

CHAPTER 12

Epilogue: Key areas of attention to improve mental health and psychosocial support for children in complex emergencies

Introduction

This dissertation presents a number of studies that were conducted with children in Burundi, Indonesia, Sri Lanka, Sudan and Nepal. The research addresses the development of a psychosocial care strategy for children in areas of armed conflict. The dissertation starts with a problem statement; a literature review that helped us to identify the most important existing intervention methods, their results and shortcomings (*chapter 2*) and an epidemiological study to assess mental health problems of children in a conflict affected area (*chapter 3*). This is followed by the presentation of a psychosocial care package, which is the focus of the research presented in the next chapters (*chapter 4*). The next section of the dissertation presents studies on the different components of the care package: the development and validation of a screening instrument (*chapters 5 and 6*); an evaluation study of a classroom-based psychosocial intervention (*chapter 7*), and; studies on perspectives, applicability and treatment mechanisms of counseling (*chapters 8, 9 and 10*). The final part of the dissertation presents a practice-driven evaluation of the overall care package (*chapter 11*).

The core underlying problem is that of a vast treatment gap in low-income countries, in general and specifically for children. The treatment gap refers to the discrepancy between the burden of psychosocial and mental health needs among children in low-income countries and the insufficient care options and professionals to address these needs.

On the *needs* side of the treatment gap, there is a growing literature of studies demonstrating the detrimental effects of war on children (Attanayake et al., 2009; Barenbaum, Ruchkin, & Schwab-Stone, 2004; Stichick, 2001). An epidemiological study that we conducted in Nepal further confirms the harmful impact of war especially for, but not limited to, former child soldiers. We compared the mental health status of children recruited to armed forces and armed groups to that of matched never recruited children (*chapter 3*). This study was the first to demonstrate that recruited children, especially girls, are at increased risk for developing mental health problems compared to never-recruited children. Furthermore, it demonstrates that the increase is only partly explained by the difference in level of exposure to traumatic stressors (Kohrt et al, 2008). Further research has demonstrated difficulties associated with community reintegration to be an important contributor to the mental health problems of former child soldiers (Kohrt et al, In press). These results imply that future programs should not uniquely address former child soldiers, but rather the child population/community at large. Subsequently, within a community approach the additional mental health needs of this group should be incorporated, as well as target the determinants of mental health problems such as reintegration difficulties, war-experiences, livelihood issues and social identity.

On the *care* side of the treatment gap, we find that availability of psychosocial and mental health care is often minimal or simply unavailable in low-income settings due to limited financial and human resources, lack of policy prioritization and limited infrastructure (Belfer, 2008; de Jong, 2002a). A systematic literature review that we conducted presents psychosocial and mental health intervention modalities and treatment effectiveness studies for children in war-affected countries (*chapter 2*). Meta-analyses demonstrate that there is a serious lack of evidence base. Evaluation studies demonstrate mixed results and only four empirical studies have been conducted. Moreover, studies are heavily skewed towards countries from former Yugoslavia and Post Traumatic Stress Disorder (PTSD) outcomes. The wider body of literature reviewed (including non-evaluation studies) demonstrates a balance between preventive and curative interventions. Unfortunately, the existing literature typically lacks rigour and depth in description of what it advocates, i.e. community-based approaches, cultural adaptations and multi-layered care.

Ultimately, major obstacles in overcoming the treatment gap for conflict-affected children in low-income settings are the lack of financial resources, dearth of evidence-based interventions, and absence of replicable mechanisms of service delivery. This brief situation analysis and problem statement is not new. There have been recent movements that have called for increased attention to unmet mental health needs globally (Lancet Mental Health Group, 2007) and there has been increased consensus within the field on guidelines how to provide mental health and psychosocial support in emergencies (IASC, 2007; Weiss, Saraceno, Saxena, & van Ommeren, 2003). While these are important initiatives, the overriding question remains *how* to translate the needs and guidelines in actual replicable programs.

