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Psychological Trauma: Theory, Research, Practice, and Policy

Posttraumatic Stress Disorder, Anxiety and Depression Symptoms, and Psychosocial Treatment Needs in Colombians Internally Displaced by Armed Conflict: A Mixed-Method Evaluation

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Posttraumatic Stress Disorder, Anxiety and Depression Symptoms, and Psychosocial Treatment Needs in Colombians Internally Displaced by Armed Conflict: A Mixed-Method Evaluation

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Armed conflict in Colombia has resulted in the displacement of an estimated 4.5 million people, or about 10% of the Colombian population. Hundreds of thousands of Colombians are exposed to violence and forced displacement annually. The present study used survey methods to assess levels of posttraumatic stress disorder (PTSD), depression, and anxiety symptoms in a convenience sample of 109 internally displaced adults residing in Medellín, Colombia. A qualitative approach including an open-ended survey and focus groups with a subsample of 44 survey respondents was used to gain a better understanding of mental health treatment needs. A large proportion of survey respondents exceeded cut-scores for clinically significant PTSD (88%), anxiety (59%), and depression (41%). Multivariate regression models showed that female gender was a significant predictor of higher PTSD symptom levels and that female gender, higher education, and being separated as opposed to married predicted higher levels of depression symptoms. Focus group findings suggest that participants are interested in specialized psychological treatments as well as broader psychosocial interventions to treat the consequences of exposure to violence and forced displacement.

Keywords: PTSD, internally displaced people, armed conflict, cross-cultural psychiatry, Colombia

Globally, civilian populations are the primary victims of armed conflicts between and across national borders. Forced displacement of civilians within the borders of their country is an all too common result of armed conflict. Colombia is the only country in the Western hemisphere where internal displacement of the civilian population continues to occur on a massive scale. In Colombia, guerrilla, paramilitary, and government forces fight for territory in a complex struggle involving drug lords and other parties interested in Colombia's valuable natural resources. Over the last four decades, this conflict has resulted in the displacement of an estimated 4.5 million people, or about 10% of the Colombian population (Internal Displacement Monitoring Centre, 2009). According to both government and nongovernmental organization (NGO) sources, between 200,000 and 400,000 individuals were forcefully

displaced annually between 2001 and 2005, and there is no evidence of decrease in rates at this time.

Internally displaced people do not benefit from the same statutes that protect and assist refugees. As such, it is the responsibility of the national government to protect and assist internally displaced people. Despite progress in legislation protecting internally displaced Colombians, access to basic resources such as food, shelter, education, and medical care has remained poor. Access to mental health treatment is virtually nonexistent (Mogollón-Pérez & Vázquez, 2008; Mogollón Pérez & Vázquez Navarrete, 2006).

It is imperative to understand the nature of the psychological distress of internally displaced people to develop appropriate evidence-based interventions. Although prevalence rates vary widely between studies, PTSD and depression appear to affect a significant number of individuals exposed to armed conflict and displacement (Steel et al., 2009). There are data supporting high rates of general anxiety and depression symptoms in internally displaced people in Colombia (Caceres, Izquierdo, Mantilla, Jara, Velandia, 2002; Puertas, Rios, & del Valle, 2006). There is also preliminary evidence of high rates of PTSD in civilians directly affected by the armed conflict (Pineda, Guerrero, Pinilla, & Estupiñán, 2002; Sistiva-Castro & Sabatier, 2005).

To develop appropriate and acceptable interventions, it is also imperative to understand whether internally displaced people are interested in treatment for depression, general anxiety, PTSD, or

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other psychosocial sequelae of violence and displacement. There has been considerable debate about whether Western diagnostic constructs and symptoms reflect distress experiences that are recognized and prioritized by non-U.S. and non-European individuals as deserving of treatment. Diagnosing PTSD and implementing “trauma-focused” treatments have been particularly targeted as potentially inappropriate in non-U.S. and non-European populations (Bracken, Giller, & Summerfield, 1995; Bryant & Njenga, 2006; Johnson & Thompson, 2008; Summerfield, 1999). Opponents to the wide-spread application of trauma-focused treatments argue that the focus on PTSD symptoms and their treatment represents an ethnocentric mentality that unnecessarily “medicalizes” distress and distracts from a more appropriate focus on recovery at the level of the social network (Miller, Kulkarni, & Kushner, 2006). An alternative perspective is that evidence-based trauma-focused therapies should be provided whenever possible to individuals who endorse trauma-related psychological symptoms, consider them germane to their experience, and consider them a priority for treatment.

Catering to individual treatment needs also requires identifying differences in trauma response among different demographic subgroups (U.S. Department of Health and Human Services [DHHS], 2001). Research in the U.S. demonstrates that women may be more at risk of PTSD, depression, and anxiety than men (Brewin, Andrews, & Valentine, 2000; Kessler et al., 2005; Tolin & Foa, 2006). Findings from large epidemiological samples across Latin America and in Colombia also suggest that women experience higher rates of anxiety, depression, and PTSD than men do (Kohn & Rodríguez, 2009; Posada-Villa, Aguilar-Gaxiola, & Deeb-Sossa, 2009).

