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School of Public Health

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

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

Overview

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

The Nature of War is changing with devastating consequences for Civilians

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

Refugee Children and Adolescents in the US

- Resettlement of ~3 million refugees in the US since 1973, roughly half are children (Bureau of Population Refugees & Migration, 2010)
- Refugees and asylees face stress of isolation, socioeconomic disadvantage, cultural adjustment language barriers, insecurity of legal status
- High levels of war-related trauma documented for refugee youth, with profound MH consequences (American Psychological Association, 2010).
- Challenges in treatment engagement and retention, very little services research

Research on Children, War & Mental Health

Children and War (Fred & Burlingham, 1943)

- Research on adults:
  - "concentration camp syndrome" (Eitinger, 1961)
  - war veterans "shell shock" (WW I, II, Vietnam)
- Focus on relationship between war-related trauma and post-traumatic stress disorder (PTSD)
  - Cambodian refugees: 50% developed PTSD (Kinzie, 1985)
  - Bosnian refugees: 25% PTSD and 17% depression dx (Weine, 1995)
- Criticism of PTSD focus- CONTEXT: There is no "post" …in many of the wars children face around the world insecurity is constant

  - Available research is limited in its application to programs and policy

Resilience: *"A construct representing positive adaptation despite* ***adversity"***

Hx of Resilience Research

- People who overcame situations normally associated with poor mental health and developmental outcomes
- Poverty, Socioeconomic Disadvantage (Werner)
- Mentally Ill Caregivers (Rutter)
- Abused and Neglected Children (Cicchetti)
- Children Exposed to Violence (Garbarino)

Resilience

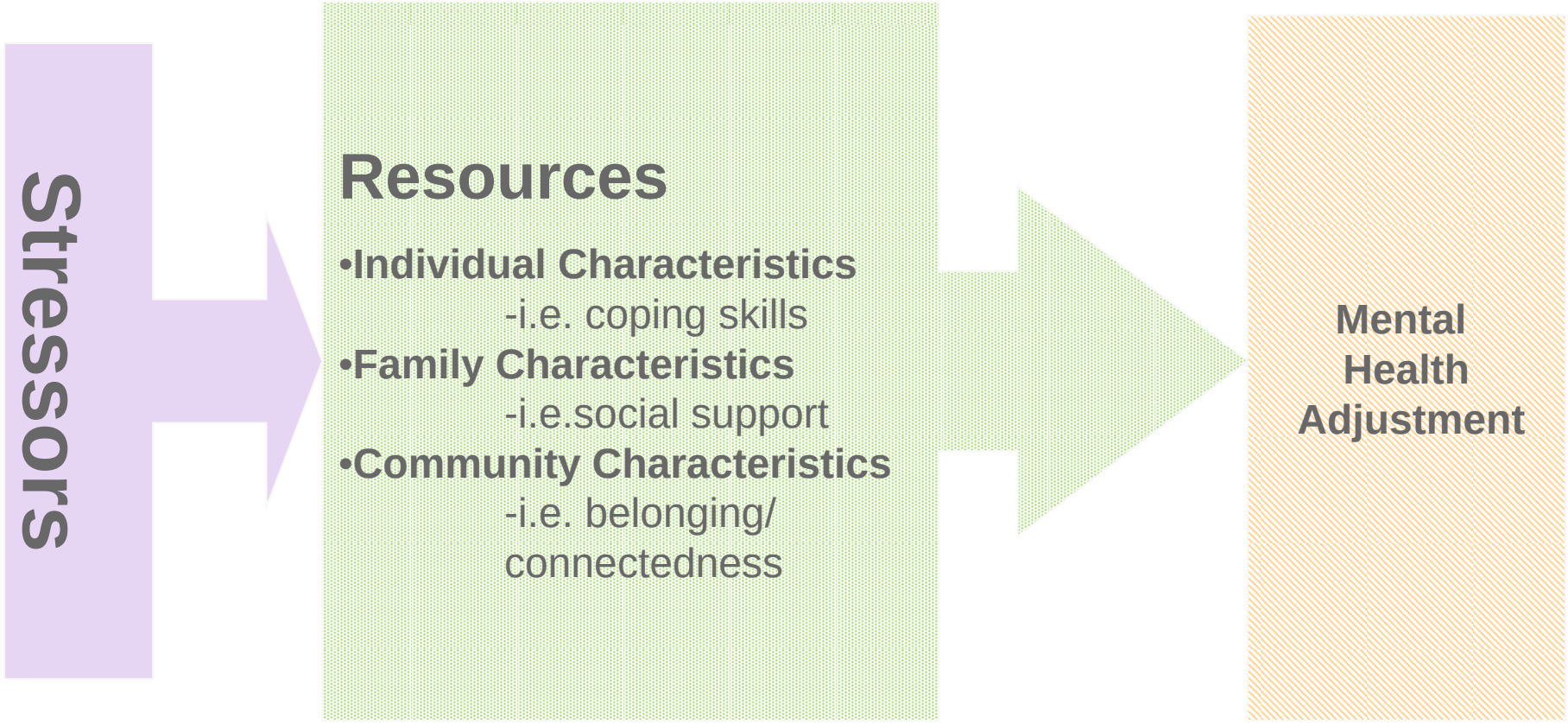
Resilience traits: traditionally refer to ***characteristics of the individual*** that helps them to achieve desirable emotional and social functioning despite exposure to considerable adversity.

Resilience as a process: ***"Resilient mental health outcomes"***

- (Masten, 1991; Cicchetti & Garmezy, 1993; Rutter, 1985. Masten & Garmezy, 1985; Werner & Smith, 1992; Luthar, 1996).

Stress-Adjustment Paradigm

(Lazarus & Folkman, 1984)



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

- Identify factors contributing to risk and resilience in children, families and communities facing adversity globally
  - focus on capacities, not just deficits
- Contribute to an evidence base on intervention strategies:
  - Contribute to closing the implementation gap
  - Develop and test high quality and effective services