In this epilogue I will highlight a set of actions that are posited as steps towards bridging (some of) the treatment gap. Furthermore, I argue that a set of underlying dilemmas will need to be addressed simultaneously. I thereby aim to provide some thoughts for researchers and practitioners about the possible future direction and development of the field of psychosocial care for children in conflict-affected countries. These key actions will be based on an almost entirely community-based approach. Below, five key areas of attention are presented. Each approach is presented in a tripartite structure: (a) presenting the problem to be resolved; (b) the specific contribution within this dissertation advancing this approach, and (c) the resulting dilemmas, gaps and future directions.

1. Employ a care package approach

Problem statement

A core question is how to organize and deliver psychosocial and mental health services for children. Given the gross lack of mental health infrastructure and human resources it is not sufficient to demonstrate that an isolated intervention is effective in reducing a specific disorder among a given sub-population. Above all, we need to demonstrate convincingly that we have a set of interventions that not only address a range of needs but also attend to the mechanisms of care delivery. The psychosocial and mental health problems in conflict-affected and poverty-stricken settings go beyond disordered individuals; it concerns a social context that is deeply affected and populations at-large that are exposed to continuous stressors and deprivation (Tol, Reis, Susanty, & de Jong, In press). This requires a multi-dimensional package of interventions that targets a broad domain of psychosocial and mental health needs.

Response

The approach presented in this dissertation has been the development of a system of care. A system approach entails a range of services from broad-access (community-based) to restrictive-access (hospital based). This approach does not dictate the use of any specific interventions or therapies, rather, it prioritizes the facilitated transfer of patients/clients between components along a continuum of care (Belfer, Remschmidt, Nurcombe, Okasha, & Sartorius, 2007), thereby aiming to broadly cover a population-at-large. In *chapter 4* we describe the content and rationale of the multi-layered care package that we have developed in Burundi, Indonesia, Sri Lanka, Nepal and Sudan. The first layer comprises a set of activities that aim to increase community resilience (e.g. social and peer support; community sensitization and psycho-education; facilitating community mobilization to support children; facilitating existing community resources). The second layer comprises focused interventions for children with active psychosocial problems who are at risk for developing psychopathology; interventions include the Classroom Based Intervention [CBI], family support and counseling. The third layer comprises specialized care for severe mental health problems (e.g. counseling, psychiatric care). The development of a care package contributes to bridging resilience-, community-, and distress- oriented approaches to emphasize the wider social context and indigenous coping strategies and a curative approach that aims to mental disorders. While current consensus advocates for the importance of both foci (IASC, 2007) few examples of care systems exist for children, (cf. Layne et al., 2008), as demonstrated by our literature review. Furthermore, available example of care systems in high-income countries tend to be highly specialized (Belfer et al., 2007; Stroul & Friedman, 1986).

Dilemmas and directions

Though I advocate for using a mental health and psychosocial support approach as commonly defined⁴, the definition risks simply hiding the major dilemmas underlying the approach. The approach entails harmonization of different theoretical approaches and therefore raises questions about what interventions or activities to choose from a large set of options – if forced to make such choice. For example, should resources be allocated to the conditions resulting in the highest burden on individual and society, or should most efforts be allotted to prevention? How does a psychosocial and mental health approach target risk factors related to political violence and contribute to determinants of well-being and health such as economic development, human rights and good governance (de Jong, 2009)? Ultimately interventions should focus on improving the social context and targeting social determinants of mental health problems (de Jong, 2002a; Miller & Rasco, 2004), while at the same time mental health infrastructure and services should be developed that cater for severe mental health problems. The former focus entails targeting dysfunctional social structures (e.g. poverty, neglect, sexual abuse and violence, inequality, violence, insecurity/instability, marginalization) to prevent development of psychosocial and mental health problems. This requires a multi-sectoral approach that, for example, includes providing vocational training, targeting domestic abuse, reducing parental substance misuse, increasing teacher classroom-management skills, and consequently collaboration with many stakeholders. Another example of aiming to repair collective social structures is to focus on restoring social capital and reducing hatred. The concept of ‘ecological resilience’ has been proposed to identify and strengthen those assets and processes existent on all social-ecological levels that have shown to have a good relationship with good developmental outcomes (Tol, Jordans, Reis, de Jong, 2009). We have been insufficiently able to do this. Research will need to further demonstrate the beneficial effects of combining direct psychosocial interventions with poverty reduction, nutritional or education-focused programs, on both socio-economic and physiological indicators as well as psychosocial and mental health indicators. Children with more severe problems should be reached with a limited set of interventions in such a

