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Helping Adolescents Affected by War, Trauma and Displacement

Judith A. Cohen, M.D.
Dr. Cohen is with the Center for Traumatic Stress in Children & Adolescents, Allegheny General Hospital

More than 60 years ago Anna Freud described the impact of war on children, noting that parental separation led to symptoms in young children that could be partially alleviated by peer support.[1] Along similar lines, a more recent study from Israel suggested that a mother's functioning predicted her children's Posttraumatic Stress Disorder (PTSD) symptoms for up to 5 years after exposure to missile attacks.[2] Both observations point to two features of warfare that are of enduring importance to our field and are all too often neglected: war affects both children and parents; and when it affects one it often critically impacts the other. Indeed, modern warfare is characterized by its civilian casualties. It is therefore fitting and timely that two articles in this issue of the *Journal* address the topic of adolescents affected by war.

Henrich and Shahar[3] were conducting a study of economically disadvantaged adolescents in Sderot, Israel and had just collected data about social support, depression and prior exposure to rocket attacks, when rocket attacks began from the nearby Gaza Strip. This created a rare opportunity for a prospective study of the interaction of rocket attack exposure and social support on the development of later depression. Five months later, depressive symptoms were again assessed, as was exposure to rocket attacks during the intervening period. Using regression analyses, the authors characterized adolescents as having high or low exposures and high or low initial social supports. They found low depression scores in those adolescents with low exposure and low social support, and in those with high exposure and high social support. Those with high exposure and low social support ended up with high depression scores. So far this makes intuitive sense: Higher trauma exposure would be associated with more severe symptoms and strong social support should provide a buffering effect. Unexpectedly, the group with low exposure and high initial social support also ended up with higher depression scores at time.[2] How to make sense of this seemingly counterintuitive finding? The authors suggest that these adolescents may have received greater social support because they were developing more depressive symptoms over time secondary to chronic poverty-related stressors. This explanation is plausible, but if these youths' depressive symptoms were obvious enough for them to receive heightened levels of social support at time 1, it seems that this should have been reflected in higher time 1depression scores (which were controlled for in the regression analysis).

An alternative (perhaps complimentary) hypothesis is that adolescents who were constitutionally (perhaps genetically) most vulnerable to developing depression in reaction to stress[4] were those who sought out and initially received higher social support than their more resilient peers, even prior to developing depressive symptoms at time 1. These would be the adolescents in the “high support” group. However in the chaos that Sderot became during the ensuing 5 months, social support was provided differentially to adolescents with high exposure to rocket attacks, with less support being provided to those with lower rocket exposure. Social support was only assessed at time 1 but it would make intuitive sense that support would be

Correspondence to Judith A. Cohen, M.D., Allegheny General Hospital, Psychiatry, 4 Allegheny Center, 8th Floor, Pittsburgh, PA 15212. *Email:* JCohen1@wpahs.org.

provided differentially to those experiencing more acute stress. This perceived relative decrease in support and concurrent increased stress (from school closures and the threat of rocket attacks even if these did not occur) could have resulted in increased depression in stress-vulnerable adolescents. Recent studies[4,5] provide intriguing hints about possible relationships between chronic trauma history and polymorphism-mediated stress responsiveness leading to differential vulnerability for developing PTSD and depression. These may prove fruitful areas of exploration for understanding differential vulnerability to stress- and trauma-related disorders and ultimately to developing individualized interventions for traumatized youth. The authors of the Sderot study[3] state that their findings highlight the importance of community efforts to bolster schools, families and peers as protective resources in times of traumatic stress. Social support is without doubt important and beneficial for most children. But what about the adolescents who were getting worse, perhaps in spite of high levels of social support? What interventions might they need? The next study sheds some light on the question of interventions for adolescents living in post-war conditions affected by multiple traumas.

Layne et al.[6] conducted a randomized controlled trial (RCT) for Bosnian war-affected adolescents within a broader context of training community providers and building capacity to serve traumatized youth. More than 1200 adolescents aged 13-19 years old were screened for trauma symptoms in 10 schools in Bosnia-Herzegovina Youth with significant symptoms who met inclusion criteria (N=159) were randomized to control group (a milieu classroom intervention with psychoeducation and coping skills) or Trauma and Grief Component Therapy model (TGCT, a 17-20 session group intervention provided during school hours including psychoeducation, coping skills, trauma narrative construction, and coping with traumatic loss and grief). Participants in TGCT reported significantly greater reductions in PTSD and depressive symptoms than participants in the milieu control condition at post-treatment and 4 months later.[6] Even though the study was not blinded, it represented a major accomplishment. Not only was it carried out in post-war conditions with scarce resources, it also offers an outstanding public health model for providing sustainable tiered services while simultaneously researching the intervention.

How do these studies relate to the broader fields of childhood trauma and child psychiatry? Three common themes emerge. First, the importance of exposure to more than one type of trauma, or "poly-victimization"[7] is becoming evident. The adolescents in Sderot and Bosnia experienced multiple adversities and likely multiple traumatic events, although only one[6] attempted to document the participants' full range of trauma exposures. Any type of child victimization increases future vulnerability for revictimization.[7] Poly-victimization is likely the norm in children who have suffered chronic situations like war, child abuse and domestic violence. Since poly-victimization is associated with worse psychiatric morbidity[7, 8], more attention needs to be devoted to identifying strategies for preventing re-victimization. A problem with current PTSD diagnostic criteria is the requirement to yoke symptoms to a single "worst" trauma; but many people have experienced multiple traumas, each perhaps associated with different symptoms. An optimal diagnostic model should therefore include the potentially additive impact of multiple traumas and multiple adversities, as well as attention to developmental, cultural, genetic and constitutional features and the role of resilience. Second, the Layne et al.[6] findings are consistent with treatment studies for other traumatized child populations,[9, 10] which suggest that *both* coping skills *and* directly addressing trauma reminders—whether through constructing a trauma narrative, more graduated exposure interventions, or both—are important components of child trauma treatment. More studies are needed to identify critical components of effective trauma treatments. Finally, the present studies confirm that particularly for multiply traumatized children and/or those with co-existing mental health symptoms, supportive interventions may be helpful but they are not adequate as stand-alone measures.[9]

As children continue to be victims in wars around the world, psychosocial interventions adapted to children's and families' specific needs are increasingly important and relevant. In the future we need to merge information from genetic, treatment and dissemination studies to learn more about underlying mechanisms of risk, match treatments to specific children and families, and develop methods for transporting effective treatments to distant providers in order to optimally treat the countless children around the world who are suffering from the multiple negative impacts of trauma, displacement and loss.

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