Differences between racial and ethnic subgroups have not been closely studied in Colombia. The lack of attention to ethnicity and racial differences in health status is reflected in the Colombian census, which did not include a comprehensive assessment of race and ethnicity in its population estimates between 1912 and 2005. Research in U.S. populations has provided mixed findings regarding differences in rates of mood and anxiety disorders between Caucasians and minority groups (DHHS, 2001). Researchers who have identified differences have proposed a range of factors that could account for them, including differences in exposure rates, socioeconomic status, social and cultural factors, and perceived discrimination (DHHS, 2001; Hunter & Schmidt, 2010; Pole, Best, Metzler, & Marmar, 2005; Pole, Gone, & Kulkarni, 2008). The U.S. Central Intelligence Agency has compiled a demographic profile for Colombia which indicates that mestizos, who are primarily of Amerindian and White European descent, comprise about 58% of the Colombian population, individuals with Afro-Colombian ancestry comprise about 20% of the population, European Whites comprise about 20% of the population, and Amerindians comprise about 2% of the population (Central Intelligence Agency, 2009). Despite the paucity of attention to race and ethnic differences in health outcome, there is ample evidence that darker skin and membership of Afro-Colombian and Amerindian heritage is associated with greater economic, political and social marginalization, either as a result of racial discrimination or due to greater representation in rural areas that are most exposed to violence and least protected by federal law (Wade, 1995). In line with this, Amerindians and Afro-Colombians are at increased risk of forced displacement (Departamento Administrativo Nacional de

Estadísticas, 2007). It is not known how ethnoracial status contributes to differences in health outcomes in Colombians affected by the armed conflict. Identifying such differences, should they exist, is crucial for developing appropriate and acceptable evidence-based treatment interventions.

Present Research

The goals of the present study are twofold. The first is to determine levels of PTSD, depression and anxiety symptoms, and the demographic correlates of these symptoms in a heterogeneous sample of internally displaced adults residing in Medellín, Colombia. An additional goal is to gain a better understanding of the types of interventions acceptable to this subset of internally displaced Colombians for the treatment of mental health problems associated with violence and forced displacement.

Method

Participants

One hundred nine participants were recruited at the Unidad de Atención y Orientación a la Población Desplazada (UAO) in Medellín, Colombia. The UAO is the service center to which internally displaced people in Medellín must present to obtain access to government-funded health care. It is also their official resource for food and shelter support and for information and referrals to health, legal, and human rights services. At the time of data collection, the center was co-administered by an NGO and the city government of Medellín. Internally displaced people who report their status as such are referred to this center by city officials and/or via word-of-mouth. The study group was a sample of convenience recruited at UAO orientation meetings, which all new service-seekers at the UAO are required to attend. Seven such meetings took place over a 3-week period in May and June of 2008. Individuals 18 years or older were invited to participate. Although the percentage of those invited who agreed to participate is unknown, the rapidity of recruitment indicated that the majority of invitees chose to enroll in the study.

Procedure

After informed consent procedures, participants completed a brief demographics questionnaire and self-report questionnaires assessing PTSD, depression, and anxiety symptoms. They also completed a questionnaire about the relevance of the PTSD questionnaire to their experience. Illiterate individuals and those requesting assistance completed all questionnaires with the help of research staff. Participants in the survey segment of the study were invited to participate in the second component of the study, consisting of focus groups. Seven focus groups were created. Groups were formed along gender and ethnoracial status lines based on the researchers' interest in understanding how violence and displacement experiences might differ between men and women and Afro-Colombians and mestizos (discussed elsewhere). Ethnoracial status was determined by participants' self-identification as “Afro-Colombian,” “mestizo,” or “other.” Given the low representation of indigenous individuals in Medellín, this category was not identified separately. Only two individuals self-identified as “other.” Forty-four individuals participated in focus

groups. Not all participants in the survey segment of the study participated in the focus groups, primarily due to group size limitations, and all participants in the surveys were invited until the focus group size limitations were met (eight participants maximum). Focus groups were conducted at the university hospital of the University of Antioquia, in the Department of Psychiatry. Focus groups were conducted by the co-Principal Investigator (PI), who is from the United States and proficient in Spanish, and a Colombian psychologist from the University of Antioquia with several years' experience working with victims of the armed conflict in Colombia.

The focus groups consisted of discussions about the effects of displacement and its precipitants on internally displaced people. The participants were informed that there was no obligation to talk about their particular experience but that we would like them to talk about what they observe in their families and other internally displaced people they know. The goal in utilizing this approach was to gather information about the experience and treatment needs of internally displaced people without participants feeling threatened or overly exposed. After an open-ended discussion of the mental health consequences of displacement, participants were asked "To whom would you go, or to whom would you refer a friend or a family member, who is suffering from some of the problems you have discussed so far?" After an open-ended discussion, participants were asked more specifically whether they thought internally displaced people would be interested in and could benefit from various forms of psychoeducation and treatment, including treatment with a psychologist or psychiatrist, psychoeducational materials, video and/or radio presentations, and Internet-based psychoeducation and treatments. The list of treatments proposed was developed over the course of the study based on suggestions made by group members in prior groups.