4 In this dissertation I followed the IASC Guidelines on Mental Health and Psychosocial Support in Emergencies (2007) in using the composite term ‘mental health and psychosocial support’, as these are overlapping concepts that refer to a broad concept that encompasses “any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders”. In turn, ‘psychosocial’ is defined as the close relation between psychological factors (emotion, behaviour, cognition) and the socio-cultural context. The use of the term ‘psychosocial’ comes largely as a humanitarian reaction against a perceived biomedical control of the field – to give more emphasize to context, resilience and non-disordered distress. As a result the intervention framework moved more towards community settings and primary prevention as opposed to clinical settings and tertiary care.

way that delivery is cost effective. In short, future efforts should more actively work towards actual integration of vulnerability and resilience perspectives.

2. Increase feasibility of care

Problem statement

Another guiding question is whether a care system is feasible in a complex emergency setting. Feasibility depends on numerous factors. De Jong (2002b) describes a set of public mental health criteria to determine feasibility of large-scale psychosocial interventions: prevalence, community concern, seriousness of problems, treatability and feasibility of treatment, sustainability, competency (knowledge and skills) and availability of mental health care professionals, political acceptability, ethical acceptability, cultural sensitivity, and cost-effectiveness. While it is difficult to evaluate/weigh all these criteria for any intervention approach, many psychosocial and mental health initiatives in low-income settings still struggle with issues of feasibility and sustainability, as they are often driven by external financing, knowledge and human resources.

Response

First, due to restricted financial resources in LAMIC any care package can be only a fraction of the available health budgets. This requires that any treatment approach should be submitted to cost analyses. Cost analyses that we conducted on the above-mentioned care package demonstrate “that mean cost per service user varied heavily between countries and type of calculations, making between-country comparison difficult. While expenditures were by no means excessive, the average cost is relatively high when compared to per capita health expenditures” (*chapter 11*). In the future, care package costs will need to be reduced in order to convince governments and donors about the cost-feasibility. At the same time, the demonstrated unit cost of care can already support donors and policymakers in making informed decisions about child psychosocial and mental health services in settings where little infrastructure is available. Second, feasibility depends on the level of compatibility of an intervention with the local context. While the transfer of ‘western’ treatment approaches have been questioned or warned against (Summerfield, 1996), we argue that a more pragmatic response to apparent needs involves adaptation of care⁵. In Nepal we have described the process of adapting counseling to increase cultural appropriateness by incorporating local beliefs, values and practices (*chapter 7*). The chapter concludes that “one has to be careful when introducing new approaches not to undermine pre-existing ways of dealing with dis-

5 When no existing services are available for the psychosocial and mental health needs of children.

stress, one has to be equally careful, however, in condemning the importation of approaches just because they are new or western" (Tol, Jordans, Regmi, & Sharma, 2005). The adaptation efforts that we have employed for counseling as well as the group-based interventions followed a two-pronged approach (Lau, 2006); (a) 'contextualizing the content' to accommodate distinctive contextual factors (e.g. emphasizing concrete problem-solving over introspection in counseling) and, (b) 'enhancing engagement' to increase community involvement and acceptance (e.g. omitting intervention components that were considered as threatening by the community, such as those perceived as signs of a new religion).

