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**A Qualitative Study of Mental Health Problems
among Children Displaced by War in
Northern Uganda**

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Abstract While multiple studies have found that children affected by war are at increased risk for a range of mental health problems, little research has investigated how mental health problems are perceived locally. In this study we used a previously developed rapid ethnographic assessment method to explore local perceptions of mental health problems among children and adults from the Acholi ethnic group displaced by the war in northern Uganda. We conducted 45 free list interviews and 57 key informant interviews. The rapid assessment approach appears to have worked well for interviewing caretakers and children aged 10–17 years. We describe

several locally defined syndromes: *two tam/par/kumu* (depression and dysthymia-like syndromes), *ma lwor* (a mixed anxiety and depression-like syndrome), and a category of conduct problems referred to as *kwo maraco/gin lugero*. The descriptions of these local syndromes were similar to western mood, anxiety and conduct disorders, but included culture-specific elements.

Key words children and adolescents • mental health • qualitative research
• northern Uganda • war

The war in northern Uganda is one of the most persistent and deadliest complex humanitarian emergencies (CHEs) in the world today (Relief Web, 2006). Over 1.8m people, most of them Acholi, have been internally displaced during the more than 20-year conflict. The camps housing internally displaced people (IDPs) in northern Uganda are extremely overcrowded and characterized by constant insecurity and risks to health (Relief Web, 2006). It is estimated that more than 25,000 children have been abducted to serve in the Lord's Resistance Army (LRA) (OCHA, 2006). Insecurity was once such that thousands of child "night commuters" from outlying villages moved into the larger towns each evening in order to avoid night time raids and abductions in their home villages.

Research on children affected by such armed conflict and displacement indicates their increased risk for a range of mental health problems (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Lustig et al., 2004; Stichick, 2001). In particular, research has emphasized the many ways in which exposure to war-related traumatic events are likely to contribute to subsequent mental distress, and in some cases, longer-term psychopathology (Stichick, 2001). A number of studies have found anxiety disorders, particularly posttraumatic stress disorder (PTSD), occurring in very high rates among war-affected children (Kinzie, Sack, Angell, Manson, & Rath, 1986; Sack, Him, & Dickason, 1999; Weine et al., 1995). Prior research in northern Uganda has indicated that war-affected youth exhibit both clinically-significant symptoms of PTSD (Derluyn, Broekhart, Schuyten, & De Temmerman, 2004) as well as problems related to depression, anxiety and hostility (MacMullin & Loughry, 2004). However, the Derluyn (2004) study was criticized by other mental health professionals for its use of the diagnostic category of post-traumatic stress disorder as the starting point for understanding these youth. Concern has also been expressed over whether asking participants to recall atrocities was ethically justified given that such traumatic exposures in northern Uganda have been well-documented (McKay & Wessels, 2004). In contrast, an ongoing survey of war-affected youth in eight sub-counties of northern Uganda indicated that young men aged 14–30 had experienced an average of 9 exposures to

serious violence; participants in the survey also reported lower than expected levels of emotional distress using adapted western mental health measures (SWAY, 2006). One quarter of the young men interviewed reported experiencing moderate to high emotional distress on a modified version of the Harvard Trauma Questionnaire. Educational and occupational functioning was unrelated to levels of distress. A majority of this sample (90%, $N = 791$) also reported high social functioning and low levels of aggression.

The reasons for such variance in the results of studies of war-affected youth remain unclear. It may be partly due to conducting assessments at different time periods during or after a conflict, to variability in types of traumatic exposure or to the influence of culture on how children react. Certainly the pervasive and longstanding war in northern Uganda is one example of more collective or ecological forms of trauma that may not be well captured by standard measures (Bagilishya, 2000; Eisenbruch, 1991). There may also be methodological reasons for the differences. Most studies use quantitative instruments based on biomedical mental health concepts such as those defined in the Diagnostic and Statistical Manual of the American Psychiatric Association/DSM-IV-TR (APA, 2000) or the International Classification of Diseases/ICD-10 (World Health Organization, 2006). These choices are usually based on prior assumptions as to what the major mental health problems will be and how they will manifest locally. Yet, as indicated in the criticisms of the Derluyn et al. study (2004), it is not always clear how appropriate such psychiatric concepts and diagnostic criteria are in these settings. It may be that concepts central to diagnosing disorders such as PTSD and depressive disorders in North American and European psychiatry (and by extension, instruments based on these concepts) are not easily compatible with local concepts.