Measures

Demographic information. Prior to completing the mental health assessments, participants completed a brief demographic survey. Variables included age, gender, marital status, ethnoracial status, educational attainment, time since arrival in Medellín, and current employment status. Marital status categories included married, divorced, widowed, single, and domestic partnership, the latter being a very common arrangement in Colombia.

PTSD. We used a 24-item checklist developed and validated by Colombian investigators Pineda et al. for the assessment of PTSD (Pineda et al., 2002). The authors validated the questionnaire using SCID-I semi-structured clinical interviews (First, Spitzer, Williams, & Gibbon, 1999) in a Colombian town population that had been partially destroyed by a guerrilla attack. Distinct from the PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993), the items in this checklist were written in Colombian Spanish to reflect the criteria for PTSD as described in the standard Spanish language version of the *DSM-IV-TR* (American Psychiatric Association, 2002). Thus, the first two items reflect criteria A1 and A2, items 3–7 reflect the cluster B criteria, items 8–14 the cluster C criteria, items 15–19 the cluster D criteria, and items 20a–20d reflect impairment in occupational and social functioning. A subject's level of endorsement for each stated experience or symptom is indicated on a 4-point Likert-type scale. In a validation study, a cut-off score of 51 was associated with

76.3% sensitivity, 84.4% specificity, 74.4% positive predictive value, and 85.7% negative predictive value for the diagnosis of PTSD (Pineda et al., 2002). Cronbach's alpha was 0.91 for the current sample, indicating high internal consistency.

Anxiety symptoms. The Zung Anxiety Scale was utilized to assess levels of anxiety symptoms (Zung, 1971). This measure has been used by the World Health Organization in global health research and was previously utilized in a large epidemiological study of general health in internally displaced people in Colombia (Caceres et al., 2002). The Zung Anxiety Scale consists of 20 items reflecting common symptoms of anxiety, including numerous somatic symptoms often accompanying anxiety. This scale measures symptomatology using a 4-point Likert-type scale indicating frequency at which subjects experience the symptom described in each item. Scores between 45 and 59 reflect mild to moderate levels of anxiety, scores above 60 generally reflect marked and severe anxiety, and scores above 75 reflect extreme levels of anxiety.

Depression symptoms. The Zung Depression Scale, which consists of 20 items reflecting common symptoms of depression (Zung, 1965), was utilized to evaluate participants for depression. It has been used and validated in Colombian Spanish-speaking populations (Caceres et al., 2002; Díaz, Campo, Rueda, & Barros, 2005). As with the Zung Anxiety Scale, it measures symptoms on a 4-point Likert-type scale. Based on the original validation study, scores of 50 or greater were associated with clinically significant depression. Scores between 50 and 59 are generally understood to represent mild depression, scores between 60 and 69 moderate depression, and scores 70 and above severe depression.

Relevance of PTSD survey to participant experience. In order to gauge the relevance of the PTSD checklist symptoms to the participants' experience, the researchers developed a PTSD Checklist Relevance questionnaire asking participants whether the PTSD checklist they completed was "highly relevant" to their lived experience. Participants were given space to elaborate on their yes/no response. The meaning of "highly relevant" was left open to participant interpretation. Responses were expected to indicate whether the PTSD checklist described experiences that were germane to participants' psychological response to violence and displacement, and as such, whether they might deserve clinical attention. The questionnaire also asked whether any of the checklist items were difficult to understand, because failure to understand questionnaire items would jeopardize the potential relevance of the survey.

Analytic Approach

SPSS for Windows, version 16.0, was utilized to calculate symptom levels, bivariate correlations between symptom levels and demographic factors, and regression analyses. Open-ended responses on the PTSD Checklist Relevance questionnaire were reviewed, and the range of responses were coded and then grouped into smaller categories for presentation. For the purposes of this study, focus group analysis was restricted to the final segment of the focus groups, in which participants described and discussed subjective treatment needs. Nvivo statistical software was utilized to organize the transcribed material and to assign and manage codes and categories. The analytic approach involved five major steps which were conducted by the co-Principal Investigator based

on methods recommended by Miles and Huberman (1994) for single coders and by Creswell (2007) for the general analytic approach. First, the transcripts were read and reread to obtain a gestalt understanding of the material. Second, two major categories of statements that reflected focus group material and the researchers' primary areas of interest were identified. These categories included (a) statements in which participants suggested types of interventions or gave their opinion about interventions suggested by the group leaders and (b) statements in which participants described the purpose or mechanism of action of an intervention. The third step involved sentence-by-sentence review of the transcripts and assignment of codes to the data. This step involved three passes through the transcripts to ensure that relevant information was coded. In the fourth step, related codes were merged into a smaller yet representative set of themes. These themes were then assigned to the above-mentioned categories for presentation.