Dilemmas and directions

The overarching criterion for the feasibility of a care approach is its sustainability. Sustainability depends primarily on institutional capacity, human resources and available funds (de Jong, 2002b). A stand-alone care package risks fragmentation and competing parallel care systems solely dependent on outside financial and technical inputs. Therefore, integration within existing community and government structures, such as health, education and child protection systems, is commonly advocated (Wessells & Monteiro, 2006), and is compatible with the State's obligation to cater for the psychosocial and mental health needs of children as enshrined in the Convention on the Rights of the Child (United Nations, 1990). Integration of a care package into existing community and government systems tends to reach more people, be more sustainable and carry fewer stigmas (IASC, 2007). While we have, for example, embedded the care package within the school system (see *chapter 3*), integration to the extent that services were carried by the local or government system did not prove possible. A second area of improvement is the structural involvement and participation of community stakeholders. There is a tender balance and some level of disharmony between the need for a structured care system and the need for community involvement. Community empowerment plays a crucial part in the process of psychosocial rehabilitation (Boyden, 2000). The relatively simple but often neglected (or made impossible due to donor restrictions) response is to include community participation in the design of the care package (de Jong & van Ommeren, 2002; Wessells & Monteiro, 2006; Tol et al, 2009), in order to ensure that intervention priorities reflect the perceived priorities and concerns of the community (de Jong, 2002b; Miller & Rasco, 2004). Third, more attention is needed for the notion of cultural adaptations of interventions, as a way to increase feasibility of care. The dilemma underlying cultural adaptations is that they are generally made on the premise that there are sufficient commonalities between different healing traditions (Kirmayer, 2004), because true treatment adaptations need to involve incorporating local beliefs and rituals around healing. Lau (2006) argues that the adaptation process should be research-informed rather than ad-hoc adjustments to minimize the risk of well-intentioned but potentially inappropriate adaptations. Following these arguments, I am of the opinion that we should follow an approach

to intervention development and adaptation that combines qualitative research into locally salient needs and available healing traditions (c.f. Tol et al., In press) with review through expert opinion and recipient stakeholder consultation of appropriateness and feasibility of (components of) treatment from high income settings (see also section four below). A fourth and final concern in relation to feasibility is quality of care. A common and advocated strategy for development of primary mental health care in the absence of professional mental health care is the training of 'community people'. Several studies have demonstrated that minimally trained para-professionals can deliver effective treatment (Ali et al., 2003; Patel et al., 2007; Tol et al., 2008). We employed a similar approach for the entire care package. While more sustainable, such an approach is not without risks. Insufficiently trained people can do harm, especially when working with children that have gone through serious traumatic experiences (Miller & Rasco, 2004). A second threat concerns the service providers themselves. Our practice driven evaluation of the care package demonstrates relatively high levels care givers' distress, especially for lesser trained (and lesser paid) service providers (*chapter 11*). Self care is commonly advocated in literature and guidelines (IASC, 2007; Mollica et al., 2004), but in practice is less common. The third risk is quality control of the provided services. On the one hand, minimally trained people are able to reach treatment effects that are similar in effect size compared to high income and highly professional settings (Silverman et al., 2008), on the other hand, among the scarce treatment evaluations within LAMIC there are several rigorous studies that find no treatment effect at all. Further research should look into the hypothesis that for children with severe mental health problems, or within social contexts that have been seriously damaged, the quality of service that can be offered by trained volunteers is insufficient. Central to responding to these challenges is capacity building. In any case, in my opinion there is an urgent need to move away from brief training courses that last several days (i.e. need for minimum standards of training for different levels of services) and from direct cascading training structures. Furthermore, structural integration of clinical supervision for counselors and other service providers within the care package is essential (Jordans, Tol, Sharma, & van Ommeren, 2003; van der Veer, de Jong, & Lanssen, 2004).

