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The Youth Readiness Intervention for War-Affected Youth

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A B S T R A C T

Purpose: Mental disorders are among the largest contributors to the global burden of disease. Since the cessation of the Sierra Leonean civil war in 2002, there have been few mental health resources available for war-affected youth. Co-occurring psychological problems are commonly reported by youth in the post-conflict setting, suggesting a need for evidence-based interventions that cater to comorbid psychological difficulties. This feasibility study outlines the implementation and evaluation of a mixed-methods approach for developing and piloting a culturally grounded group mental health treatment—the Youth Readiness Intervention (YRI)—for war-affected Sierra Leonean youth.

Methods: Participating youth (N = 32; 50% female; ages, 15–24 years) were allocated to one of four gender- and age-stratified groups, facilitated by gender-matched Sierra Leonean interventionists. The intervention comprised adapted cognitive behavioral therapy techniques to address issues pertinent to war-affected youth. Analyses comprised assessments of reliable symptom change, mental health, functional adaptation, and interventionist fidelity outcomes.

Results: The YRI was found to be acceptable, feasible and associated with reliable changes in internalizing and externalizing symptoms and improvements in functional impairments and emotion regulation (mean effect size, $d = .64$).

Conclusions: Youth struggling with the mental health consequences of past trauma due to war merit special attention. The YRI presents a feasible and acceptable intervention for use in this low resource setting. A randomized controlled trial is planned to further test intervention effectiveness and scalability.

IMPLICATIONS AND CONTRIBUTION

War-affected youth often exhibit co-occurring psychological problems, suggesting a need for evidence-based mental health interventions. Our findings indicate that the Youth Readiness Intervention significantly reduced internalizing and externalizing symptoms and improved functioning among trauma-exposed youth. Interventions that "ready" youth for educational and vocational activities have potential for increasing well-being and economic recovery.

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The World Health Organization estimates the level of untreated mental disorders among adults in low- and middle-income countries to be as high as 78% [1]. For children and adolescents, the figure is likely to be similar [2]. Risks for mental disorders are exacerbated in regions affected by armed conflict [3]. Among adolescents, psychological distress due to trauma exposure is often expressed in higher rates of post-traumatic stress symptoms, depression, anxiety, and externalizing behaviors (e.g., aggression, hostility) [4–6]. Although many war-affected youth demonstrate great resilience, those who continue to suffer elevated levels of distress and impairment in the post-conflict environment are at risk for poor health and development, low rates of school completion, and poor economic self-sufficiency [7,8].

Few interventions exist to address mental health problems in war-affected youth beyond the immediate crisis period. To date, those that have demonstrated effectiveness have focused on singular disorders or symptom groups (such as post-traumatic stress disorder [9], grief [10], or depression [11]). Given the experience of multiple traumas and loss, and the ongoing instability that characterizes many post-conflict environments, it is important that the scope of interventions be broadened beyond models targeting a singular disorder to anticipate comorbidity and diverse manifestations of complex trauma [12]. Despite its centrality to security and development, the evidence base for feasible, effective, and sustainable mental health interventions for youth in war-affected settings is limited.

The Sierra Leonean civil war (1991–2002) was characterized by pervasive violence, displacement, and loss and became infamous for its extensive involvement of children. Children were vulnerable to forced abduction, family separations, repeated exposure to and involvement in violence, as well as frequent physical and sexual abuse [4]. After the cession of war, we began a longitudinal study (2002–present) to examine trajectories of psychosocial adjustment among a cohort (N = 529) of male and female war-affected youth, including former child soldiers and noncombatants. Our research indicated that the mental health of war-affected youth was not only influenced by past war experiences, but also by post-conflict adversities and limited resources [13]. Risk factors such as stigma, child abuse, neglect, and daily hardships were associated with poor mental health outcomes [13], whereas protective factors such as access to education and adequate social support partially mitigated risks for these outcomes [4,13].

Today, 76% of Sierra Leoneans are younger than 35 years. Unemployment, violence, and poverty remain persistent problems. Furthermore, strategies to advance youth employment and educational opportunities (e.g., the $20 million Youth Employment Scheme supported by the World Bank) may be inaccessible to many troubled youth whose persistent symptoms and functional impairments make interactions with peers and supervisors challenging [14]. The evidence indicates potential for improvements in mental health, but interventions are needed to address the comorbidity and diversity of problems confronting youth to help them maximize both educational and employment programs. The aim of the present study was to develop and assess a behavioral intervention for war-affected youth that would address comorbidities in psychopathology and prepare youth to engage in educational and vocational opportunities. The resulting Youth Readiness Intervention (YRI) was assessed in a feasibility study. We hypothesized that the intervention would result in improvements in internalizing and externalizing symptoms, functioning, and emotion regulation capacities.

Methods

Participants

We conducted a pilot trial of the intervention among four groups of eight participants (N = 32), stratified by gender and age (separate groups for males and females; ages, 15–17 and 18–24 years). Participants were recruited based on referrals from community elders and service providers who identified youth with ongoing psychological and behavioral difficulties. Inclusion criteria comprised the following: war exposure, age of 15–24 years, a total score of half a standard deviation (SD) above the longitudinal study mean for externalizing and internalizing subsections of the Oxford Measure of Psychosocial Adjustment (OMPA) [15], and report of functional impairment on the World Health Organization Quality of Life-BREF instrument (WHOQOL-BREF; [16]. Exclusion criteria comprised active suicidality, serious cognitive impairment, or psychosis. Ethics approval was granted by the institutional review board at the Harvard School of Public Health.

Measures

All outcome measures were forward and backward translated into Krio using the World Health Organization standard protocol [17]. Validation and pilot testing was conducted for all measures to ensure reliability, validity, and acceptability.

Psychological symptoms. The OMPA was used to evaluate internalizing symptoms (anxiety/depression; 16 items), externalizing symptoms (hostility; 12 items), and prosocial/adaptive behavior (16 items) [15]. The measure was developed and validated with former child soldier samples in Sierra Leone and Uganda [15] and had previously demonstrated sound reliability and validity among samples of war-affected youth [13]. In the present sample, reliability (Cronbach alphas at baseline) was $\alpha = .74$ for internalizing symptoms, $\alpha = .75$ for externalizing symptoms, and $\alpha = .73$ for prosocial/adaptive behavior.

Functional adaptation. Functional adaptation was measured using three subscales of the WHOQOL-BREF [16]; physical health ($\alpha = .78$), psychological health ($\alpha = .58$), and environment ($\alpha = .82$).

Emotion regulation. Capacities in emotion regulation were measured using an adapted, 36-item version of the Difficulties in Emotion Regulation Scale ($\alpha = .85$) [18]. The measure integrates six dimensions of emotion regulation: emotional response to nonacceptance, difficulties engaging in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity.

Intervention fidelity. A local clinical supervisor completed a fidelity monitoring tool immediately after each weekly supervision session from therapist report of the content, as well as audio recordings listened to in their entirety. The tool was developed