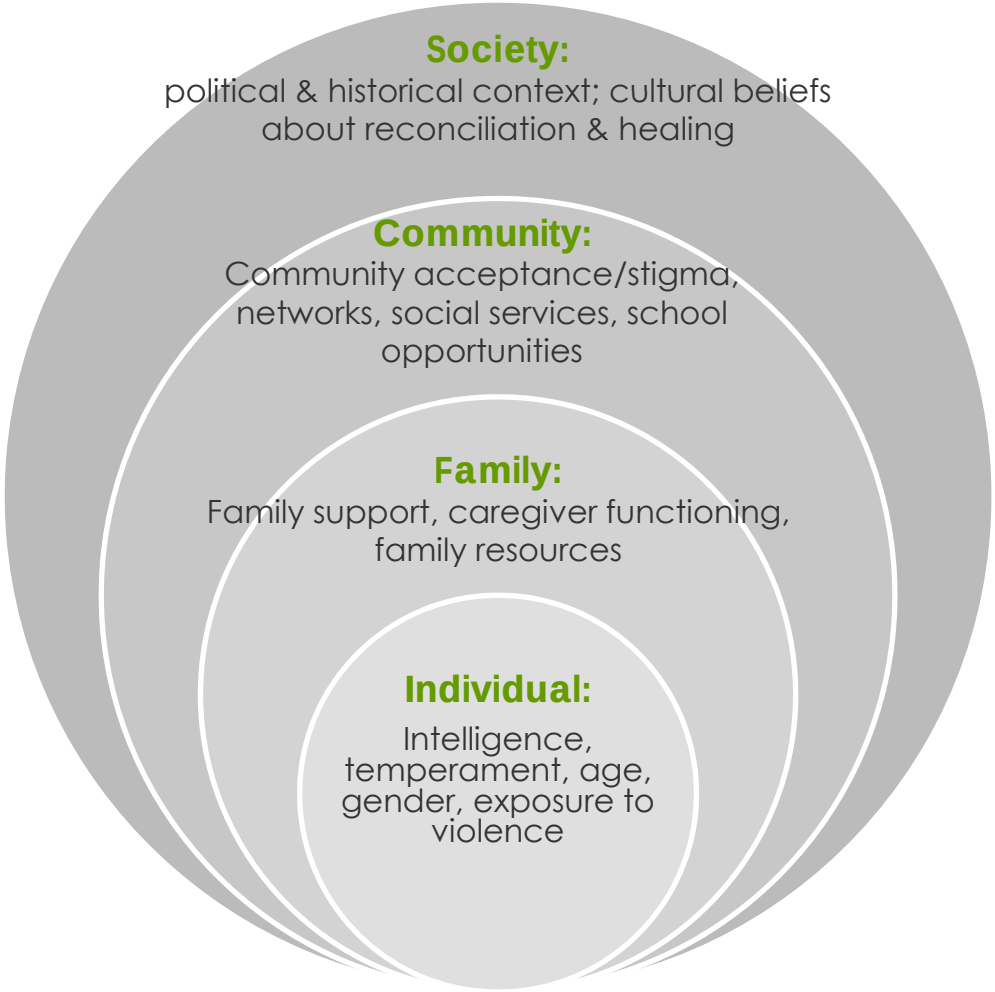
Issues: Developmentally-informed Prospective/Longitudinal Research

Need:

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

Currently:

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



Intensity, Duration & Meaning of Violence
after Bronfenbrenner, 1979; Betancourt & Kahn, 2008

Culture in Assessment/Measurement and Intervention Development

"Ethnographic studies demonstrate convincingly that concepts of emotions, self, and body, and general illness categories differ so significantly in different cultures that it can be said that each culture's beliefs about normal and abnormal behavior are distinctive"

(Kleinman 1988, p.49)

Typical Use of Questionnaires in Assessment and Evaluation

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

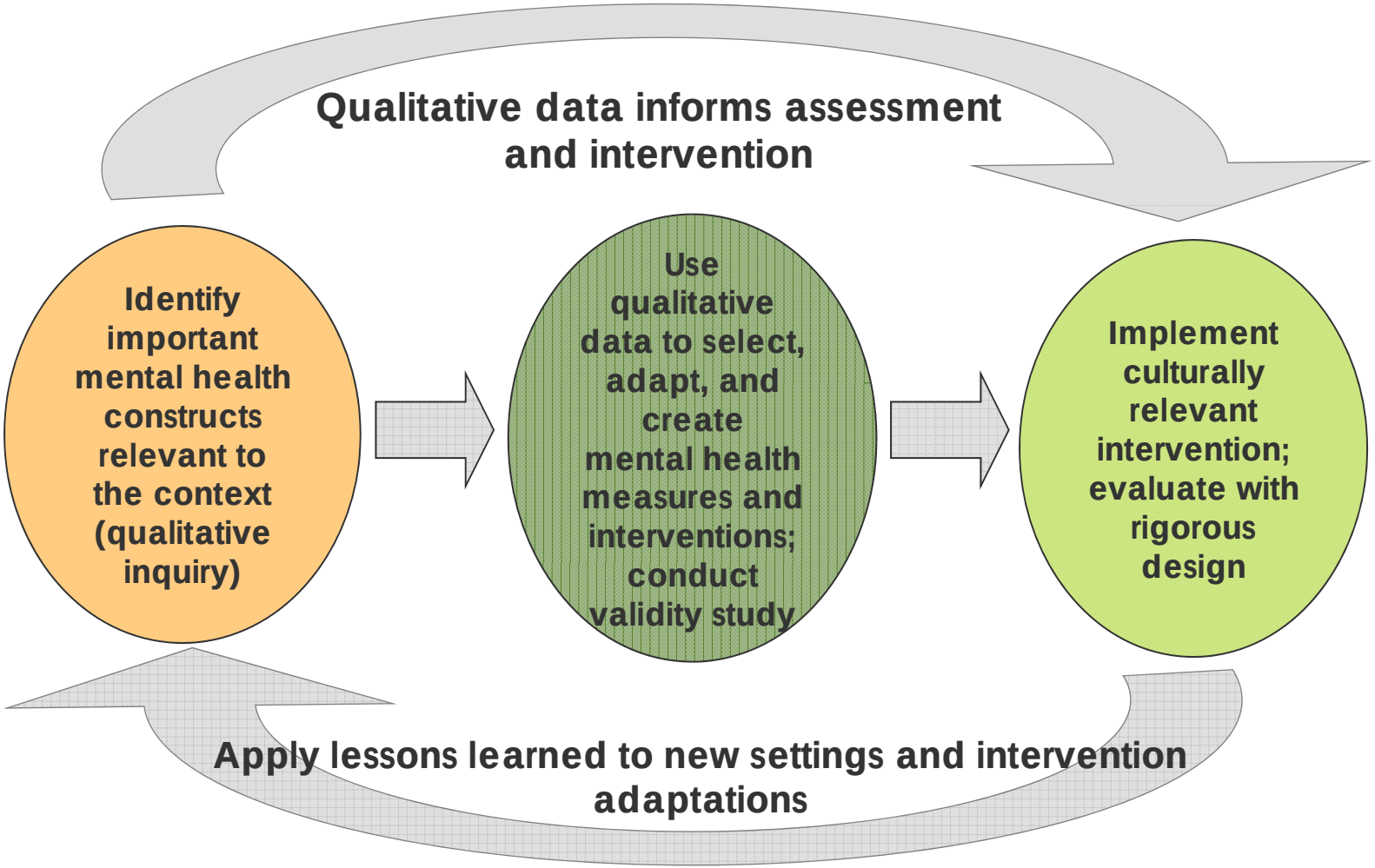
Problems with Relying on Western Measures in Cross-Cultural Research