3. Improve access and detection to care

Problem statement

The next question is whether care is accessible. The availability of a care package does not guarantee that potential clients will actually access the offered services. Barriers to care include under-detection of psychosocial and mental health problems as well as suspicion, discrimination, stigma and shame related to both problems and treatment (Pumariega, Rogers, & Rothe, 2005; Tyano & Fleishman, 2007). One strategy to increase detection is to increase the level of awareness of children's psychosocial and mental health problems among direct

and indirect caretakers. A second strategy is the utilization of population-based screening. Arguments for primary screening include the increased opportunity to plan services and better allocate limited resources to the most needed groups and individuals. However, these arguments for screening are only valid if services are available upon screening. Furthermore, the lack of context-specific and valid instruments in LAMIC has been raised as a major obstacle (Mollica, et al., 2004). Similarly, there is the question of relevant indicators. What should instruments screen for? Disorder-specific screening tools are often incompatible with the need for broad and non-specific interventions (Miller, Kulkarni, & Kushner, 2006a). Increasingly research is demonstrating that, even in situations of recurrent traumatic exposures, accumulated current distress is as good or better a predictor of mental health problems compared to traumatic experiences *per se* (Panter-Brick et al., 2009; Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008). Recent efforts in LAMIC have focused on instruments that measure daily functioning (Bolton & Tang, 2002; Tol et al., In press) and detect generic psychological distress rather than psychopathology (Miller et al., 2006b).

Response

We have developed and validated an instrument to detect child psychosocial distress. The instrument uses a generic template covering domains of distress as well as resilience (exposure to stressors, social-behavioural problems, perceived coping and social support), at different ecological levels (child-level and school-level), and incorporates context specific probes. *Chapters 4 and 5* present the results of concurrent and construct validation studies of the Child Psychosocial Distress Screener (CPDS), demonstrating good accurateness in detecting indication for caseness for psychosocial treatment in Burundi. Moreover, the CPDS is a tool that measures a stable common core construct across three of the four settings, with contextual variance. These studies contribute to the broader field in a few ways. First, it adds a resource to scarcely available validated instruments in LAMIC. Validation is crucial not only for cross-culturally adapting existing instruments but especially for newly developed instruments, which take context into account from the outset of development. Second, the CPDS adds to a current trend for instruments that measure non-disordered distress (see above). Third, it is a tool that is context-sensitive and developed within low-income settings. Context specificity is related to the way the instrument is developed (i.e. inclusion of locally salient probes) as well as to the way a common underlying construct is manifested differently across settings. Fourth, because of brevity and the ability to be administered by non-specialists, the CPDS can be an appropriate instrument to screen large populations of conflict-affected children. Parallel to the screening procedure much effort is given to increasing the social validity of the spectrum of interventions to improve access to care; labeling and positioning the group intervention within the school context, which is viewed favorably and less threatening.

Treatment procedures that are viewed as acceptable and credible by potential consumers and community members are more likely to be sought and adhered to (Sue & Zane, 1987).

Dilemmas and directions

Population-based screening comes with several dilemmas. The feasibility and appropriateness of population-based screening have been questioned (Offord, 2000), especially in low-resource settings. Skepticism is mostly based on the practice of screening without the availability of subsequent treatment, a problem that was successfully addressed in our presented approach. Other difficulties remain. First, screening carries with it the risk of increased stigmatization, even if cautionary measures like sensitization and community involvement are taken. Labels related to mental illness and treatment often carry heavy stigmas and constitute a major barrier to screening and care (Ani & Ani, 2008; Tyano & Fleishman, 2007). A second pitfall is the meaning of a distress-based construct. For example, cross-cultural construct validation of the CPDS demonstrated its validity in three out of four settings, yet the exact interpretation of the construct is open for interpretation by lack of criteria and categorization of non-disordered distress. Horwitz (2007) argues for the importance to distinguish distress from disorder, stating “that distress that is initiated and maintained by social conditions is distinguished from disorders that are dysfunctions of internal psychological mechanisms”. More attention is required for the development of culturally-grounded instruments that take into account the origins of experienced suffering, as this has significant implications for treatment development and planning.

