including children's own perceptions of positive and negative psychological states, and the personal and environmental factors they believed contributed to these states. The project also used a broad notion of psychosocial wellbeing to avoid the narrow focus on trauma and its conceptual, ethical and practical challenges; instead an adapted version of the PWG was used including human capacity (individual capacities), social ecology (relationships with family, relatives and peers), and material environment (material conditions of life) conceptualising people as social actors and not traumatised victims. The project used three different methodologies: mapping exercises and diagrams such as risk/resource maps, body maps, spider diagrams and problem trees; listing of issues, sorting and ranking them to reveal priorities within the targeted population; and exploration of fictional situations or events which are used as a proxy of the real experiences of the children. The authors argued that drawing and group discussion are often more attractive to children than writing or interviews; their aim is apart from considering local views to make children feel comfortable and express their views. They also recognised that these methods cannot identify children with mental health problems, as such monitoring would require other methods.

Stark et al. (2009) also used a similar methodology to identify local understandings of reintegration of girls formerly associated with armed groups in Sierra Leone. The project was a collaboration of Columbia University with Christian Children's Fund and used a participatory ranking method (PRM) to assess girls' reintegration; this method combines the principles of focus group methodology with participatory rural appraisal activities, and includes free-listing and participatory ranking activities. Girls and young women from various ethnic groups who participated in the conflict were invited to participate. During the FGDs facilitators focused on critical events and experiences that marked the girls' successful reintegration since the end of the conflict, over seven years from the time of the discussion. While the girls were engaged in the discussion, a note-taker recorded the listed characteristics, qualities and behaviours identified by the group; the discussion continued until 10 specific indicators of wellbeing and successful reintegration were suggested or until no further suggestions were made by the girls. The facilitator then asked the girls to choose local objects to represent each of the indicators suggested; objects included sticks, stones, leaves etc. Each object represented an indicator and then the facilitator asked the group to agree among themselves which indicator was the most important to a girl's ability to reintegrate. The facilitator drew a line on the ground and at one end put the object representing this indicator. The group continued ordering or reordering the object, until the girls reached consensus on the ordering of indicators. In most groups a similar process of ranking for indicators of poor reintegration was used. Data from all groups and their indicators were collected and then the frequency of suggested indicators of good and poor

reintegration was assessed and indicators were listed by the average (median) rank assigned to them in all groups. Based on findings from the free-listing exercise, specific function questionnaires were developed and used in community-based surveys.

Apart from free-listing to identify specific aspects of a domain and develop questionnaires for community-based surveys, the Brief Ethnographic Interviewing also enables researchers to 'quickly and systematically gather and organize information…to develop culturally relevant indicators for evaluating the effectiveness of psychosocial and mental health interventions'. Developed by Jon Hubbarb, Research Director for the Center for Victims of Torture Minneapolis, this tool involves using a short semi-structured interview framed around a question to systematically collect information on a specific topic of interest from a group or community. Participants are asked to think of a person they know and reply to a number of short questions regarding this person (Hubbard, nd).

Jayawickreme et al. (2009) used qualitative data collected through the 'Reducing the Effects and Incidence of Torture' (RESIST) Programme in northern and eastern Sri Lanka under the guidance of Hubbard, to develop culture-sensitive measures assessing the nature and extent of psychosocial problems and wellbeing. Data were collected by two semi-structured questionnaires (the Adult War Problems Interview (AWPI) and the Adult Competencies Interview (ACI)). In the APWI interview participants aged 18 years or older were first asked to think of two people – one man and one woman – they knew who had conflict-related problems and to list the top four problems given in just one phrase for each problem as well as their main problem; then to state why the conflict affected negatively some people and not others; and lastly to mention what measures should be taken to help those negatively affected. In the case of the ACI interview, participants were asked to think again of two people they knew who were doing well in life, list the top four attributes of doing well and identify the main attribute; they were also asked why some people were doing well and others not and why they thought this happened. Collected data were then coded using the NVivo software and analysed thematically. The next step was to test the preliminary questionnaires based on these data and evaluate the validity of the instrument. In addition, a number of international depression and PTSD diagnostic measures were also going to be administered to examine the degree of overlap.

Evaluating a programme in Northern Uganda, Betancourt et al. (2008) also combined qualitative and quantitative techniques and explored local perceptions of mental health problems affecting children (aged 10-17) in Internally Displaced Persons (IDP) camps. The first qualitative part of the research employed a rapid assessment methodology, used in previous cross-cultural mental health research in sub-Saharan Africa. Information was collected from children and their caretakers through free-listing and KIIs. These interviews revealed several local syndromes with symptoms similar to many DSM criteria for mood, anxiety and conduct disorders along with culture-specific symptoms. The symptoms of these local syndromes were used to create the Acholi Psychosocial Assessment Instrument (APAI), which assesses symptoms along a continuum rather than placing children into a specific diagnostic category. After developing APAI, this locally derived measure along with a Western measure, the SDQ, and questions on functional limitations were tested through a survey administered to adolescents and one primary caregiver.