The purpose of this qualitative study was both to test a method of rapid ethnographic assessment designed to explore local mental health concepts, and to use this method to explore the local applicability of western mental health concepts among a population of Acholi war-affected children. In this way we wanted to determine whether mainstream psychiatric concepts were applicable and significant to the local situation rather than assuming that this was the case. Our study question was "What do children and their caretakers consider to be the most important mental health problems affecting Acholi 10–17 year olds in IDP camps and how do they understand these problems?" Our investigation included exploring the local names of these problems, how they manifest, what are the causes and what is commonly done to address them. Comparison of the resulting data with psychiatric concepts of mental health problems and good functioning was later used to select and create appropriate instruments for later quantitative assessments of these problems and related dysfunction. The

approach is the same as one previously used among adult populations (Bolton, 2001). However, this study is the first time we have used this approach with children and their caretakers.

The study formed the first step in a collaborative process between Boston University (where the first and last authors were based at the time) and World Vision (WV) and War Child Holland (WCH), organizations implementing assistance programs in northern Uganda, including the sites of this study. This collaboration used both qualitative and quantitative assessment methods to improve program design, monitoring, and evaluation. A report of the entire process (which has since been completed) is available from the authors on request.

METHODS

PARTICIPANTS

Study participants were Acholi children (boys and girls) 10–17 years and adults (mostly caretakers) living in the Awer and Unyama camps of Gulu District, northern Uganda. These camps were chosen because they are near to Gulu town (important in terms of security) and because World Vision and War Child Holland were developing programs for IDP children and adolescents in both sites. For the free lists we chose a sample based on the principle of “maximum variation” (Guba & Lincoln, 1989) by defining the dimensions of variation in the population deemed most relevant to our research questions and systematically selecting individuals representing the most important variations on these dimensions. Thus, the sample included children and their caretakers from both camps, both genders, representing an age range from 10–17 years. We also sampled children attending school and not attending school, those formerly abducted by the LRA and those never abducted. All children were required to have lived in the camp for at least three months. 15 adults (12 female) and 31 10–17-year olds (15 female) participated in Free Listing (FL) interviews.

Key Informants (KIs) were identified by the FL respondents as described above. In all, 32 adults (16 female) and 25 10–17-year olds (13 female) participated in KI interviews. KIs included young adults who were well-known in the IDP camps, parents or relatives of young children, traditional healers, and some teachers and health professionals. All spoke Acholi Luo and lived in the IDP camps. Exclusion criteria included persons with a severe cognitive or physical disability who were impaired and unable to answer questions in Luo. This was assessed by the local research assistants who were trained and instructed to only enroll study participants who demonstrated the capacity to understand and give informed consent on the study procedures and content.

PROCEDURES

The study procedures were reviewed and approved by local camp leaders and the World Vision psychosocial program staff. The study design was approved by the Institutional Review Board (IRB) at Boston University and all interviewees provided informed consent. All staff were trained in research ethics and all precautions were taken to protect participant identities and minimize any adverse effects that might result from the interviewing process.

Interviews were conducted in July and August of 2004. As in previous assessments among adults, two qualitative interviewing methods were used: Free List (FL) followed by Key Informant (KI) Interviewing. Interviews were conducted in the Acholi Luo language by 10 local Luo-speaking Acholi interviewers and two non-Acholi non-Luo speakers who worked with the assistance of Luo-speaking translators. Interviewers also spoke English and were trained and supervised by the authors. Interviewing was done in pairs with one person serving as the lead interviewer and the second person serving as primary note taker and "quality control". The latter role included feedback to the lead interviewer as to their rapport with the participant, their use of non-leading interviewing methods, and their use of probes to fully explore the locally-described mental health constructs. Members of each team could alternate their roles or not, according to their preference. Despite initial concerns, interviewers reported that the presence of two interviewers did not appear to affect the openness of interviewee responses. This was a subjective judgment based on interviewees' perceived willingness to talk and on whether the interviewer felt that they had been able establish rapport with the interviewee.