4. Increase evaluated and evidence-based care

Problem statement

One of the most central and recurrent questions in the recent global mental health literature is whether treatment is efficacious and effective. There have been repeated calls for more evidence, as several reviews demonstrate that the evidence base for mental health care in LAMIC is weak (Patel et al., 2007; *chapter 2*). Currently, merely four trials have been published on treatment for children in LAMIC, with moderately positive results (Bolton et al., 2003; Dybdahl, 2001; Layne et al., 2008; Tol et al., 2008).

Response

Chapter 7 presents a cluster randomized controlled trial to evaluate the Classroom Based Intervention in Nepal. Results demonstrate short-term beneficial effects for pro-social behavior (girls), general psychological difficulties & aggression (boys), and hope (older age). We

argue for its use as a secondary prevention intervention for at-risk children in conjunction with other interventions for more symptomatic children, because CBI is beneficial for social-behavioral and resilience indicators among subgroups of children but not for psychiatric symptoms. While there is an apparent need for efficacy studies, it would be infeasible and too narrow a perspective to only consider controlled trials as method of evaluation of care. Alternatively, there are several models that present the development of treatment evidence in stages especially for complex interventions (Campbell et al., 2000; Rounsaville, Carroll, & Onken, 2001; Veerman & van Yperen, 2007); while others have argued for more 'realistic' forms of evaluation that include context and process (Slade, Kuipers, & Priebe, 2002). These staged models have in common that they move from theory-formation evaluations at the start of the process to conducting RCTs as a last stage. Congruently, while there is a push for more efficacy studies, it could be argued that for some of the interventions it is too early for RCT's in LAMIC settings. Evaluation of treatment should rather be a combination of methods and questions, a spectrum that includes both practice-driven evaluation, effectiveness *and* efficacy research. Such broad evaluation framework is compatible with recent Medical Research Council guidance on evaluation of complex interventions (Craig et al., 2008). *Chapter 11* presents a practice-driven evaluation of the multi-layered care package through a set of indicators; (a) perceived treatment gains; (b) treatment satisfaction; (c) therapist burden; (d) access to care; (e) care package costs. The results demonstrate the direct usefulness of systematic practice-driven evaluation for improving care, e.g. the need to reduce high levels of distress among service providers, planning of services based on level of access to different levels of care, need for cost reductions or financial planning based on unit-cost data.

Dilemmas and directions

An underlying dilemma (or future step) in relation to creating a stronger evidence base for psychosocial and mental healthcare in LAMIC is whether we should adapt Evidence Based Treatment (EBT) from high-income settings, as it have a proven track record (albeit in different cultural settings), or do the socio-cultural differences between high- and low-income settings require a separate set of EBTs? The former option can build upon adaptations of Evidence Based Treatment (EBT) for different or minority cultural groups (Lau, 2006). Studies have found that tailoring interventions for specific populations can both increase and dilute the effectiveness of an intervention (Ngo et al., 2008). The question that Ngo and colleagues (2008) therefore ask is how to strike a balance between fidelity to EBT and culturally-informed care and they report on previous research that has demonstrated important cultural issues to be integrated into any treatment, such as help-seeking preferences, expressions of distress, communication styles, migration experiences, family values and socio-political history. They conclude that core components of the EBT should remain intact while the intervention is implemented in a group-specific way. Such approach also has downsides. Rousseau and

Kirmayer (2009) warn that 'although recognizing that there are important convergences between healing traditions is important, amalgamating everything under a western manual-based approach can be seen as reductionistic and ethnocentric'. Moreover, they argue that the role of potentially active ingredients within cultural adaptations needs to be considered as influencing effectiveness. While this is an important debate, it is mostly centered on use of EBT for minority cultural groups in high-income countries. Also, most EBT is disorder specific, which, even if efficacious in different cultural settings, would have limited use in most LAMIC. The discussion and methods of adaptation of EBT within LAMIC settings should be broadened and phased. First, attention should be given to theory formation and building a generic treatment response to a set of common mental disorders (based on a common factors approach – see next section) as a fundament for development and adaptation of treatments. Second, specific EBT treatment elements can be added, for example through a methods of distilling common elements of EBT from available literature, which can be matched subsequently to sub-populations, individuals or contexts (Chorpita, Daleiden, & Weisz, 2005). Third, making cultural adaptations to the identified (manual-based) EBT components will need to be made after in-depth understanding of the context. Fourth, this should be tested through rigorous efficacy and effectiveness studies, in order to create a separate evidence base in LAMIC. Hinton and colleagues (2005) provide an excellent example of an evaluation study of a culturally adapted EBT in Cambodia, which entailed targeting context-specific idioms of distress and context-specific treatment components in treating PTSD and panic disorder.