- **Cultural validity:** How closely concepts in a questionnaire match local concepts; Western/outside concepts may not apply locally
- **Unknown local concepts:** Are there important local issues/concepts unknown to us? How to include questions we don't know we should be asking?
- **Translation problems:** Who translates? Translation-back translation methods inadequate, can result in semantic equivalence but real-world insignificance (i.e. lighting fires)
- **RISK: Evaluations don't accurately measure impact**

Use a Mixed Methods Approach: (qualitative + quantitative methods)

Photo courtesy of Laurie Wen

A Model for Designing and Evaluating Mental Health Services in Diverse Cultural Settings



SIERRA LEONE

Our Team & Collaborators

Harvard University

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

IRC

- Marie de la Soudière
- Catherine Wiesner
- Jane Warburton
- Jodi Nelson

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In Sierra Leone

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


The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
GUINEA
LIBERIA
ATLANTIC OCEAN
NORTHERN
WESTERN AREA
EASTERN
SOUTHERN
SIERRA LEONE
Mamou
Kindia
Médina Dula
Falaba
Dubréka
Tabili
Coyah
Musaia
Gberia Fotombu
Bafodia
Kabala
Banian
Konta
Kamakwie
Koinadugu
Bendugu
Fandié
Forécariah
Kukuna
Kamalu
Fadugu
Madina Jct.
Bambaya
Karina
Kurubonla
Alikalia
Mateboi
Pendembu
Bumbuna
Bendugu
Yombiro
Kambia
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Gbinti
Binkolo
Mange
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Makeni
Kayima
Kortimaw Is.
Bendou Bodou
Port Loko
Magburaka
Tefeya
Yomadu
Lunsar
Masingbi
Koidu-Sefadu
Koundou
Lungi Int'l Airport
Pepel
Matotoka
Yengema
Freetown
Ferry
Masiaka
Mile 91
Njaiama-Sewafe
Njaiama
Wellington
Yonibana
Yele
Tongo
Gandorhun
Koindu
Hastings
Tungie
Songo
Bradford
Waterloo
Mongeri
Falla
Kailahun
Buedu
York
Rotifunk
Panguma
Bomi
Manowa
Giehun
Taiama
Bauya
Moyamba
Boajibu
Pendembu
Banana Is.
Njala
Dambara
Bendu
Yawri Bay
Mano
Lago
Shenge
Sembehun
Bo
Segbwema
Daru
Plantain Is.
Sieromco Mokanje
Gerihun
Kenema
Bumpe
Tikonko
Blama
Tokpombu
Gbangbatok
Sewa
Nitti
Kpetewoma
Koribundu
Sherbro River
Turtle Is.
Sherbro I.
Matru
Sumbuya
Bonthe
Potoru
Gorahun
Waanje
Pujehun
Zimmi
Kongo
Bendaja
Lake Mabesi
Lake Mape
Sulima
Bopolu
Lofa
Bomi-Hills
Saint Paul
Bong
Robertsport
Lake Piso
Kle
Kaba
Mongo
Great Scarcies
Little Scarcies
Seli
Bagbe
Niger
Meli
Mabole
Rokel or Sèl
Pampana
Moa
Mano
Lola
Kolente
SIERRA LEONE
National capital
Provincial capital
City, town
Major airport
International boundary
Provincial boundary
Main road
Secondary road
Railroad
0 20 40 60 80 km
0 10 20 30 40 50 mi
10°00'
9°30'
9°00'
8°30'
8°00'
7°30'
7°00'
6°30'

Background

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

"Mohammad is crying," drawing by former child soldier, Sierra Leone

The Return Home

Demobilization, Disarmament & Rehabilitation (DDR) 2002

Interim Care Centers

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

*many youth returned home without formal DDR

Research Design

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

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

(Betancourt et al, *Comparative Education Review*, 2009; *Social Science &Medicine*, 2009; *Child Development* 2010; *J of the Am Acad of Child & Adolescent Psychiatry* 2010)

Summary of Sample

Participants aged 10-17 at baseline	Wave I (2002)	Wave II (2003/4)	Wave III (2008)
ICC-served Group	N = 259	N = 151	N = 183
Comparison Group	N = 136	N = 58	N = 87
Self-reintegrated	--	N = 127	N = 117
Totals	N = 395	N = 336	N = 387

TOTAL N = 529

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

Measures

Demographics

Age, gender, SES collected via youth self-report

Psychosocial Adjustment **(Depression, anxiety, hostility, prosocial behaviors/attitudes, confidence)**

Oxford Measure of Psychosocial Adjustment (McMullin & Loughry 2004)

War Experiences **(Deprivation, witnessing, victimization, perpetration)**

Columbia Child War Trauma Questionnaire (Macksound & Aber 1996)

Community and Family Acceptance

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

Perceived Community Stigma

Everyday Discrimination Scale (Williams 1997)

Standard Scales of Depression, Anxiety, PTSD

Hopkins Symptom Checklist (Derogatis et al 1974)
Child Posttraumatic Stress Disorder Reaction Index (Pynoos et al 1996)

Access to Opportunities & Services

In School, Working
Post-War Adversities Index (Layne et al 1999)

Findings: War Experiences
(Betancourt et al, JAACAP 2010)

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

Painting of rebels using drugs, child in ICC Sierra Leone

Findings: Distribution of Main Variables

	Range of scale	T1 N=260^	T2 N=147^	T3 N=179^
Age		15.13 (2.22)	17.41 (2.38)	21.75 (3.16)
Outcomes				
Externalizing problems	0-48	19.32 (5.18)	20.24 (6.30)	18.52 (4.44)
Internalizing problems	0-64	34.54 (7.64)	35.44 (7.63)	34.83 (6.45)
Adaptive/prosocial behaviors	0-72	58.27 (7.30)	59.29 (7.46)	57.42 (7.21)
Post-conflict Hardships				
Stigma due to being a child soldier	0-18	…	2.50 (3.63)	1.61 (3.09)
Post-conflict hardships	0-16	…	…	5.03 (3.54)
Post-conflict Protective Factors				
Social support	0-84	…	…	41.32 (13.45)
Community acceptance	0-12	10.50 (2.55)	10.38 (2.41)	9.85 (2.71)
In school at time of assessment	--	165 (63.5%)	111 (75.5%)	86 (48.9%)
Working	--	…	…	43 (24.0%)

Characteristics of the sample (former child soldiers in Sierra Leone) and distributions of main variables at each assessment reported as Mean (SD) or frequency (%)
^N=number of participants with complete data available at each time point who were included in the analyses.