Results

The demographic characteristics of the full sample of 109 participants are summarized in Table 1. The vast majority (84%) of participants self-identified as mestizo, whereas 21% self-identified

Table 1
Demographic Characteristics and PTSD, Anxiety, and Depression Scores in the Sample (n = 109)

Age (years; <i>M</i> [<i>SD</i>])	37.81 (14.3)
Gender (<i>n</i> [%])	
Male	44 (40.4)
Female	65 (59.6)
Ethnoracial status (<i>n</i> [%])	
Mestizo	84 (77.1)
Afro-Colombian	23 (21.1)
Other	2 (1.8)
Marital status (<i>n</i> [%])	
Married	19 (17.4)
Single	30 (27.5)
Domestic partner	35 (32.1)
Separated	13 (11.9)
Widowed	9 (8.3)
Missing data	3 (2.8)
Educational attainment (<i>n</i> [%])	
No formal education	14 (12.8)
Some or all primary school	47 (43.2)
Some or all secondary school	37 (34.0)
Some university training	2 (1.8)
Missing data	9 (8.3)
Employment status (<i>n</i> [%])	
Employed	5 (4.6)
Unemployed	104 (95.4)
Time since displacement (<i>n</i> [%])	
Less than 1 month	41 (37.7)
More than 1 month but less than 1 year	39 (35.8)
More than 1 year	24 (22.0)
Missing data	5 (4.6)
PTSD Checklist score (<i>M</i> [<i>SD</i>])*	68.9 (14.3)
Exceed diagnostic cut-off (<i>n</i> [%])*	91 (88.3)
Zung Anxiety Scale score (<i>M</i> [<i>SD</i>])	47.7 (8.2)
Exceed diagnostic cut-off (<i>n</i> [%])	65 (59.5)
Zung Depression Scale score (<i>M</i> [<i>SD</i>])	48.5 (9.0)
Exceed diagnostic cut-off (<i>n</i> [%])	45 (41.3)

* *N* = 103.

as Afro-Colombian. There were more women than men in the sample, and most participants reported being either single, in a domestic partnership, or married. Educational attainment was fairly low with the majority reporting either no formal education or some primary school education.

PTSD

Surveys of three participants were eliminated because they did not endorse a recent criterion A1 event. Surveys of three additional participants were eliminated when calculating the total PTSD checklist score because of missing data. Of the remaining 103 subjects, 91 (88.3%) exceeded the cut-off score for a PTSD diagnosis. The mean PTSD checklist score for these 103 subjects was 68.9 (*SD* = 14.3), comparable to the mean score of 70.4 (*SD* = 22.9) reported by Pineda and colleagues in patients with PTSD as diagnosed by SCID interview (Pineda et al., 2002). Eighty-four (81.6%) reported impairment in relationship and/or occupational functioning. When the PTSD checklist responses were analyzed by symptom clusters, 61 (59.2%) of 103 participants met full symptom criteria (fulfilled clusters A, B, C, and D) and also endorsed impairment in relationship and/or occupational functioning.

Female gender was a significant correlate of higher PTSD checklist score after controlling for other demographic variables, including age, ethnoracial status, marital status, highest education grade, employment status, and time since arrival in Medellín ($B = 9.00$, $\beta = .30$, $t = 2.46$, $p = .016$). No other demographic variables, including ethnoracial status, were significantly correlated with PTSD scores. When the sample was divided into groups by time since arrival in Medellín, we found no significant difference in PTSD checklist scores between individuals reporting being displaced less than a month, more than a month but less than 1 year, and 1 year or more prior to study evaluation.

Anxiety Symptoms

The mean score for the Zung Anxiety Scale was 47.69 (*SD* = 8.21). This reflects a mild to moderate level of anxiety on average. Fifty-nine participants (54.1%) fell into the mild to moderate range, whereas six participants (5.4%) reported symptoms consistent with severe anxiety. Although the group as a whole only reported mild-to-moderate levels of general anxiety symptoms, a significant proportion reported that anxiety symptoms resulted in social and/or occupational impairment. In fact, 74 respondents (67%) reported that anxiety symptoms resulted in at least some impairment in relationship functioning, and 78 respondents (71.6%) reported that anxiety symptoms impaired their ability to work or to look for work. No demographic variables, including gender and ethnoracial status, were significant predictors of Zung anxiety scores.

Depression Symptoms

The mean score for the Zung Depression Scale was 48.54 (*SD* = 9.02), which falls short of the threshold of 50 which indicates clinically relevant depression. However, 45 participants (41%) scored above 50, among whom 34 participants (31%) had scores consistent with mild depression, 10 (9%) had scores consistent with moderate depression, and one individual reported symptoms

suggestive of severe depression. Furthermore, 67 respondents (61.5%) reported at least some impairment in relationship functioning because of their symptoms, and 78 subjects (71.6%) reported at least some impairment in their ability to work or look for a job as a result of their depression symptoms.