With regard to the evaluation of a care system, future efforts should look into the effects on system-level, or community-level, outcomes rather than only individual-level outcomes. This is especially salient given the results of two major studies that failed to find superior clinical outcomes for children in the system of care compared to care as usual (Bickman, Noser, & Summerfelt, 1999). While these are important findings, it is important to note that our choice for the implementation of a care system (if at all comparable to the comprehensive and specialized services in the reported studies) was not an effort to enhance treatment effectiveness but rather to put in place care *per se*.

5. Increase understanding of care and theory formation

Problem statement

How and for whom does a treatment work? This has been the question of much treatment process research. This research appears to have mostly taken place until the 90's and exclusively in high-income settings. The lack of a current research emphasis on this issue is unfortunate because treatment process research can play an essential role in theory formation, and in turn defining treatment objectives, especially in settings where mental health interventions

are a new phenomenon, different populations are reached or different problems targeted. Developing and later testing of hypotheses of what treatment mechanisms are effective can play a decisive role on what interventions to employ and how to employ them.

Response

In line with the above arguments we conducted a series of eleven single-case studies in Burundi (*chapter 10*). The study generated hypotheses on effective treatment mechanisms of individual counseling. Five treatment mechanisms appear associated with client improvement representing a combination of universal therapist variables (therapeutic alliance and client-centeredness), specific problem-focused intervention strategies (problem-solving and trauma-focused exposure) and a systemic perspective. We argue that this combination of common factors and specific treatment elements suggests the potential applicability of *integrative counseling* as an adequate form of intervention. Besides these treatment mechanisms, the study demonstrates that the counselor is the best predictor for outcome trajectories. It appears that the 'qualities and skills of the person delivering a treatment ... may be as important as the actual model of the intervention' (Kennedy, 2009). While preliminary, this research contributes to better determining the active ingredients in interventions for children. Beyond the direct results of the study, I would argue for the usefulness of $n=1$ design for research and clinical practice, especially in low-income settings. Single case studies can provide rich data on active ingredients and common factors of interventions and therefore help choose, adapt or develop interventions (Borckardt et al., 2008). Moreover, the use of $n=1$ designs as a service evaluation, or clinical reflection, tool is relatively simple. Iwakabe and Gazzola (2009) present ways in which single-case studies can be aggregated and synthesized to enhance clinical understanding.

Dilemmas and directions

In my opinion, there are two perspectives that deserve more structural attention in better understanding effective treatment mechanisms for children in low-income countries. First, renewed efforts to study potential common factors across treatments, as well as treatment process research that can identify effective treatment mechanisms for specific problems, may support a process of development of a more generic treatment that integrates several treatment mechanisms and therefore would be more applicable within low resource settings. Much like we conclude in the above-mentioned $n=1$ study, Wissow and colleagues (2008) have argued for an approach of combining common factors in mental health treatment (i.e. commonalities across treatments such as therapeutic alliance) with common practice elements (i.e. intervention strategies targeting symptom clusters such as exposure for PTSD symptoms), specifically for primary care providers. The argument that greater attention should

