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Mental health and armed conflict: The importance of distinguishing between war exposure and other sources of adversity: A response to Neuner

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In a recent article in *Social Science & Medicine* (Miller & Rasmussen, 2010), we examined findings from research on the various factors that appear to influence mental health in conflict and post-conflict settings. We focused in particular on two categories of stressors that have received considerable attention in the literature: direct exposure to the violence and destruction of war, and "daily stressors", the stressful social and material conditions that are often caused or exacerbated by armed conflict. Our aims were twofold: (1) to elaborate an empirically-based model delineating the various pathways by which armed conflict influences the mental health of civilians, and (2) to offer a framework for intervention based on that model, which might help to bridge the often contentious divide between advocates of what we labeled "trauma-focused" and "psychosocial" approaches. As we note in the article, trauma-focused advocates generally assume that psychological distress in war-affected populations is primarily the result of direct exposure to specific war-related events, and that effective interventions should focus on the amelioration of war-related trauma (PTSD) through specialized clinical treatments. In contrast, psychosocial advocates view distress as stemming largely from the stressful conditions of everyday life in settings of organized violence—conditions such as poverty and the loss of livelihoods, displacement into overcrowded and impoverished refugee settlements, heightened family violence, the destruction of social networks and the corresponding loss of social support, and the marginalization of groups such as widows, sexual assault survivors, former child soldiers, and people with war-related disabilities. From a psychosocial perspective, altering those stressful conditions is likely to improve mental health, while at the same time enhancing people's innate capacity to heal from potentially traumatic experiences of violence and loss (Betancourt & Williams, 2008; Boothby, Strang, & Wessells, 2006).

The model we proposed, based on our review of the available research, is one in which daily stressors partially mediate the relationship between war exposure and mental health (Miller & Rasmussen, 2010). In our model, war exposure still exerts a direct effect on mental health; however, it is a significantly smaller effect than what we find when daily stressors are not included in the model. Beyond any discussion of mediation, it is quite evident that war exposure and daily stressors *both* account for significant variance in mental health status in settings of armed conflict. Because daily stressors represent continuous or proximal threats to mental health (by persistently elevating stress levels and taxing available coping resources), we suggested that it might be useful to first aim at reducing daily stressors as an approach to improving mental health, before providing specialized clinical treatment to individuals whose distress might abate with the repair of their social ecology. We also noted that whereas trauma-focused advocates generally focus on ameliorating symptoms of PTSD presumed to be related to prior exposure to armed conflict, there is growing evidence that in conflict settings other sources of traumatic stress may be elevated as well, such as child abuse and domestic violence,

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and thus may contribute strongly to elevated PTSD symptom levels. A narrow focus on healing war-related PTSD runs the risk of overlooking *ongoing* sources of trauma that may affect people on a continuous basis.

In this issue of *Social Science & Medicine*, Neuner (2010) offers a thoughtful commentary on our paper. Neuner, whose intervention research group generally fits within the trauma-focused approach, is primarily concerned with the lack of an evidence base for prioritizing psychosocial over trauma-focused interventions (the sequenced approach to intervention we proposed). He rightly notes the lack of controlled outcome studies demonstrating the effectiveness of psychosocial interventions in conflict and post-conflict settings. He also critiques the psychosocial framework as including everything from individual counseling to community-based interventions aimed at altering widespread social problems that may or may not be linked to mental health.

Perhaps more fundamentally, Neuner challenges the basic premise of our paper by questioning the utility of distinguishing between war exposure and other types of stressors (Neuner, 2010). He questions whether what we have called daily stressors are in fact *causally* related to mental health, and suggests that causality may actually work in the opposite direction; that is, he suggests that poor mental health may lead people to experience high levels of daily stressors, or to perceive situations as stressful that healthier individuals might not. He further suggests some daily stressors may be hidden from view and therefore be difficult to identify, and that in any case, it would be hard to assess which daily stressors are most strongly related to mental health in any given setting and should therefore be targeted for change. In effect, Neuner has suggested that we are advocating empirically unproven intervention strategies in order to target social-ecological variables that are difficult to identify and may not be causally related to mental health anyway. In his view, treating PTSD using specialized, expert-driven interventions that have at least some empirical support is the appropriate role of mental health organizations working with conflict-affected populations.