PROBLEM AND CHILD TASK/ROLES FREE LISTING EXERCISE

FL participants (15 adults and 31 children and adolescents 10–17-year olds) were asked two questions, each of which was designed to elicit responses in the form of a list. All responses were recorded verbatim on a standard FL record sheet in the respondent's own language. The first FL was based on the question "What are the problems of children in this camp?". Interviewers probed for as many problems as possible and also asked for a short description of each problem. Interviewers recorded, in the respondents' own words, the names of problems and the short description given to each one. At the end of the FL interview (but before the respondent had left), interviewers reviewed the problem names and descriptions for reference to problems of thinking, feeling, or relationships. These were regarded as potential mental health issues. Interviewers were instructed to ask respondents for (and record) the names and contact

information for community members who were particularly knowledgeable about each of these mental health problems either because of their connections within the community or because people consulted them about the problem. Here 'community member' excluded persons working in the community but not from the community, such as health workers or other persons with outside training. These knowledgeable persons formed the initial group of informants for the second qualitative method.

The second FL used the question "What do boys/girls in this community do?". This question explored the routine activities and tasks that children engage in. As with the "problems" FL, interviewers probed for as many activities/tasks as possible and recorded short descriptions of each one. Girls were asked only about girls and boys only about boys. Caretakers were questioned according to the gender of their child. The resulting data are not presented in this article but were used to form a scale of functional limitations that was used in later phases of this research.

In both cases, we developed the FL questions based on our prior experience. We then presented them to our interviewing team for discussion based on: (1) their translatability and (2) their perception of whether the question in its local form would be understood in the way intended. This led to changes in the questions that were then asked of the participants. Questions were chosen after discussing a number of other possible ways to frame the questions with our local staff. We monitored the participants' ability to answer via the initial reports of the interviewers. Had we encountered problems we would have changed the questions again, but they appeared to work well.

On completion of the FL interviews, the authors reviewed the results in collaboration with World Vision local staff to select which mental health problems would be explored in depth.¹ This choice is based on which issues (and how many of them) the implementing organization is able to address, and is part of the rapid assessment methodology. Rapid assessment is achieved by focusing not on all the mental health problems that are described in the free lists but only on those frequently mentioned problems that are likely to be addressed by the implementer. For example, epilepsy was frequently mentioned but not explored because World Vision did not have the resources to provide effective drug therapy. Based on these discussions with World Vision we agreed to identify no more than five or six related problems that could be addressed by one or two interventions. On this basis, five local syndromes were selected for more detailed investigation by key informant interview (following section). The first three problems (*two tam*, *kumu*, and *par*) bear similarity to the psychiatric categories of mood and depressive disorders. The fourth syndrome (*ma lwor*) shares similarities with criteria for anxiety disorders and a fifth local syndrome (*kwo marac/gin lugero*) shares some similarities with

conduct and oppositional defiant disorders, but describes behavioral problems of relevance for children and adolescents in the IDP camps studied.