Internalizing

	War experiences	Post-conflict hardships	Protective Factors
Baseline			
Intercept	34.94***	34.94***	35.01***
Age first involved in fighting	0.32+	0.34+	0.29
N of years in fighting forces	0.56*	0.55*	0.42+
Witness violence	0.22	0.12	0.05
Killed/injured others in war	0.26	-0.37	-0.28
Victim of rape/sex assault	4.60*	4.25+	4.34*
Stigma of being child soldier		1.22**	0.89
Daily hardship score		-0.26	-0.24
Social support			0.29
Working, not in school			-0.27
Cumulative school attendance			-0.1
Avg. community acceptance			-1.21**
Change over time			
Intercept	0.3	0.47	0.47
Age first involved in fighting	-0.35*	-0.29*	-0.27+
N of years in fighting forces	-0.33+	-0.26	-0.21
Witness violence	-0.04	-0.02	0.02
Killed/injured others in war	1.22+	0.47	0.34
Victim of rape/sex assault	-0.15	-0.39	-0.38
Stigma of being child soldier		0.26	0.22
Daily hardship score		1.38***	1.33***
Social support			0.08
Working, not in school			-0.22
In school at time of assessment			
Intercept			0.6
Level of community acceptance at time of assessment			
Intercept			-0.86*

Longitudinal Analyses of Outcomes among Ex-CAAFAG (N= 260)

Internalizing
(anxiety & depression)

Baseline higher internalizing:

- Longer with armed group
- Victim of rape
- Stigma

Increasing internalizing:

- Young age at time of first involvement
- Many daily hardships

Protective factors

- Higher community acceptance at baseline
- Community acceptance improves over time

Longitudinal Analyses of Outcomes among Ex-CAAFAG (N= 260)

Externalizing	War experiences	Post-conflict hardships	Protective Factors
Baseline			
Intercept	19.67***	19.68***	19.72***
Age first involved in fighting	-0.21	-0.2	-0.22
N of years in fighting forces	-0.05	-0.05	-0.13
Witness violence	0.2	0.12	0.16
Killed/injured others in war	0.66	0.2	0.21
Victim of rape/sex assault	3.73+	3.48+	3.58+
Stigma of being child soldier		0.89*	0.73+
Daily hardship score		-0.26	-0.17
Social support			-0.24
Working, not in school			-1.33
Cumulative school attendance			-0.22
Avg. community acceptance			-0.60+
Change over time			
Intercept	-0.29	-0.22	-0.09
Age first involved in fighting	0.09	0.11	0.12
N of years in fighting forces	0.04	0.07	0.1
Witness violence	0.29	0.29	0.22
Killed/injured others in war	1.16*	0.93+	0.90+
Victim of rape/sex assault	-0.64	-0.7	-0.78
Stigma of being child soldier		-0.01	0.03
Daily hardship score		0.51+	0.4
Social support			0.38
Working, not in school			1.15+
In school at time of assessment			
Intercept			1.01
Level of community acceptance at time of assessment			
Intercept			-1.08***

Externalizing (hostility)

Baseline higher externalizing:

- Stigma

Increasing externalizing

- Killed/injured others

Protective factors

- Increases in community acceptance

Adaptive/Prosocial Behavior

	War experiences	Post-conflict hardships	Protective Factors
Baseline			
Intercept	**59.32*** **	**59.33*** **	**58.80*** **
Age first involved in fighting	**-0.05**	**-0.03**	**0.05**
N of years in fighting forces	**-0.2**	**-0.19**	**0.06**
Witness violence	**-0.32**	**-0.37**	**-0.4**
Killed/injured others in war	**1.93+**	**1.53**	**1.24**
Victim of rape/sex assault	**0.58**	**0.42**	**0.83**
Stigma of being child soldier		**0.42**	**0.91**
Daily hardship score		**0.59**	**0.46**
Social support			**-0.03**
Working, not in school			**0.95**
Cumulative school attendance			**1.50** **
Avg. community acceptance			**1.69***
Change over time			
Intercept	**-0.89** **	**-0.95** **	**-0.55**
Age first involved in fighting	**-0.12**	**-0.15**	**-0.23+**
N of years in fighting forces	**-0.06**	**-0.09**	**-0.15**
Witness violence	**0.18**	**0.26**	**0.03**
Killed/injured others in war	**-2.60*** **	**-1.88***	**-1.29+**
Victim of rape/sex assault	**0.34**	**0.63**	**0.13**
Stigma of being child soldier		**-0.91** **	**-0.61+**
Daily hardship score		**-0.24**	**0.03**
Social support			**0.93***
Working, not in school			**0.38**
In school at time of assessment			
Intercept			**2.69*** **
Level of community acceptance at time of assessment			
Intercept			**1.93*** **

Longitudinal Analyses of Outcomes among Ex-CAAFAG (N= 260)

Adaptive/Prosocial Behavior

Baseline higher adaptive/prosocial behavior:

- More years in school
- Higher community acceptance

Decreasing adaptive/prosocial behavior:

- Killed/injured others
- Stigma

Protective factors

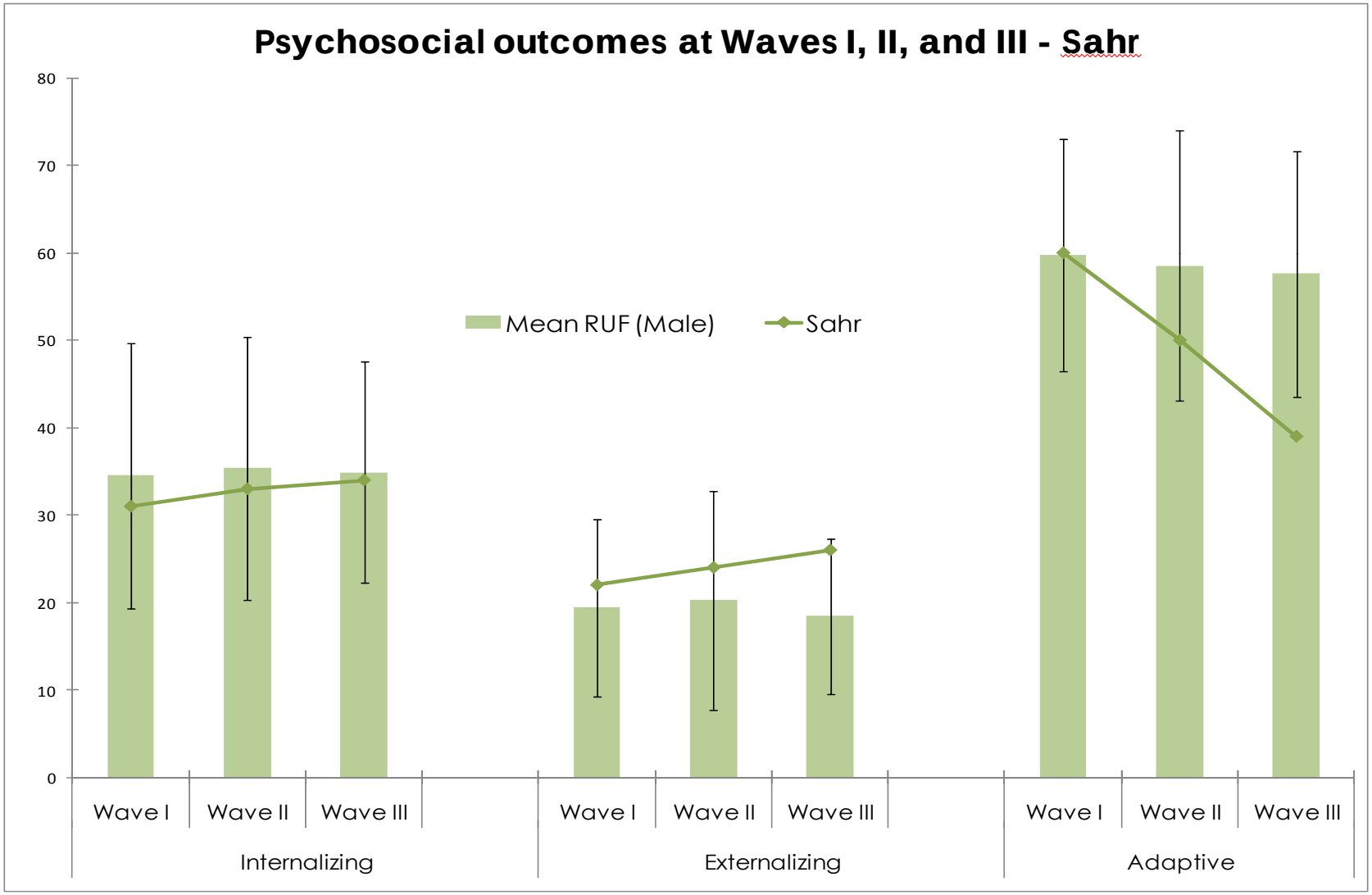
- Increases in community acceptance
- Remaining in school
- Social support

VIGNETTES: LINKING THE STATISTICS TO LIFE STORIES

Sahr

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

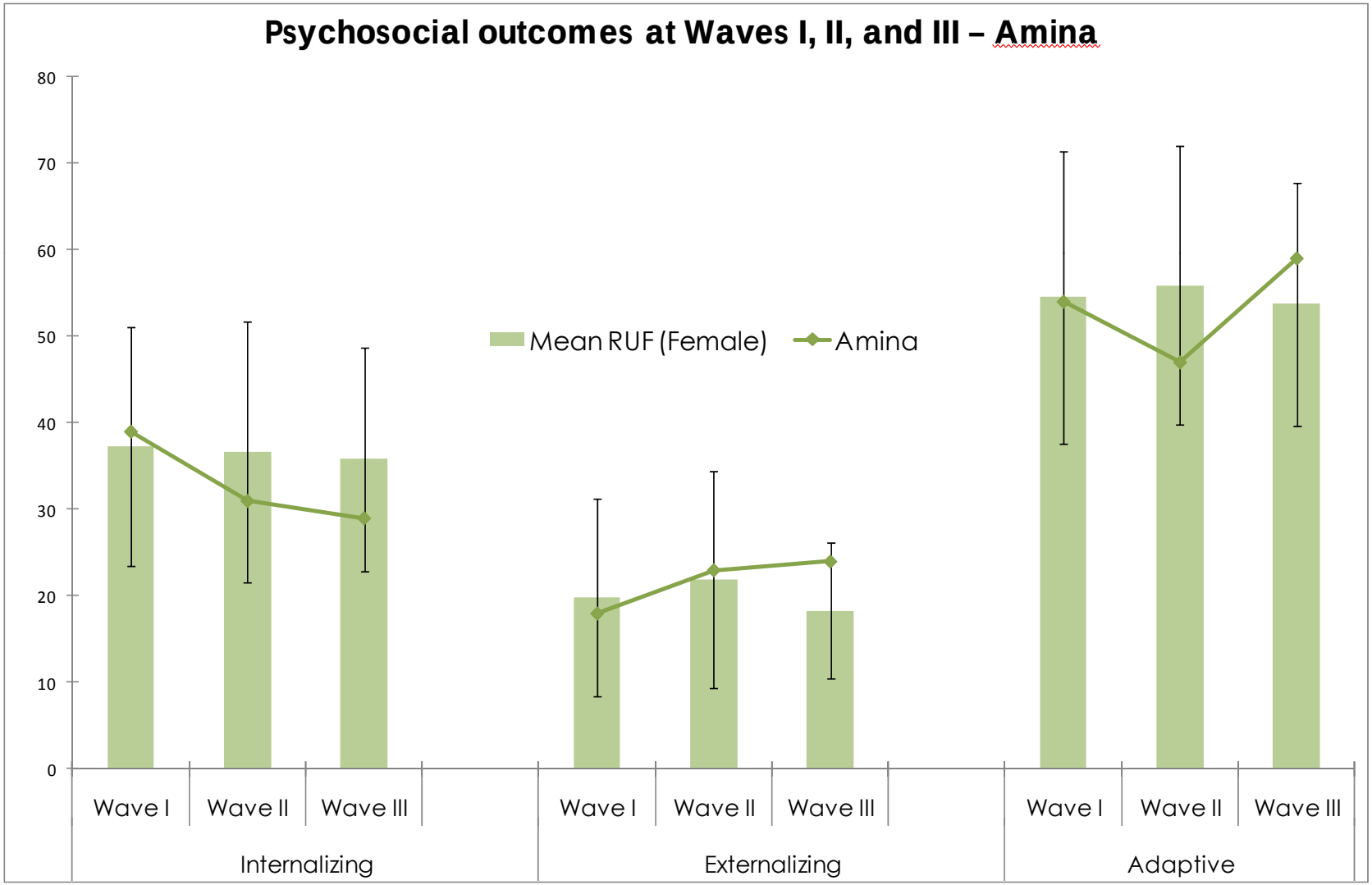
How is Sahr's experience reflected in the data?



