

Mental Health and Childhood Adversities: A Longitudinal Study in Kabul, Afghanistan

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Objective: To identify prospective predictors of mental health in Kabul, Afghanistan. **Method:** Using stratified random-sampling in schools, mental health and life events for 11-to 16-year-old students and their caregivers were assessed. In 2007, 1 year after baseline, the retention rate was 64% ($n = 115$ boys, 119 girls, 234 adults) with no evidence of selection bias. Self- and caregiver-rated child mental health (Strengths and Difficulties Questionnaire), depressive (Depression Self-Rating Scale), and posttraumatic stress (Child Revised Impact of Events Scale) symptoms and caregiver mental health (Self-Report Questionnaire) were assessed. Lifetime trauma and past-year traumatic, stressful, and protective experiences were assessed. **Results:** With the exception of posttraumatic stress, one-year trajectories for all mental health outcomes showed significant improvement ($p < .001$). Family violence had a striking impact on the Strengths and Difficulties Questionnaire data, raising caregiver-rated scores by 3.14 points (confidence interval [CI] 2.21–4.08) or half a standard deviation, and self-rated scores by 1.26 points (CI 0.50–2.03); past-year traumatic beatings independently raised self-rated scores by 1.85 points (CI 0.03–3.66). A major family conflict raised depression scores by 2.75 points (CI 0.89–4.61), two thirds of a standard deviation, whereas improved family life had protective effects. Posttraumatic stress symptom scores, however, were solely contingent on lifetime trauma, with more than three events raising scores by 5.38 points (CI 1.76–9.00). **Conclusions:** Family violence predicted changes in mental health problems other than posttraumatic stress symptoms in a cohort that showed resilience to substantial socioeconomic and war-related stressors. The importance of prospectively identifying impacts of specific types of childhood adversities on mental health outcomes is highlighted to strengthen evidence on key modifiable factors for intervention in war-affected populations. *J. Am. Acad. Child Adolesc. Psychiatry*, 2011;50(4):349–363. **Key Words:** family risk, conflict, resilience, violence, post-traumatic stress disorder

Afghanistan is a challenging setting in which to undertake child/adolescent mental health research. One of the five poorest countries in the world,¹ its public health profile bears witness to a noxious combination of ongoing conflict and chronic poverty. Access to health care has markedly improved² since the 2001 ousting of the Taliban regime, as have educational opportunities for children,^{3,4} but pronounced inequalities remain.⁵ Two large-

scale surveys have documented, for adults, traumatic experiences, loss of social functioning, and a spectrum of poor mental health outcomes.^{6,7} Recent studies⁸⁻¹¹ have focused attention on Afghan youth, in response to global concern for child/adolescent mental health in war zones.¹²⁻¹⁴ Such work has drawn attention to the mental health impact of daily stressors and societal violence, namely threats to psychological well-being that are not solely consequent on war.¹⁵ All work to date, however, has been cross-sectional, unable to discern the prospective impact of different kinds of adverse exposures.

In conflict areas, mental health research has primarily focused on war-related trauma and



This article is discussed in an editorial by Dr. Theresa S. Betancourt on page 323.

posttraumatic stress disorder rather than a broader set of predictor and outcome variables, and individuals rather than families as units of analysis and intervention.^{8,16,17} Few longitudinal “naturalistic” studies of youth in community settings are available,¹⁸ with noteworthy exceptions in Mozambique,¹⁹ Iraq,^{20,21} Gaza,²² and Sierra Leone,²³ and fewer still encompass family-level research. One key debate^{16,24} focuses on the relative importance of exposure to different kinds of militarized, domestic, and structural violence, namely whether mental health outcomes are primarily driven by war-related trauma, family-level violence, and/or structural barriers taking the form of institutional, social, and economic stressors. Most existing surveys, however, have focused on single childhood adversities predicting single disorders, rather than clusters of adversities and changes over the life course.²⁵ Even in low- and middle-income countries unaffected by war, few prospective studies of children and adolescents have teased out the relative impact of area-level, family-level, and individual-level predictors of poor health.²⁶ Thus, when it comes to the predictors of child/adolescent mental health, much less is known about the impact of neighborhood, social class, family conflict, and parental depression than about individual-level predictors such as age, sex, and war-trauma exposure.

In 2006, we conducted a school-based survey to establish baseline mental health data for 11- to 16-year-olds and adult caregivers ($n = 1,011$ child–adult pairs) in three regions of the country,¹⁰ including 364 children and 364 caregivers in the capital Kabul. We also collected extensive qualitative data on psychosocial suffering, resilience, and everyday stressors in face-to-face interviews with the 1,011 children and 1,011 adult respondents.¹¹ One year later, we recontacted Kabuli participants to reappraise risk factors and assess intervening-year events. This article reports on the sample with repeated measures at baseline (T1) and follow-up (T2), focusing on youth but using caregiver data where relevant to characterize family environments. We examined changes in mental health over time, including individual and contextual risk/protective factors, using a wider set of mental health indicators than traditionally studied for war-affected children. Specifically, we hypothesized that intervening-year events (relating to individual, family, and neighborhood circumstances) and baseline risk factors

(such as lifetime trauma and gender) would predict T1 to T2 trajectories. To inform existing debates, we empirically tested the prospective impact of ongoing individual and social stressors and the sustained impact of lifetime trauma exposure.

METHOD

Research Design

In Afghanistan, schools provide the best setting to interview a community-based sample of male/female children/caregivers. Nationally, 64% of 7- to 14 year-olds (48% girls, 77% boys) enrolled in school in 2004 through 2005.³ There are formidable cultural barriers to interviewing male/female participants in other settings, such as mosques or homes, given security concerns and restricted opportunity for interview privacy. Our baseline survey (T1: May through July 2006) adopted a stratified random-sampling design across several regions. The follow-up (T2: October through November 2007) was conducted only in Kabul, due to heightened insecurity and logistic constraints, with the same field team (three male, three female interviewers, a professional translator, and a bilingual project manager). At T1, we achieved balanced gender and geographic coverage of 6% of listed schools and 4% of target-age students (Figure 1). We contacted government-operated schools, with probability sampling proportional to size and additional stratification by single-sex/coeducational schools and city zones.¹⁰ We compiled age-specific class lists in selected schools and randomly sampled 11- to 16-year-olds, excluding siblings. At T2, we recontacted the same schools and reinterviewed 64.3% of students and primary caregivers; adults who assumed day-to-day childcare responsibility were, in 61.5% of cases, the same person at baseline and follow-up.

The protocol was approved by international and local ethics committees, including the Ministry of Education in Afghanistan. Written informed consent was obtained from school directors, oral consent from children, caregivers, and teachers, and procedures for potential referral of participants with physical/emotional problems were specified.²⁷ All participants agreed to the T2 interview, given good rapport built at T1, a small gift, and a free health examination. Given an absence of systematic record-keeping at schools, it was not possible to trace students who had left; their families were lost to follow-up.

Mental Health Indicators

We developed two-language versions (Dari/Pashtu) of several standardized rating scales recommended for epidemiologic research in schools and/or conflict settings, including Muslim communities in Pakistan, Bangladesh, Bosnia, and Gaza.¹⁰ We selected brief, locally applicable questionnaires with demonstrated psycho-

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