KEY INFORMANT INTERVIEWS

Once we selected the mental health problems to explore, those persons described by FL informants as knowledgeable about those problems were approached by the interviewers to be interviewed as Key Informants (KIs). These KIs (32 adults and 25 10–17-year olds) were interviewed in-depth about the selected problems from the free lists. KI interviews began with an open question such as “Tell me about the problem of X”. Once commonly used syndrome terms began to emerge, we would seek more detail about them using probes such as (for the example of the local syndrome *kumu*): “People around here told us about the problem of *kumu*. How does a child with *kumu* feel?” and “How does a child with *kumu* behave?” or “How does a child with *kumu* think about themselves? . . . About others?”. If asked for guidance or further explanation by the respondents, we asked them to respond based on whatever they thought the question/concepts meant to them. In our experience, respondents did not have problems with these questions (based on the interviewers’ subjective judgment and by reviewing the nature of replies given). The KIs were also probed on perceived causes of the problems of interest and what people do about the problem (if anything). KIs were also probed for additional mental health issues that were not mentioned on the FLs. When a cluster of signs and symptoms was described together, interviewers were instructed to ask “Is there a word for these sorts of problems or for someone who has a lot of these types of problems?”. Unlike in the free list interviews, interviewers were instructed to interview the same KI repeatedly to the extent that the person was available and until no new information was presented.

DATA ANALYSIS

At the end of each day of interviews, the interviewers met with World Vision staff and the authors to review the interview experiences and the interview notes, and to transcribe the Luo interview notes into English. This review included identifying problems in the interviewing process and topics that emerged in the interviews that required further exploration. In such instances, interviewers were directed to return to conduct additional interviews with the FL or KI participants.

FL DATA ANALYSIS

Data from the FL interviews were first summarized into lists that included every response and the number of times that response was mentioned. These lists were then reviewed by the authors and the interviewers for responses that were conceptually identical (even though the wording was different). Such items were combined into a single item and the number of responses summated. For example, if “hunger” was identified by 10 respondents and “lack of food” by another five, this would be combined into a single item referred to either as “hunger” or “lack of food” and listed as being reported 15 times. These composite free lists are shown in Table 1.

TABLE 1
Main problem themes emerging from free listing exercises ($N = 45$)*

<i>Theme</i>	<i>Number Reporting N (%)</i>
Lack food	34 (74)
Lack clothing	31 (67)
Lack school fees, uniforms, books, etc.	30 (65)
Insecurity/fear of abduction	18 (39)
Diseases (sexually transmitted, due to poor hygiene, malaria)	14 (30)
Poor hygiene (latrines, bathing, soap, etc.)	13 (28)
Lack parents	9 (20)
Lack of safe housing/shelter	9 (20)
Males disrupting females/girls staying with soldiers/rape	9 (20)
Lack money (general)	8 (17)
Dropping out of school	7 (15)
Stubborn, don't listen to parents	7 (15)
Fighting	6 (13)
Rude or spoilt (children)	6 (13)
Lack of bedding	6 (13)
Getting married/having children young	5 (11)
Boredom, disinterest, idle	5 (11)
Children sleeping in town	4 (9)
Stealing	4 (9)
Lack of medicines	4 (9)
Lack clean drinking water	3 (7)
Disabled	3 (7)
Roaming camp	3 (7)
Fleeing rebels	3 (7)
Being sent away with relatives	3 (7)
Children who return after abduction are “weird”/difficult	3 (7)

* Problems mentioned by three or more respondents.

KI DATA ANALYSIS

Analysis was limited to syndromes described by multiple KIs as being “common” in the population of Acholi IDP children and adolescents. The authors daily reviewed the description of each of the locally-described syndromes as they appeared in the interview records. In this way the team developed a composite description of each syndrome. In most cases, only symptoms agreed to by at least three or more KIs were retained in the final syndrome descriptions. The choice of three or more KIs was arbitrary but was made by examining patterns in the symptom data (i.e., a majority of symptoms had three or more endorsements).

In some cases, symptoms that represented an important theoretical or contextual issue were retained even if they did not receive multiple endorsements. For example, the symptom of not caring whether one lives or dies was only endorsed twice, but was retained for describing *two tam* given its clinical significance in this context. Several symptoms such as loss of appetite, feeling weak, and not sleeping were shared between one or more syndromes.

RESULTS

FREE LIST DATA

The free listing exercise was conducted among 45 adult and child respondents. Only three adult males were interviewed because we emphasized interviewing child caretakers and few male caretakers were available during the daytime when interviews were conducted. The summary of results (Table 1) reveals a wide range of psychosocial and other problems affecting children in the Gulu and Awer IDP camps. These problems ranged from lack of food, lack of clothing and lack of school fees to concern about the continued insecurity or fear of abduction, rape, children dropping out of school, fighting, being stubborn or disobedient and idleness/disinterest. Selected FL problems related to thinking, feeling or relationships (our functional definition of mental health problems) were used as the foci of the in-depth KI interviews.