Amina

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

How is Amina's experience reflected in the data?



Summary

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

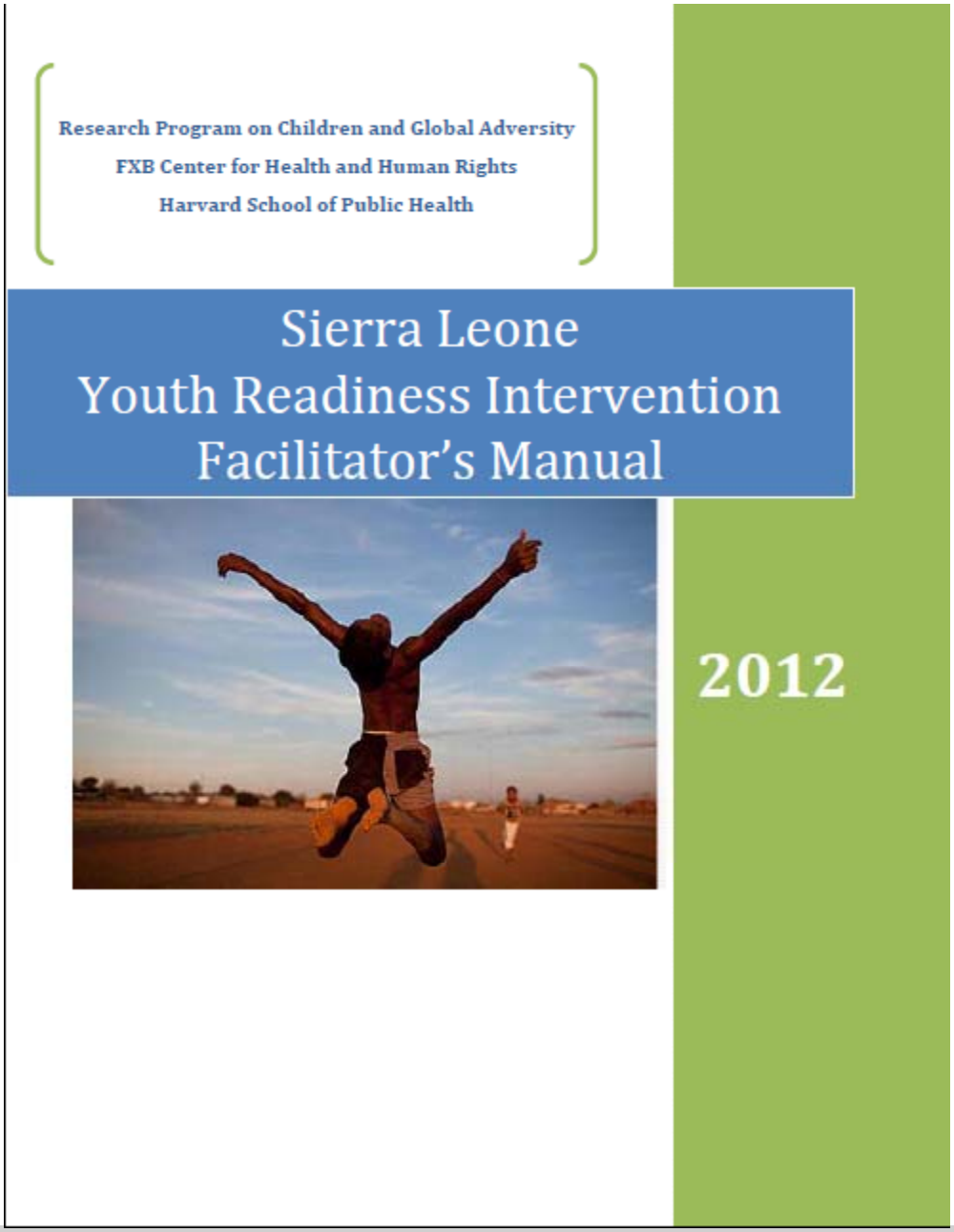
- Poor outcomes greatest in those with an accumulation of **war-related and post conflict risk factors**:
  - War Experiences: rape, participation in injuring/killing others
  - Post-conflict Experiences: stigma (manifest differently for boys & girls), daily hardships

- Predictors of good psychosocial adjustment include **variables that can be leveraged via interventions**:
  - Community acceptance/reducing stigma
  - Social support
  - School access

Community Association for Psychosocial Support (CAPS)