Analysis of the demographic predictors of Zung depression scores showed that female gender ($B = 6.12, \beta = .34, t = 3.06, p = .003$), higher education ($B = .67, \beta = .27, t = 2.28, p = .025$), and being separated as opposed to married ($B = 8.31, \beta = .29, t = 2.28, p = .025$) were significant predictors of higher depression score in a regression model including other demographic variables. The relationship between depression score and Afro-Colombian, as opposed to mestizo, ethnoracial status nearly reached significance when controlling for the other aforementioned demographic variables ($B = 4.74, \beta = .20, t = 1.92, p = .058$).

PTSD Checklist Relevance

Out of 109 total participants, 92 (84%) reported that the PTSD checklist was not difficult to understand, whereas 17 (16%) reported that one or more questions were difficult to understand. None of the participants expanded on their yes/no response. When asked if the PTSD checklist was highly relevant to their personal experience 94 respondents (86%) responded “yes,” 9 (8.5%) responded “no,” and 6 (5.5%) did not respond to this item. Fifty-three respondents (48.6%) either wrote or dictated a narrative explaining why they thought the questionnaire was or was not highly relevant to their life experience. By far, the most common explanation for participants’ endorsement of the questionnaire as highly relevant was that the items closely described their experiences, both physical and emotional (stated by 36 respondents). Six respondents provided a detailed description of personal experiences of threats and violence. Seven participants stated with less detail that the questionnaire items reflected their overall experience of violence or the disruption in their lives resulting from displacement. Eleven participants described specific symptoms they were experiencing, including avoidance of memories of upsetting events, hypervigilance, hyperactive startle reactions, fear and anxiety, and persistent painful memories. Seven participants

described a feeling of pervasive sadness that would not go away as well as expectation that they would never forget certain experiences. Five participants requested psychological support and/or alluded to wanting to help others in a similar condition.

Psychosocial Treatment Needs as Identified in Focus Groups

Results from focus groups were indicative that internally displaced Colombians in Medellín who seek services at the UAO recommend treatment intervention for mental health problems resulting from armed conflict and displacement. The most common spontaneously recommended resource in all focus groups was a psychologist. The most common recommendation other than speaking with a psychologist was that of group gatherings (“reuniones” as described by focus group members in Spanish). These gatherings would range from more structured forums in which a leader would provide psychoeducation and guidance to informal social gatherings for displaced individuals organized by institutions like the UAO. Group members also recommended other potentially useful interventions and/or resources, including psychoeducational material in books, videos, pamphlets, or through TV and radio programs. More sparsely represented ideas included massage, evaluation by medical professionals to make sure nothing was physically wrong, and talking to priests.

Models of Intervention as Described by Focus Group Participants

With the goal of gaining a better understanding of what models of therapeutic intervention would be acceptable to internally displaced Colombians, we identified statements in which the purpose and/or mechanism of the intervention was described. From 161 statements, 31 codes initially emerged. These were then narrowed down into nine broader codes, or themes, described in Table 2. The most common theme by far describes the therapeutic intervention in terms consistent with a supportive type of therapy. In most cases, participants were referring to an in-person therapy or group therapeutic activity. The intervention would primarily provide a forum for being listened to, for venting, for feeling understood and

Table 2
Categories Describing Models of Therapeutic Intervention Suggested by Group Participants

Category	Category description
Supportive therapy	Forum for being listened to, understood, encouraged—either with a trained professional or in a group setting
Cognitive-behavioral or behavioral therapy	Skilled professional who guides person to assimilate and/or forget traumatic experiences and/or learn skills to relieve symptoms
Recreation and distraction	Activities that distract individuals from daily stressors, distressing thoughts and memories, and allow them to relax
Community building	Activities that decrease sense of loneliness, experiences of discrimination, and create sense of belonging and of community
Material support	Intervention addresses material needs and provides job training
Drug treatment	Treatment of mental health symptoms by a medical professional
Psychoeducation	Psychoeducation using TV, radio, video, and/or written material
Role recovery	Intervention that provides specific guidance in rebuilding one’s life: through occupational training and developing “proyecto de vida”
Outreach	Intervention accesses distressed individuals who don’t seek treatment due to stigma or other barriers

valued, for regaining morale and hope, or in the words of one participant, to get grounded.

Several participants specifically assigned the task of healing to a professional trained to address psychological issues. Within that framework, several participants described what they thought the mechanism for healing by a trained professional would be. For example, one participant emphasized the importance of “detoxifying” one’s mind and “assimilating” past events so that they would lose their psychological impact, an understanding rather aligned with trauma-focused cognitive-behavioral approaches. He said, “With regard to all we’ve talked about, to detoxify the mind, the most appropriate person is a psychologist, to help one assimilate things. . . .As I was saying before, one doesn’t forget; the events just lose their impact.” Other participants described the therapy as a means to “clear one’s head” of distressing thoughts and experiences, in some cases with the goal of essentially forgetting the distressing events that had occurred. Several participants spoke of the role of the skilled professional as prescribing activities or behaviors they could engage in to alleviate particular symptoms, somewhat similar to a more behavioral approach.