KEY INFORMANT INTERVIEWS

Local Syndromes

Upon analysis of the free listing and KI interview data, seven local syndromes or problem clusters were identified. The symptoms and features of five of these locally-described syndromes are listed in Table 2. These include:

TABLE 2
Signs and symptoms for the 5 local mental health syndromes

<i>Two tam</i>	<i>Kumu</i>	<i>Par</i>	<i>Kwo Maraco</i>	<i>Ma Iwor</i>
Lots of thoughts	Loss of appetite	Lots of thoughts	Fights	Clings to elders
Constant worries	Pain in the heart	Wants to be alone	Uses bad language	Thinks has no future
Body pain	Sits with cheek in palm	Easily annoyed	Is disrespectful	Constantly running
Brain isn't functioning	Cries when alone	Holds head	Misbehaves	Does not like noise
Think self is of no use	Does not sleep at night	Loses concentration in class	Drinks alcohol	Fast heart rate
Thinks about suicide	Talks about problems	Drinks alcohol	Loses interest in school	Fears being alone
Talks about problems	Lies down all the time	Thinks about suicide	Disinterested	Loss of appetite
Sits alone	Has lots of worries	Doesn't greet people	Deceitful	Wants to be alone
Loses interest in school	Headaches	Sits alone	A rough person	Does not sleep at night
Headaches	Feels cold	Lots of worries	Uses drugs	Drinks alcohol
Feels sad	Weak	Does not think straight	Disobedient	Doesn't greet people
Does not care if lives or dies	Does not feel like talking	Cannot do anything to help themselves		Thinks people are chasing him/her
Thinks of bad things	Disobedient	Does not trust		
Doesn't feel like talking		Mutters to self		
Forgetful		Insults friends		
Weak		Disobedient		
Cries continuously		Weak		
		Cries continuously		

Two tam was described as a problem of having “lots of thoughts”. In Western diagnostic terms, it has features of mood and anxiety disorders. *Two tam* shares symptoms with the DSM IV definition of Dysthymia (DSM IV-TR; s.300.4) including low self-esteem, poor concentration and feelings of hopelessness. It also includes some of the DSM IV criteria for Major Depressive Disorder, (DSM IV-TR; s.296.3) – depressed mood (being sad or tearful), diminished interest in activities, fatigue, feelings of worthlessness or excessive guilt, diminished ability to think/concentrate, and recurrent thoughts of death or suicide, as well as somatic complaints without medical cause such as headaches and pain all over the body. The symptom of not feeling like talking may indicate social withdrawal or social impairment due to depression. Other symptoms of *two tam* – talking about having problems, and anxiety symptoms including having many thoughts and constant worries, are more suggestive of related anxiety.

Kumu, like *two tam*, has features of mood disorder and anxiety. Informants described it as a problem of experiencing extreme and persistent grief or sadness. Sitting with one’s cheek in the palm and sitting alone were said to be highly characteristic of *kumu*. Both of these behaviors were frequently demonstrated by key informants to demonstrate what a child with *kumu* is like. DSM IV criteria for Major Depressive Disorder (DSM IV-TR; s.296.3) are reflected in the symptoms of depressed mood, crying, decreased appetite, insomnia and fatigue or loss of energy nearly every day. Somatic complaints were again observed as possible expressions of sadness including feeling cold, having headaches and feeling a lot of pain in the heart, as well as lying down all the time and feeling weak. Disobedience and a lack of desire to talk may reflect irritability, which is a feature of depression among adolescents (DSM IV-TR; s.296.3). Like *two tam*, *kumu* includes talking about having problems as well as anxious features such as having many worries.