be paid to the attributes of effective therapists is confirmed by research that demonstrates that therapists account for a greater proportion of the variance in treatment outcome than any particular model of psychological intervention (Kennedy, 2009). Kim and colleagues (Kim, Wampold, & Bolt, 2006) find that an average of 8% of variance in outcomes in multiple comparative psychotherapy studies was attributable to therapists compared to 0% due to the particular treatment delivered. Second, one of the major gaps in the present (medical/psychological) literature, including this dissertation, is a developmental perspective. A developmental perspective would assure a better understanding of the influence of culture on notions of autonomy and individuation, child-rearing, acceptable problem presentations and developmental norms (including expectations for developmental milestones) (Pumariega et al., 2005). Culture-specific notions of child development have a direct impact on therapeutic processes for children; issues of containment and social formulation of problems, of early maturity of children due to responsibilities, of privacy, of therapeutic relations and roles of healers, of attachment and parent-child dyadic functioning (Punamäki, 2008; Qouta, Punamäki, & El Sarraj, 2008). Moreover, a developmental perspective would entail a more significant role for family-based interventions, something that is largely lacking in mental health initiatives (presented in the literature) for children in LAMIC. Dybdahl's study (2001) on mother-child care is a rare example of the contrary. Current mental health initiatives are by-and-large based on western notions of child development. This critique has been raised in the literature, for example by Boyden (1994) who further argues for a more central role of a child's agency and the wider socio-cultural context in psychosocial programs. Related is the need for future programs to include contextual and developmental processes that contribute to resilience of children in war zones (Qouta et al., 2008). For example, Punamäki (2006) provides a developmental overview of resilience-enhancing activities for war-affected children, arguing for the need for tailoring resilience building to increase age-specific strengths and decrease age-specific risks.

Concluding remarks

The ultimate goal underlying this dissertation is to scale up care and replicate context-specific and evidence-based psychosocial and mental health care packages for children in LAMIC. Before scaling up, however, we need to know better what works, how it works and how it should be delivered. In each of the above-mentioned areas of focus much more progress will therefore need to be made. The presented package and studies, as well as the action areas presented in this chapter, are merely a starting point. In addition, there are several fundamental gaps and dilemmas that need to be addressed. There is a pressing need to move towards a set of cost-effective interventions that will help in more equitable resource allocation. The relatively high cost, the multitude of interventions and needed human resources

make the care package difficult to integrate within existing community and government systems. Further development and research are needed to increase and demonstrate sustainability, broaden the spectrum of services, and expand the theory formation and evidence base of interventions.

One of the central themes of this dissertation is the interplay between research and intervention development. Much more research is needed to come to an evidence-based care package for children in LAMIC. There is especially a need for research with direct application to service provision. There is a large gap between the academic setting conducting empirical research that has a tendency to be too detached from the 'field reality' and the humanitarian sector that often shies away from empirical research and relies heavily on programmatic evaluations that have limited generalizability. Globally, research-practice gaps may contribute to limited impact of child mental health interventions, and can be categorized as a failure to implement EBT or the implementation of interventions that cause harm, without rigorous evaluation, or result in no effect (McLennan, Wathen, MacMillan, & Lavis, 2006). This chapter has outlined the need for research that focuses on the following broad areas; (a) efficacy and cost-effectiveness of intervention, and: (b) treatment process research. Specifically, the dissertation has raised several research questions that need further exploration. What is the longitudinal impact of primary prevention interventions, and does it actually prevent development of severe mental health problems? What is the efficacy of integrative counseling for children presenting with common mental disorders? What is the role of identified active treatment ingredients in determining efficacy? In addition a recent global mental health research agenda includes five out of ten child-focused priorities (Tomlinson et al., 2009).

Finally, in trying to develop an evidence-informed care system, we have heavily relied on methods of treatment and research that are commonly practiced in high-income settings. While this was often the starting point, these methods often proved insufficient for the settings where we worked. This dissertation has therefore undergone a broadening of perspectives. This has meant looking at the children's ecology as opposed to their individual suffering only, at non-specific psychological distress as opposed to pathology only, at multiple interventions instead of a single intervention approach, at a broad community-based evaluation perspective including practice-driven perspectives and efficacy research. Ultimately, broadly-focused approaches such as this are crucial to close the gap between children's needs and the services available to address them.

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