Betancourt et al. (2012) were also involved in a collaborative programme between the Harvard School of Public Health and Partners In Health (PIH) in Rwanda aiming to develop and evaluate a mental health community-based intervention to assist poor rural families and prevent the onset of mental health problems among children. The programme selected a mixed-methods approach. First, qualitative research was used to gain knowledge about culture-specific problems and the dynamics of families affected by HIV and AIDS. Qualitative data were, then, used to guide the selection and adaptation of quantitative measures for assessing family dynamics and the mental health of children participating in the intervention. Interestingly, traditional healing resources were integrated into formal clinical strategies, local terminology was used and community advisory boards (CABs) were established to provide feedback and guidance to the intervention. The authors claim that lessons learnt from this project are useful for research in other settings, and that the described approach could be used as a model to plan and evaluate mental health services in low-income settings with only limited appropriate services.

The setting of the intervention was a poor rural area affected by the 1994 genocide and the HIV and AIDS epidemic, with limited mental health services available and mental health problems largely neglected. Information on the mental health needs of children and adolescents was particularly lacking. The research team wanted to have a thorough understanding of how their mental health problems were seen locally and explore ways to improve mental health or reduce the risk of developing mental health problems for these children and their families. This information was then integrated into the design of the Family Strengthening Intervention-Rwanda (FSI-R) aimed to strengthen family communication, parenting skills and problem-solving, and promote knowledge and access to appropriate resources. The intervention was seen as a first step to help families affected by HIV to navigate daily changes and cope with daily stressors.

Qualitative research confirmed that the genocide and HIV undermined children's mental health, affected family relations, caregiving and child development, and disrupted traditional networks of social support. High levels of family conflict were frequent and compounded by poor education and poverty. Thus an intervention was indeed much needed. Yet the issue was how to design it. Given that interventions tend to be based on existing evidence, as much of the latter comes from Western settings, what was required was a methodology that integrated current clinical knowledge with knowledge of local psychopathology to create a culturally suitable intervention. It was particularly important to understand how this specific culture affected the expression of mental health problems and protective processes. The critical first step, therefore, was qualitative examination of local perceptions of mental health problems, and of resources contributing to resilient outcomes. Once this information was available, assessment tools originally used for other populations might be reviewed and adapted using culturally relevant terminology. If qualitative research revealed that local problems were greatly different from what is already known in Western settings and no existing mental health assessments could apply to this population, new measures could be designed based on qualitative data.

The first qualitative study aimed to investigate local perceptions of mental health problems experienced by HIV-affected youth. Children and their caregivers were interviewed using once again free-listing and KIIs methodologies, already used for cross-cultural mental health research in sub-Saharan Africa. The study identified several categories of locally defined syndromes indicative of the mental health needs of local children. Interviews highlighted the importance of strong family and community support and the consequences that result from a lack of these networks. The view of mental disorders as spirit possession or madness was a common theme in these interviews. One year later the second qualitative study using FGDs and local terminology was carried out to identify the particular protective factors for children and families during times of hardship. Combined qualitative findings from both studies were then used to design the intervention. As data revealed the interconnectedness of individual, family and community factors, it became evident that the intervention had to include all three levels and thus a family-strengthening intervention was needed instead of a group-based or individual one. The intervention also adopted a strengths-based approach built on the stress adjustment paradigm: changes in life events create stress that if mismanaged can lead to emotional and behavioural problems. Given that people turned to available individual, family and community resources to manage stress effectively, these resources had to be supported. Yet lack of any previous example of this approach in sub-Saharan Africa, led to the selection and adaptation of an American model with promising results.

This model focuses on identifying and strengthening family resilience, providing psycho-education, improving communication and parenting skills, and helping families to better use existing resources. Building on it, the FSI-R was a culturally adapted family strengthening intervention aiming to increase family resilience by enhancing existing strengths, particularly family unity and good parenting. The key components of the FSI-R were chosen to address the risk factors the qualitative research revealed for families affected by the genocide and HIV, including misinformation, fear of HIV, limited hope for the future, lack of communication among family members, and economic and social stress. Again in accordance with the qualitative finding about the strong community networks in Rwanda, local community members were invited to get directly involved in the design and implementation of the intervention; thus four (clinical staff, community leaders, adult community representatives, and youth community representatives aged 10 to 17 years) 10-person CABs were created to help in adapting the existing model to the Rwandan cultural context and the realities of the HIV-affected families. The FSI-R was to be first piloted in a small number of families who were going to provide feedback on its cultural and contextual acceptability; then the intervention would be revised and re-piloted among more families and assessed through a randomized controlled trial (RCT) facilitated by trained community health workers. The RCT was viewed as particularly important for the statistical analysis of the effectiveness of the intervention.