Several participants suggested that interventions involving distraction and recreation would allow individuals to forget their daily stressors, distract them from distressing thoughts and memories, and allow them to relax. For example, one individual stated:

“The worst is to have an idle mind and not have anything to do. . . . The only thing I can do is to start thinking about the memories that I still have, and those are bad memories. Because in those memories is everything I went through with the people I loved who are no longer alive. . . .”

Organized recreational and social activities were also described as therapeutic because they would create opportunities to share psychoeducational knowledge and practical survival tips. Perhaps most importantly, group members stated these activities would decrease the sense of being alone, of being ostracized, and would enable displaced individuals to develop a sense of community. For example, one participant stated, “[It would be nice to convene in a place] and hang out with people like me. So as not to feel so. . . insignificant. . . . Because here one really feels looked down upon.” In line with this, some expressed comfort and enthusiasm at the idea of belonging to a community of displaced people.

“Let’s say, I think that we’re, that we’re, that we’re not of say Afro-Colombian culture, or indigenous culture, nor. . . .one could say that our culture is that of the displaced, this would be like our region. There’s a displaced person, I’m a displaced person. He’s no longer Black, I’m not Black, that guy isn’t either—we’re all displaced people.”

Another member expressed the increase in trust and ability to share when in the company of people with similar experiences. He said, “Things change immediately with a group, that is, people who’ve been through the same as you. Trust—that changes—people feel less inhibited about talking about things.” This phenomenon was made manifest during the focus group themselves. A large percentage of members of all groups spontaneously expressed a sense of relief, a feeling of being supported, and gratitude for being listened to, during the focus groups.

The importance of material support was also emphasized by group participants. One woman emphasized that emotional and occupational support need to go hand-in-hand, as “venting” would be of limited utility if one’s family’s basic needs were unmet.

Many individuals emphasized the importance of occupational training as a distraction from traumatic memories as well as a means to rebuild one’s life in a completely new environment for which most displaced people have not been prepared. They also described this as a way to relieve the feelings of shame related to handouts and being treated like invalids. This participant’s statement was endorsed by many: “What I want is for nobody to be giving me food because I can earn it on my own. Because. . . .because getting handouts makes you look and feel like an invalid.”

Several interventions, primarily therapies and psychoeducational interventions through various media, were described as useful in that they would help individuals gain a better understanding of their emotional experiences and would help them to find solutions to their problems. Although rarely mentioned, some participants suggested drug treatment to relieve symptoms such as insomnia and anxiety.

Group members also gave their opinion on Internet-based treatment programs, a form of intervention of interest to the group leaders. The responses ranged from enthusiasm about this approach to concern about limited access due to financial constraints, technical skill, and illiteracy. However, several participants endorsed enthusiasm for programs that would combine literacy and technical training with a psychotherapeutic component.

Finally, several individuals suggested the importance of outreach to internally displaced people. Although participants identified stigma as the primary indication for outreach interventions, a range of barriers emerged as additional themes in focus group discussions. The impediments to accessing psychological support fell into four major categories: stigma or fear of being labeled as “crazy;” lack of care provider time to provide adequate services; fear of discovery when revealing one’s personal experiences; and lack of access and technical ability to utilize services. The fear of stigma was primarily associated with seeing a psychiatrist; however, seeing any mental health provider was considered stigmatizing by some. For example, one participant said, “Someone might say to another person—‘hey, let’s see a psychologist.’ [The response would be:] ‘Me? What am I going to see a psychologist for? You think I’m crazy?’” One individual who felt strongly that displaced individuals should be obligated to attend meetings with psychologists stated, “People are ignorant because they don’t have access to the information. That’s why they’re afraid, that’s why they run away from the people who can empower and help them.”

Discussion

Our findings demonstrate high levels of PTSD, depression, and anxiety symptoms in the sample. Findings from a systematic meta-analysis of PTSD and depression in populations affected by armed conflict indicate that nonrepresentative samples, smaller sample size, and assessments using self-report measures are methodological factors which contribute to elevated rates of PTSD and depression (Steel et al., 2009). These three factors likely affected the elevated scores in this study. However, the meta-analysis also identified substantive factors that contribute to high rates of depression and/or PTSD, including degree of exposure to violence, experiences of torture, a source conflict that is ongoing, the general state of politically motivated violence in the country, and displacement. Although we do not have measures assessing the former two

variables, all internally displaced Colombians are exposed to the latter three predictors. These factors may very well contribute to the elevated symptom reports in the sample. The fact that 88% of the sample scored higher than the cut-off score for PTSD and 59% met full criteria for PTSD based on analysis by symptom clusters provides reason for concern and indicates a need for further evaluation.