The Youth Readiness Intervention

Interventionist Manual



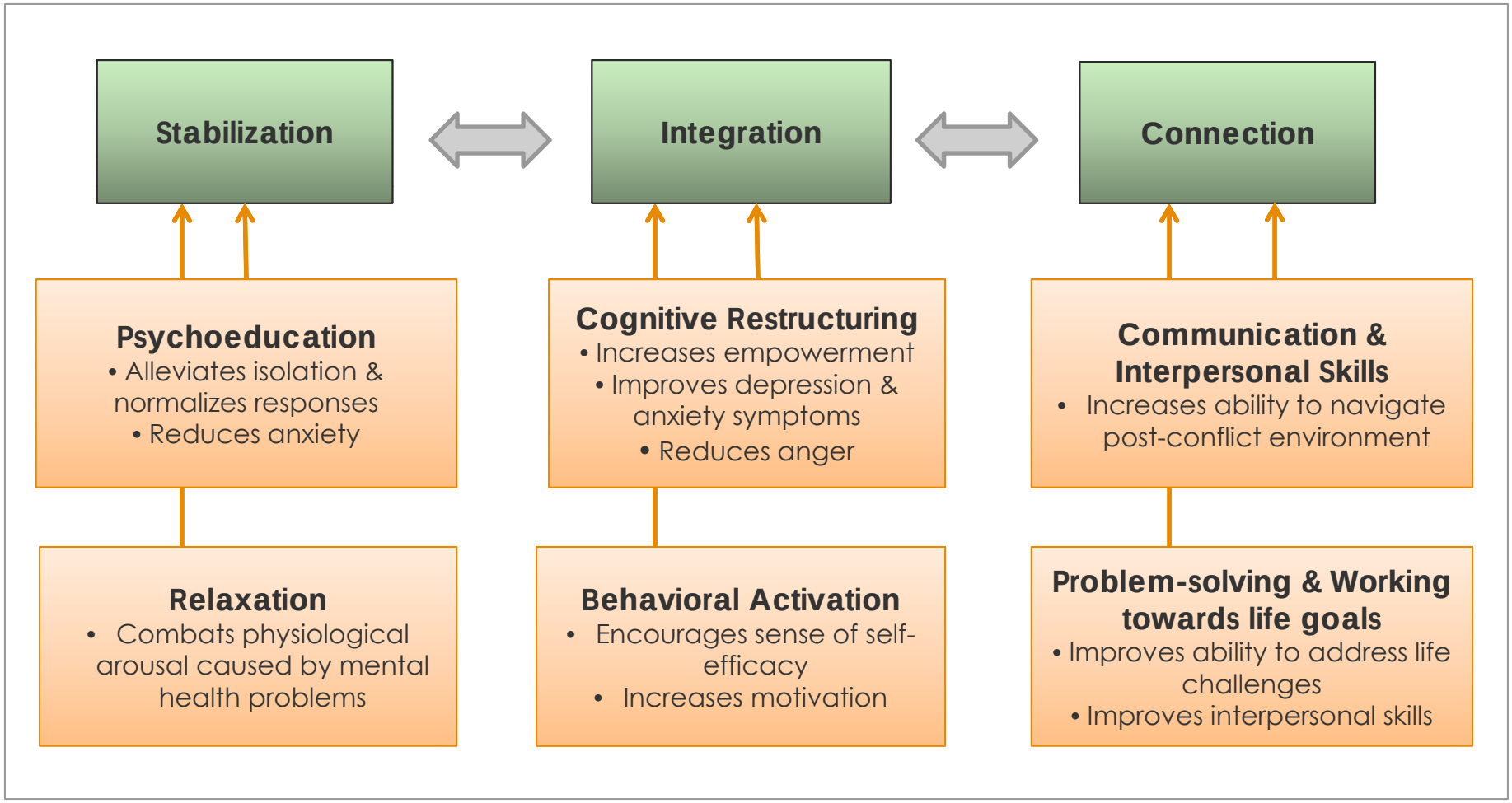
Youth Readiness Intervention

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

The Youth Readiness Intervention: Addressing the Past, Facing the Future

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

YRI Theory of Change



Making the Transition from the Evidence Base to Local Relevance

- These treatments have robust evidence of effectiveness in the US and UK
- paucity of data in low and middle income countries, particularly war-affected regions

Mixed Methods Process of Intervention Development & Cultural Adaptation

Kono & Freetown

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

    Including session outlines, exercises and activities, and a group facilitator training material which can be piloted in Sierra Leone
  - **Ongoing Process!**

YRI Intervention Plan

STAGE A: Kapu sense noh kapu wod

EDUCATION & OUTREACH

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

STAGE B: Yu get pawa for cheng yu layf

SKILL BUILDING FOR SUCCESS – YOUTH GROUP SESSIONS

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

Clinical Training:

Importance of strong local partnerships.

Next Steps

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

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

Scaling up: Integration of the YRI within employment and educational programs to support successful transitions

RWANDA

HARVARD School of Public Health

Partners in Health

The Family Strengthening Intervention (FSI) in Rwanda

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

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

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

Partners in Health


RWANDA
National capital
Prefecture capital
Town, village
Airport, airstrip
International boundary
Prefecture boundary
Road
Track
UGANDA
DEMOCRATIC REPUBLIC OF THE CONGO
BURUNDI
UNITED REPUBLIC TANZAN
Kafunzo
Merama
Kagitumba
Rwemhasha
Lubirizi
Nyagatare
Kabale
Muvumba
Gatunda
Gabiro
Ngarama
Byumba
Mulindi
Katuna
Butaro
Kidaho
Kisoro
Cyanika
Rutshuru
Lake Mutanda
Lake Bunyonyi
BIRUNGA NAT'L PARK
Ruhengeri
Kiramba
Cyamba
BYUMBA
KAGERA
NATIONAL PARK
Kagera
Kagitumba
Lac Rwanyakizinga
Lac Mikindi
Lac Hago
Lac Kavumba
Lac Ihema
Lac Muhazi
Lac Nasho
Lac Mugesera
Lac Mpanga
Lac Cyambwe
Lac Rweru
Lac Cyohoha Sud
Lake Mujunju
Lake Bisongou
Kora
Busogo
Mutura
Kagali
Goma
Gisenyi
Nyundo
Nemba
RUHENGERI
Kinihira
Kinyami
Muhura
Rutare
Rukara
Rushashi
Kabaya
Ngaru
GISENYI
Mbogo
Murambi
Shyorongi
Nyabarongo
Ngororero
Kiyumba
Kinyinya
Kigali
Gikoro
Rwamagana
Kayonza
Kicukiro
Bicumbi
Runda
Bulinga
Butamwa
Gitarama
GITARAMA
KIGALI
Kigarama
Kibungo
Rukira
Sake
KIBUNGO
Rusumo
Kirehe
Bare
Nemba
Gashora
Rilima
Bugesera
Mabanza
Kibuye
KIBUYE
Birambo
Gishyita
Bwakira
Rwamatamu
Masango
Ruhango
Gatagara
Nyabisindu
Rusatira
Kaduha
GIKONGORO
Karaba
Gikongoro
Karama
Rwesero
CYANGUGU
Gisakura
Kamembe
Cyangugu
Rwumba
Kitabi
Bukavu
Cyimbogo
Karengera
Nyakabuye
Bugumya
BUTARE
Butare
Gisagara
Ruramba
Busoro
Munini
Runyombyi
Bugarama
Akanyaru
Ngenda
Rwinkwavu
Lac Kivu
Ile Idjwi
Ile Bugarura
Ile Wahu
Ile Gombo
Lowa
0 10 20 30 40

Background

- Rwanda is characterized by **compounded adversities**:1994 genocide, the HIV/AIDS epidemic, extreme poverty (UNAIDS, 2008; Kayirangwa et al., 2006)
- **Damaged family networks** abraded by genocide and HIV/AIDS cause dramatic shifts of responsibilities between parents and children (Doku, 2009; Bauman et al., 2006; Lester et al., 2006)

Background: Children Affected by War and other adversity in Rwanda

- Children who have lost caregivers are at increased risk of **depression & PTSD** (Dyregrov et al, 2000).
- Youth heads of households display higher levels of **depression, social isolation & emotional distress** (Boris et al, 2006)
- **Social and economic hardships** pose further risks to mental health (Bachmann & Booysen, 2003; Nampanya-Serpell, 2000; Brouwer et al., 2000)

Rwanda: Families Affected by HIV/AIDS

- HIV is a family illness
- For HIV-affected families at high risk for mental health problems, **preventive mental health interventions** are needed (Denison et al., 2009; Biddlecom et al., 2009; Bell et al., 2008)
- Prevention can be **integrated into routine HIV testing and treatment** (Chatterjee et al., 2008)
- **Strengths-based preventive programs** that enhance natural resources have demonstrated effectiveness in large-scale trials (Beardslee et a., 1998, 2003, 2006; Lee et al., 2009)

preliminary research

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

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

Syndromes:

- Agahinda kenshi
- Kwiheba
- Guhangayika
- Umushiha
- Uburara

Protective Processes:

- Kwihangana
- Kwigirira icyizere
- Ubufasha
- Kwizerana
- Uburere bwiza

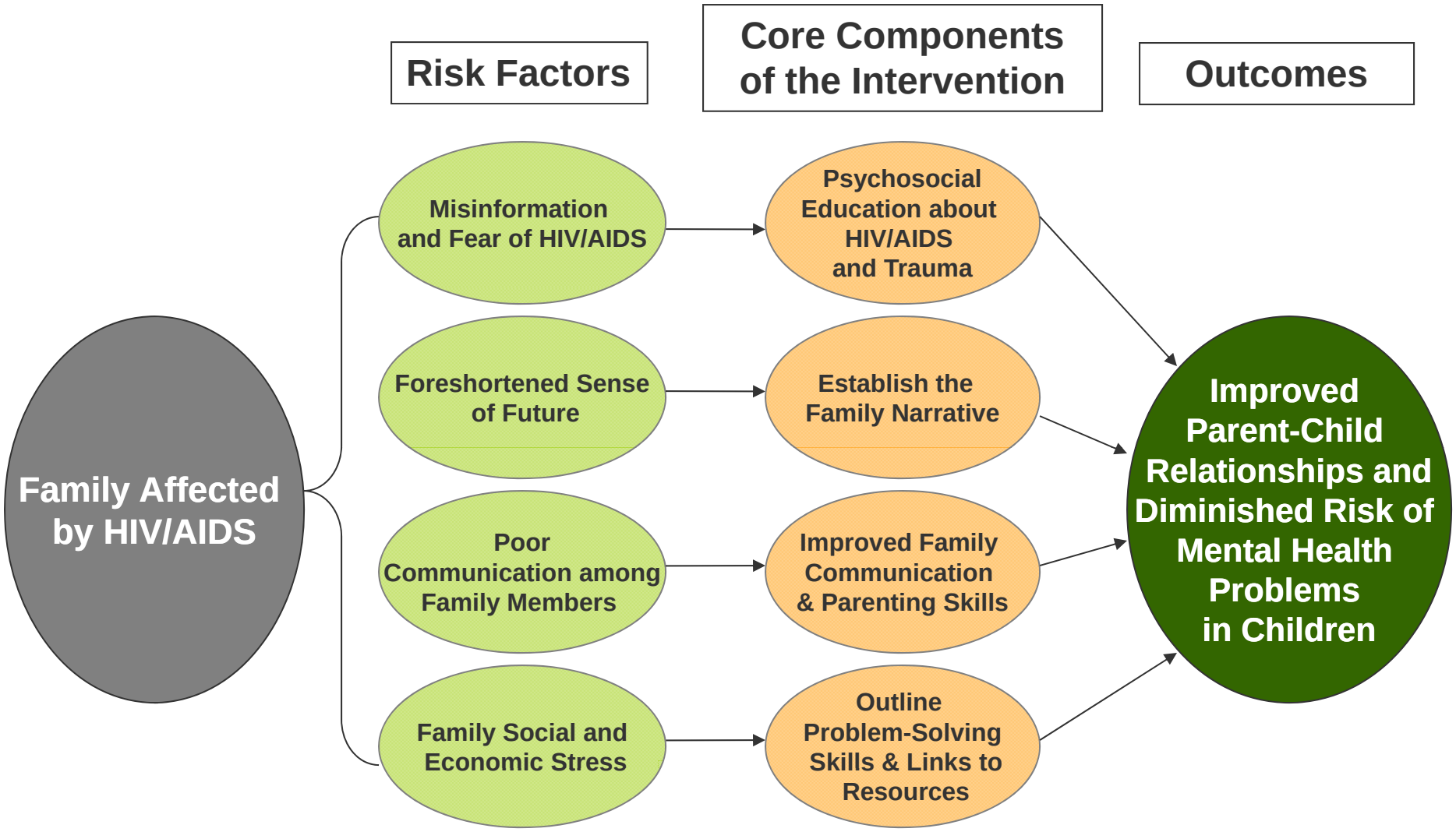
Betancourt, T. S., Meyers-Ohki, S. E., Stulac, S. N., Barrera, A. E., Mushashi, C., & Beardslee, W. R. (2011). Nothing can defeat combined hands (Abashize hamwe ntakibananira): Protective processes and resilience in Rwandan children and families affected by HIV/AIDS. *Social Science & Medicine, 73(5), 693-701.*

Betancourt, T. S., Rubin-Smith, J., Beardslee, W. R., Stulac, S. N., Fayida, I., & Safren, S. A. (2011). Understanding locally, culturally, and contextually relevant mental health problems among Rwandan children and adolescents affected by HIV/AIDS. *AIDS Care, 23(4), 401-412.*

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

- **Evidence-based intervention** (National Registry of Effective Programs & Practices) originally developed for offspring of depressed caregivers by Dr. William Beardslee
- Designed to be administered by a **wide range of providers**
- As a **family-based** preventive model, it focuses on identifying and enhancing resilience and communication in families who are managing stressors due to parental illness
- Good "fit" for the setting and context of HIV in Rwandan families

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



Core Components of the Family-Strengthening Intervention for Rwanda (FSI-R)

Intervention Development in low Resource Settings

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

In Conclusion..

- Reframing "child mental health interventions": must consider the child in context and **target resilient outcomes** as the goal
- Need to **look beyond the individual** to **family, school and community protective influences** on child mental health
- Should **identify modifiable risk and protective processes** that may be leveraged by intervention

"I think about what I have been through and this gives me more determination to do well in life."

19 year-old male former child soldier from Kono
(just promoted to his final year of secondary school)

Thank you!

What are the Implications of an ecological approach for your own clinical work?: Vignette

- Fatima, 10 year old girl from Afghanistan
- referred by mother for a psychological assessment at a torture treatment center
- mom concerned about the traumatic events that her daughter had experienced in her home country and in flight to the United States
- "*worried about everything that she has seen and experienced"; "she doesn't let herself be a child"*
- *"Fatima needs a mother figure"*

Vignette

1. Where do you see resilience/vulnerability factors in this case? At the level of *the child*? The *family*? The *community*? What are the implications for treatment planning?
2. What are the resources/vulnerabilities/opportunities that an organization would need to consider (i.e. staff capacity? Links to other services?) What are some capacity building needs/suggestions for working with such populations?
3. What roadmap would you propose for programmatic decisions? Where are the leverage points, assets to build on in intervention planning? What would be key elements of your treatment plan in this case?