Betancourt has also used this approach to develop a group mental health intervention for war-affected youth in Sierra Leone. A mixed methods approach (see figure 8) was again used to design and evaluate a culturally appropriate intervention, the Youth Readiness Intervention (YRI). The aim was to assist young people affected not only by past war experiences but also by post-war adversities such as the stigma of being a former child soldier, family abuse or neglect. Data on ongoing symptoms and sources of resilience among youth were collected through interviews with youth (both boys and girls), caregivers and local experts working with war-affected youth to identify problems of the target group and determine the treatment components of the intervention. All findings were then compared to ensure its convergence with prior longitudinal data and reviewed by CABs that included parents, youth and teachers. Results were used as the foundation to develop the intervention (Betancourt et al., 2014).

Figure 8: Phases of a mixed methods approach (Betancourt et al., 2014)
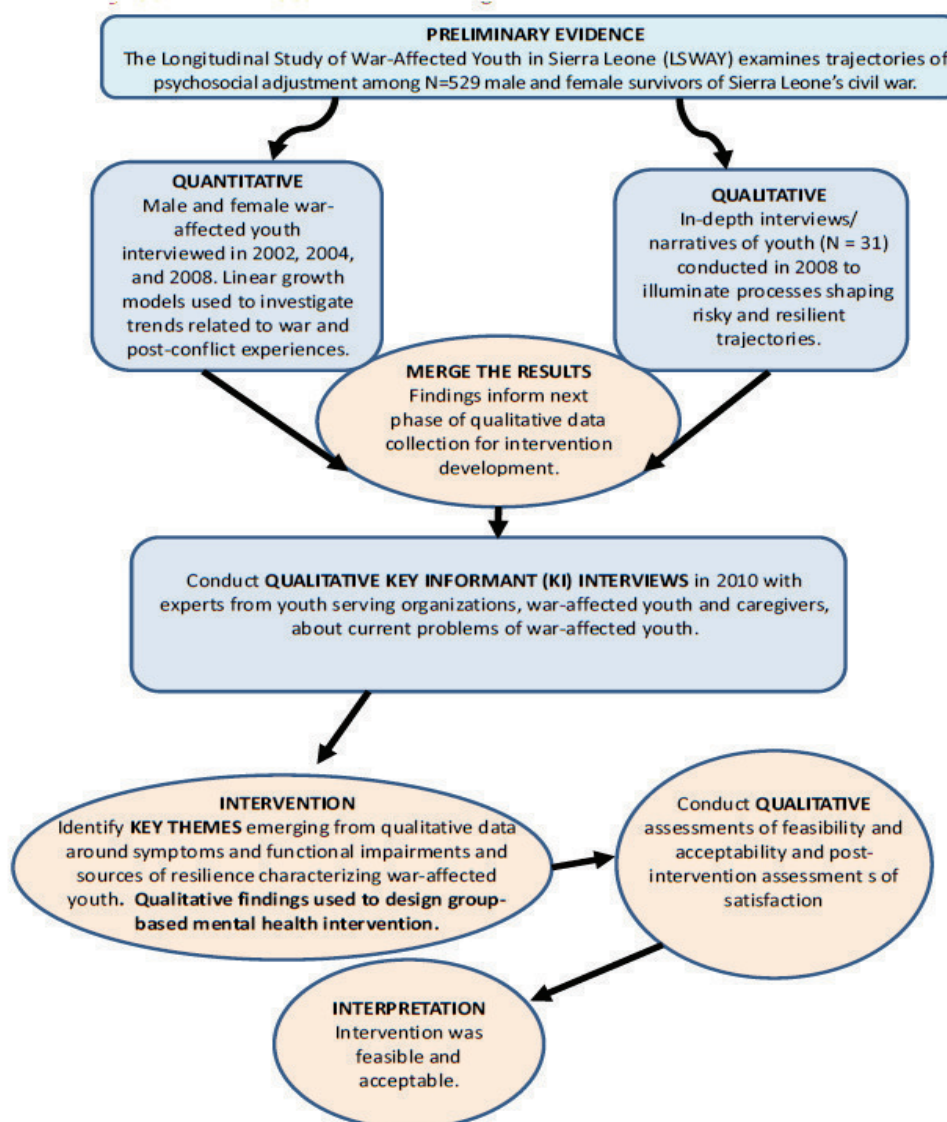
Aiming to evaluate programmes for child psychosocial wellbeing, Bragin (2005) also supported the use of qualitative and participatory methodologies. She stressed that it is important to develop an understanding of children's daily normative behaviour in each context, what is perceived to be normal and usual child growth and development from birth to the age that each society considers to represent adulthood, and which the existing community coping mechanisms for stressful situations are. For that reason, she used FGDs and a structured interview to guide them. Children, youth and adults (mothers or caretakers, fathers and community elders) that participated in her study were asked to describe their daily activities and significant community events, community norms and children's hopes and aspirations before and under current conditions, and how their problems could be alleviated. Importantly, Bragin also notes that to avoid inflicting more pain, research programmes aiming to assist children should inquire about children's experiences in a careful and general way, while they should also have in place mechanisms for specialised assistance before investigating the details of their experiences; such experiences should also be revealed only to trusted persons within the community, who are socially and emotionally prepared to help.

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