Points of agreement

Although the available data strongly support the usefulness of distinguishing between war exposure and other sources of adversity (i.e., daily stressors), we do find merit in several of the points raised in Neuner's commentary. First, we agree that a compelling argument can be made for a multi-level approach to intervention, in which specialized clinical services are provided concurrently with, rather than subsequent to, psychosocial interventions aimed at repairing the social ecology. We have received considerable feedback on our original paper from field-based practitioners as well as researchers. While there has been strong support for the distinction we have made between war exposure and daily stressors as determinants of mental health (and for the importance of targeting daily stressors as an approach to improving mental health), we have also heard some frustration from clinicians who, like Neuner, question the practical utility of a sequenced approach to intervention. As one colleague asked at a recent conference where we presented a version of the paper, "What am I to say to the mother who brings her traumatized child into the clinic for treatment? Shall I tell her to wait while we first alter the social environment?"

Hubbard and Pearson (2004) have thoughtfully argued the case for concurrent, multi-level interventions, based on their work with severely traumatized and depressed refugees from Sierra Leone living in Guinean refugee camps. They noted that a minority of camp residents experienced PTSD and depression so severe that it not only impeded their ability to function but also limited their capacity to benefit from psychosocial resources available within the camps. For these individuals, a culturally adapted, trauma-focused intervention was developed. The group-level program, which also fostered an increase in social support among participants, yielded significant benefits in terms of symptom reduction. By maintaining a long-term presence in the camps, project staff were able to train local community members in the intervention model, provide ongoing supervision, and adapt the intervention as needed to the evolving conditions within the camp.

In advocating a sequenced approach to intervention that prioritized altering the social ecology before offering specialized clinical services, our concerns were twofold. First, it can be difficult to distinguish normal stress reactions from actual disorder in need of treatment, particularly in settings of ongoing adversity (a point we discuss in our original paper). Indeed, there are examples in the literature (including an intervention study by Neuner's own group) of PTSD symptom levels dropping markedly when political violence abated or conditions of greater safety were established (Neuner, Karunakara, & Elbert, 2004; Thabet & Vostanis, 2000). Consequently, we are cautious about advocating specialized care for potentially transitory trauma reactions that might diminish with the provision of social support and a greater degree of safety. We share the concern of researchers such as Bonanno (2004), who argue that the mental health field has tended to underestimate people's capacity for resilience and recovery, while at the same time overestimating the need for professional treatment in the wake of stressful life events (Bonanno, 2004). Moreover, as a field we have learned about the hazards of prematurely offering specialized trauma-focused interventions that may actually impede the natural process of recovery from exposure to traumatic stress (Bisson & Deahl, 1994; Hobbs, Mayou, Harrison, & Worlock, 1996).

However, to the extent that appropriate steps can be taken to distinguish transitory stress reactions from actual cases of disorder in need of treatment, we would support the provision of clinical treatment concurrently with psychosocial activities aimed at reducing the salience of ongoing environmental stressors. We would certainly encourage clinicians to adopt a broad view, and not limit their focus to the post-traumatic effects of direct war exposure. By considering the full range of stressors affecting program clients, and understanding the variety of mental health outcomes other than PTSD that may arise (including culturally specific indicators and idioms of distress), we believe clinical programs are likely to have more powerful and sustained effects. Such a broader view necessarily means fostering linkages with other programs that are positioned to target ongoing sources of traumatic stress (e.g., domestic violence projects, child protection organizations) that lie outside the scope of traditional clinical services. Consistent with the IASC guidelines (2007), we would also encourage the development of local capacity in the implementation of clinical interventions, and the incorporation of local values and practices regarding psychological healing.

In his commentary, Neuner suggests that such a broad view is the norm among trauma-focused researchers, who he believes do not focus specifically on war-related trauma, but consider the broad range of traumatic stressors to which war-affected populations may be exposed (Neuner, 2010). Unfortunately, the evidence simply does not support this assertion. Several reviews of the literature on mental health in war-affected populations document how few studies have assessed sources of distress other than direct war exposure (Barenbaum, Ruchkin, & Schwab-Stone, 2004; de Jong, 2002; Miller & Rasco, 2004). Domestic violence, for example, has seldom been assessed as a source of distress in war-affected communities, despite its strong association with PTSD and other types of distress in the literature (Bennice, Resick, Mechanic, & Astin, 2003). It is of course possible that practitioners in the field

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