Par is a third local syndrome with mood and anxiety features. Local informants referred to *par* as a problem of having many worries. It shares a number of symptoms with the DSM IV description of Dysthymia (DSM IV-TR; s.300.4), including depressed mood, poor concentration, and feelings of hopelessness. Some features of Major Depressive Disorder (DSM IV-TR; s.296.3) are present including diminished ability to concentrate as well as recurrent thoughts of death or suicide. There are a number of anti-social features of *par* that may be reflective of adolescent expression of sadness through irritability (i.e. disobedience, insulting friends, being easily annoyed) or through withdrawal and preoccupation (wanting to be alone, not greeting people, and muttering to oneself). The more anxious features of *par* include experiencing many thoughts and worries. *Par* has been identified in one other report on war-affected Acholi people in Pader district issued by Médecins Sans Frontières Holland (MSF-Holland, 2004[DG1]).

Ma Lwor is a local term for an anxiety-like problem of children and young people. *Ma lwor* shares symptoms with DSM IV-TR criteria for Generalized

Anxiety Disorder (DSM IV-TR; s.300.02) including sleep disturbance and excessive anxiety as well as symptoms of increased arousal and restlessness such as a fast heart rate, an aversion to noise, and constantly running around. An aversion to noise, thinking that one is being pursued, and clinging to elders may reflect hyper-arousal and re-experiencing, which are part of the Post Traumatic Stress Disorder Diagnosis/PTSD (DSM IV-TR; s.309.81). On the other hand, thinking that one has no future, wanting to be alone, loss of appetite, drinking alcohol, and not greeting people are mood disorder symptoms suggesting that *Ma lwor*, like *two tam*, *kumu*, and *par*, is a mixed disorder (with mainly anxiety features).

Kwo maracolgin lugero are two local terms used to describe young people who have a bad lifestyle (*kwo maraco*) or are “being rude” (*gin lugero*). *Kwo maracolgin lugero* shares some symptoms with DSM IV-TR criteria for oppositional Defiant Disorder (DSM IV-TR; s.313.81) including actively defying or refusing to comply with adult requests. *Kwo maracolgin lugero* also shares some symptoms with Conduct Disorder (DSM IV-TR; s.312.82) including violating major age-appropriate societal norms or rules including aggressive behavior, such as fighting, that causes or threatens physical harm to others. Further similarities with conduct disorder include deceitfulness, using bad language, drinking alcohol and using drugs (in this case marijuana and the local drug, *jai*). Being a rough person, disrespectful and being disinterested, particularly losing interest in school, all appeared as locally-distinct expressions of *kwo maracolgin lugero* and represent violations of rules and social norms in this setting.

Two other syndromes were also identified. However, unlike the five syndromes above, these were not investigated in detail during the qualitative study. This was either because they did not appear to be common, appeared to reflect environmental stressors rather than true mental health disorders, or because World Vision and War Child did not have the resources to address them in a subsequent intervention.

The first of these was a locally-described psychosis called *cen* said to be caused by spirit possession. *Cen* includes symptoms of extreme aggressiveness, auditory and visual hallucinations and severely impaired reality testing. This disorder was described as being “haunted” particularly by the “spirits of those you have killed” and referred in particular to former combatants who had participated in killing. As such, *cen* was not considered to be a common disorder among the general IDP youth population. An ongoing survey of war-affected males in other districts of northern Uganda found that 5% of the respondents reported being afflicted by *cen* (SWAY, 2006). At the time of this study, although residential care at the World Vision center for former child soldiers was an option, there was no available community treatment model or clinical expertise within World Vision to appropriately serve children identified with this type of violent or psychotic symptoms.

The second syndrome referred to fear of rebel attack and included anxiety and self-protective behaviors due to the ongoing state of insecurity and chronic threat of attack by LRA rebels in the IDP camps. This cluster of problems was not considered a mental health “disorder” since such responses as “fear of leaving the camp to gather firewood” or “fear of rebel attack” are likely to be normal responses to the abnormal circumstance of life in a war zone.