Other studies have demonstrated that social and economic factors, including social isolation and unemployment, contribute to mental distress in survivors of mass conflict and displacement (Johnson & Thompson, 2008; Roberts, Damundu, Lomoro, & Sondorp, 2009; Roberts, Ocaka, Brown, Oyok, & Sondorp, 2008). Although we did not formally assess social support, the focus group discussions provide evidence that such support was lacking and that this might contribute to elevated symptom levels. Because unemployment characterized the occupational status of the vast majority of participants we could not detect an effect, but it is possible that this also contributed to high symptom levels. With respect to marital status, several studies in the U.S. and abroad indicate that being married is a protective factor for mental illness (Roberts et al., 2008). Consistent with this, we found that being separated as opposed to married was a predictor of higher depression scores.

Finally, although high rates of acute stress or posttraumatic stress symptoms might be considered normal shortly after displacement, and do not necessarily predict future or persistent PTSD (Bryant, Creamer, O'Donnell, Silove, & McFarlane, 2008), we did not find any difference in symptom levels between individuals displaced more than a year compared to individuals displaced less than a year prior to the evaluation.

On the whole, the data suggest that participants experienced higher levels of clinically significant PTSD symptoms as compared to depression and anxiety symptoms. The vast majority (88%) of participants exceeded the diagnostic cut-off score for PTSD, with a mean score far exceeding that cut-off score. In contrast, the mean depression score fell just short of the cut-off for clinical significance and the mean anxiety score just surpassed the level of clinical significance. This finding may be explained by the greater degree of specificity of PTSD for the nature of distress experienced by individuals affected by trauma. Responses to the open-ended PTSD Checklist Relevance questionnaire indicate that participants experienced a number of symptoms that are specific to PTSD, including hypervigilance and hyperactive startle reactions. Nonetheless, that 41% of the sample scored in the range of clinically significant depression and that 59% of participants endorsed clinically significant levels of anxiety suggest that these categories of mental illness are also worthy of attention.

The higher levels of PTSD and depression symptoms among women in this sample support the literature indicating that worldwide, civilian women are at greater risk of developing PTSD than men. Research on populations affected by armed conflict and displacement also demonstrates such a gender difference in levels of psychiatric distress (Caceres et al., 2002; Johnson & Thompson, 2008; Ranasinghe & Levy, 2007; Roberts et al., 2009; Roberts et al., 2008). Although the basis for such differences is not clear, greater peritraumatic emotionality in civilian women is a potential explanation for gender differences in PTSD (Lilly, Pole, Best, Metzler, & Marmar, 2009). It has also been suggested that men may express distress through higher levels of somatization, higher

levels of substance abuse, and higher levels of externalizing behavioral disorders (Kessler et al., 2005; Lilly et al., 2009). Twelve of the 20 items in the Zung Anxiety questionnaire describe somatic symptoms (as opposed to 5 of 20 in the Zung Depression questionnaire), such that a higher degree of somatization among men may balance out with higher levels of nonsomatic anxiety symptoms in women and explain the similar levels of total anxiety symptom scores among men and women in the sample. Epidemiological research in Colombia also indicates that rates of substance use disorders in men far exceed rates in women (Posada-Villa et al., 2009). Because alcohol use is a socially acceptable behavior in Colombia, especially among men, substance use may be a relatively nonstigmatizing way of coping with and numbing psychological distress (Ávila Cadavid, Escobar Córdoba, & Chica Urzola, 2005). Assessments of distress based solely on assessments of PTSD, depression, and anxiety may therefore underestimate distress in men.

We did not find that ethnoracial status predicted PTSD or anxiety symptom levels in our regression model. However, we did find a trend association between Afro-Colombian ethnoracial status and higher depression scores. Research indicates that very large sample sizes are necessary to detect race/ethnic differences in PTSD rates (Brewin et al., 2000). Research in the U.S. suggests that a higher degree of exposure could explain findings indicating higher PTSD rates among Blacks as opposed to Whites (Hunter & Schmidt, 2010; Pole et al., 2008). Given the lack of attention to ethnoracial status and mental health in Colombia, and given the higher vulnerability of Afro-Colombians and non-White Colombians to political violence and forced displacement, we believe this topic deserves further exploration. With respect to Hispanic ethnicity in general, research in the U.S. indicates that Hispanics may be at higher risk of PTSD than non-Hispanic Whites. The elevated PTSD symptom levels in this study may therefore reflect a higher risk of PTSD in Hispanics in general. On the other hand, epidemiological research does not support higher rates of PTSD in the general Colombian population compared to the general U.S. population (Kessler et al., 2005; Posada-Villa et al., 2009).

An unexpected finding was the relationship of higher educational attainment with higher depression symptoms. Higher educational attainment has generally been shown to be protective (Brewin et al., 2000; Caceres et al., 2002; Shalev, Peri, Canetti, & Schreiber, 1996). A potential explanation for this finding is that individuals from rural areas with a higher education may have expected a certain degree of occupational and social stability to result from their education and therefore might experience a greater sense of loss when those expectations were shattered by experiences of violence and displacement. Such findings deserve further exploration.