EXISTING INTERVENTIONS

When asked what local people normally do to help children facing these sorts of problems, particularly *two tam*, *kumu*, *par*, and *ma lwor*, local respondents indicated that it is common to “sit with” a child individually or in groups to provide comfort and help a child talk about their problems. For the conduct-like problems of *gin lugero/tic marac*, there was less of a clear sense of what could be done. Multiple key informants indicated that the best solution was for service organizations like World Vision and War Child to come in and set up programs to help such children. These responses indicated little confidence in local resources or practices for addressing conduct-related problems. These findings may also reflect the degree to which social and cultural structures that traditionally provided for the protection and guidance of children have become eroded in this setting of persistent displacement, insecurity and the despair and hopelessness that results.

DISCUSSION

This study had two purposes. The first was to test a qualitative research methodology for use among war-affected children and adolescents. There are few instances of the use of the combination of methods described here among children and adolescents in the existing literature. One prior study used free listing in combination with focused group interviews to study attitudes about reproductive health in teenage boys in the US (Marcell, Raine, & Eyre, 2003). A recent study in Rwanda used a similar version of these methods to study psychosocial support and marginalization of children and adolescents living in youth-headed households in post-conflict Rwanda (Thurman et al., 2006). As in the Rwanda study, this approach appeared to work well among war-affected Acholi youth (aged 10–17 years), as well as with their caretakers. The interviewing methods were well accepted by the respondents in that interviewers reported little difficulty in engaging respondents. Few problems were encountered in the interviewing process. The greatest challenges related to scheduling and the

degree to which participants were able to keep appointments for return visits (should they be busy upon first contact) due to digging (harvesting their garden plots, which were often outside the IDP camp). Records of child interviews using this methodology were of comparable detail and length to those among adults, both for the caretakers interviewed in this study and in previous studies of adults using the same approach (Bolton, 2001; Wilk & Bolton, 2002).

Our second purpose was to explore local concepts of mental illness. This study identified seven mental health syndromes among children aged 10–17 years living in displaced persons camps in northern Uganda. Of these, we explored five syndromes in detail because they appeared to be common, severe, reflective of mental health problems (rather than appropriate responses to a difficult situation) and potentially treatable using resources available to existing service providers. The types of problems revealed are not surprising in this population of children exposed to displacement, loss due to war as well and the day-to-day adversity that characterizes life in the overcrowded IDP camps of Gulu District. In the diagnostic terms of current psychiatric nosology, these five syndromes can be divided into two broad categories: anxiety/depression-like disorders (*two tam*, *kumu* and *par* which have more depression-like features, and *ma lwor* which has more anxiety features) and conduct problems (*kwo maraco/gin lugero*). Many of the symptoms of these local syndromes are identical to those of psychiatric disorders of mood, anxiety and conduct problems. For mood disorders, symptoms shared with psychiatric diagnoses included depressed mood, diminished interest in activities, fatigue, feelings of worthlessness or excessive guilt, inability to diminished ability to think/concentrate, and recurrent thoughts of death or suicide. For anxiety problems, shared symptoms included increased arousal and restlessness including having a fast heart rate and constantly running around. For conduct problems similar symptoms included aggressive behavior that causes or threatens physical harm to others such as fighting as well as associated symptoms of deceitfulness, using bad language, drinking alcohol and using drugs.

Culturally specific symptoms also emerged. For example, “sitting *kumu*” (sitting while holding one’s cheek in their hand) and not greeting people were described as symptoms of the locally derived mood disorder *kumu*. Not greeting people was also an important sign of both *par* and *ma lwor*. In the Acholi culture, to not extend a kind greeting to others you encounter is offensive and an important indicator of distress. Such important local idioms of distress would not be captured without investigating these issues using qualitative methods. Yet, these symptoms may well be important manifestations of mental health symptoms. In much of Europe or North

America, cheek in palm is a bodily idiom for sadness and perhaps lack of hope or energy, whereas not greeting people may be interpreted as reflecting preoccupation or withdrawal.

Although the locally-described syndromes of *two tam*, *kumu* and *par* are similar to one another, there are significant differences. For example, suicidal ideation or feeling that life is not worth living is a feature of *two tam*. *Par* contains the symptom of thinking of suicide, but has more anti-social features such as disobedience, drinking alcohol and not greeting people. *Kumu* in comparison consists of less severe items, bearing more similarity to dysthymia characterized by persistent depressed mood than to Major Depression. Somatic complaints with no known medical cause were also observed across these three local depression-like syndromes resonating with other research on the importance somatic complaints as signs of distress in refugees (Eisenbruch, 1991; Kinzie et al., 1986)

While mood and anxiety problems emerged as important issues in the study, conduct problems were equally salient. Conduct problems were frequently mentioned in the free list interviews and included sexual violence or high risk of sexual activity (20%), dropping out of school, (15%) being stubborn (15%), rude or spoiled (13%) and fighting (13%). These conduct problems deserve attention in that they also represent high-risk behaviors. They should also be seen in the context of a larger social breakdown which was vividly described in the free list and key informant interviews: adults struggling with their own despair, loss and subsequent mental health problems as well as alcohol abuse and extreme poverty. As a result, young people in the camp are not monitored closely and there is a great deal of opportunity for young people to be involved in more negative survival strategies such as trading sex for food, shelter or protection as well as antisocial behavior representing the other side of this exploitative equation such as sexual violence.

Our intent subsequent to this study was to use the resulting data to develop and test instruments to quantitatively assess the problems identified here. While there are many similarities between the local syndromes that emerged from this study and psychiatric mood, anxiety and conduct disorders, we also found enough differences in terms of how symptoms are expressed to suggest that simply translating existing mainstream psychiatric instruments to assess emotional and behavioral problems in this population would be insufficient. As a result, we later used the qualitative data to develop and validate a locally-relevant scale of emotional and behavioral problems reflecting these five syndromes (Betancourt et al., 2009). This same instrument was eventually used to screen young people into a trial of mental health interventions for the problems that emerged from the qualitative study (Bolton et al., 2007).

LIMITATIONS

The methods presented here involve the use of only two qualitative methods of data collection, despite a wide variety of methods available. Our intent in using only two methods was to develop a rapid approach that would be feasible for use by service providers in planning their programs. By limiting the approach to two methods we were able to complete training and data collection in two weeks. Under circumstances of increased time and resources, additional methods would provide greater depth and increased data triangulation.

Our methods relied on handwritten field notes written in Acholi by pairs of interviewers and later translated into English by these same interviewers. We did not use tape recorders because of the privacy concerns (the possibility of recognizing voices if the tapes are lost) and the length of time and resources it would take to transcribe interviews. While the use of interviewing pairs (who both take notes and combine these notes into a single record) is meant to improve accuracy, this is unlikely to reach the level of accuracy of transcribed recordings. Also, while the interviewers are bilingual, they are not professional translators. Therefore, the quality of their translation, even when working together, is likely to be less than that of a professional.

Finally, the decision to focus the key informant interviews only on the five problems that were likely to be addressed by the service provider constitutes a limitation in the data. For programmatic reasons we decided not to explore the local disorder *cen*. However, this is clearly a severe disorder that would warrant further research. Such information would be critical for informing additional models of intervention, particularly should current peace negotiations result in an end to the current situation of insecurity.

CONCLUSION

The research presented here demonstrates that a rapid ethnographic assessment method can be applied to describe and explore local perceptions of mental health problems among Acholi children displaced by war in northern Uganda. Our impression is that the approach proved suitable for use with children, given that the interviewers reported few difficulties and that both children and adults were able to provide useful information on the mental health problems affecting Acholi children and adolescents in the IDP camps from a local perspective. Several locally defined syndromes similar to mood, anxiety and conduct disorders in current psychiatric nosology were identified along with a number of culture-specific symptoms. The research addressed an immediate mental health

services need by providing contextual information on how local Acholi IDP youth and their caregivers think about mental health problems. The findings will inform subsequent assessment and intervention efforts to improve services for these war-affected youth.

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NOTE

1. While War Child supported the study, their staff was not involved in the study.

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