The focus group discussions revealed great interest in psychologically based interventions for PTSD. The strong interest in supportive-type therapies and the positive response to the focus groups themselves suggest at least some role for supportive group therapy. Additionally, some participants, despite lack of formal education, were very articulate in describing mechanisms by which therapies might aid individuals to process traumatic experiences. The interest in receiving support from psychologists as well as descriptions of cognitive and behavioral mechanisms for healing suggests an important potential role for trauma-focused, evidence-

based therapies in the treatment of internally displaced Colombians.

The focus groups also highlighted the importance of redeveloping social networks for displaced people, as so many participants discussed group gatherings of various sorts as therapeutic. These focus groups revealed that there is a longing to recreate a sense of community but that individuals find themselves isolated and fearful to do so, either because of a hypervigilance and mistrust attributable to prior traumatic experiences and/or because of the reality of ongoing danger in their current environments.

Group members also described groups as therapeutic through their ability to distract displaced people from unpleasant memories. It is possible that this interest in distraction as a form of therapy reflects an avoidant coping strategy, which would be consistent with a diagnosis of PTSD. Such a coping strategy could jeopardize adherence to trauma-focused therapies. On the other hand, this may also reflect participants' lack of knowledge about the mechanisms of effective treatments for psychological problems or a lack of confidence that such therapies are available to them. Finally, such an interest in distraction may also reflect an intuitive awareness that some displaced people may not experience the degree of safety and social and emotional stability needed to engage in exposure-based therapies.

The issue of stability highlights what should be considered an obvious point when dealing with populations affected by armed conflict and displacement: psychological support is an important but partial component of intervention programs. Intervention programs should recognize and address, as much as possible, the material needs of the communities through housing assistance, occupational and literacy training, food support, childcare, and general medical care. These are all challenges with which the Colombian government and global communities working with immigrants and geographically displaced people must contend.

There are several limitations to this study. This study interviewed a convenience sample of individuals seeking support from a government and NGO co-administered center. Although this is the central resource center for internally displaced people in Medellín, some displaced Colombians are not referred or choose not to seek services due to a desire for anonymity, lack of resources to travel to the center, or other reasons. Although individuals and families who are adapting well after displacement may not seek services at the UAO, which would indicate that this study overestimates distress, the most psychologically distressed individuals may also not have the wherewithal to seek services, in which case survey results would underestimate distress. This service-seeking population cannot be considered representative of the displaced population in Colombia. As mentioned previously, indigenous groups are largely absent in the population. Afro-Colombians were also relatively few in number. Anecdotally, the researchers noted that Afro-Colombians were less highly represented at the UAO during the months of study implementation as contrasted with the prior year. This may simply reflect the fluctuations in the geography of violence and displacement at any given time. Although literacy and educational attainment were fairly low, people able to come all the way to Medellín may also have more education and economic resources than many displaced people from rural areas, and therefore may not be culturally representative of

most internally displaced Colombians. Additionally, because we oversampled Afro-Colombians and men for our focus groups, the focus group sample cannot be considered representative of the larger sample of survey respondents.

The project was also limited by the use of self-report questionnaires. Although the PTSD checklist had been validated in a Colombian population directly affected by the armed conflict, a few participants described difficulty in understanding the questionnaire, and many required assistance from research staff, which may in some cases have biased their responses. Furthermore, to ensure privacy and minimize potentially upsetting disclosures of trauma experiences, we did not inquire about the details of traumatic experiences using quantitative measures, although we did allow such information to be disclosed spontaneously in focus groups. Prior to testing any trauma-focused interventions, it will be paramount to better evaluate the nature of traumatic experiences and PTSD diagnoses in internally displaced people.

The focus groups may also have been affected by bias. It is likely that focus groups led by a psychologist and a psychiatrist will favor positive endorsement of psychological interventions, especially among individuals who may be eager to garner any support they can for their suffering. On the other hand, participants had little difficulty in expressing their reservations about psychiatrists, whom they viewed as primarily caring for "crazy" people. Their ability to discuss this in the presence of a psychiatrist supports the authenticity of their remarks.

Conclusions

This study reveals high levels of mental distress in a sample of internally displaced Colombians. It also demonstrates the usefulness of the PTSD construct in describing experiences that study participants consider worthy of intervention. A high interest in therapy with psychologists and other skilled clinicians suggests an important role for trauma-focused treatments, which may be most beneficial when implemented in the context of broader interventions aimed at psychosocial rehabilitation. Active outreach by mental health professionals may also be useful in overcoming stigma-related barriers to help-seeking in this population. Given the large fraction of the Colombian population affected by armed violence and forced displacement, these findings call for further investigation of treatment needs and greater investment into psychosocial interventions for internally displaced Colombians. These findings may also be used to guide intervention studies in other conflict-affected populations.

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