The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings

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There is a growing consensus concerning the scope and components of mental health and psychosocial interventions needed to assist populations exposed to mass conflict. The Adaptation and Development after Persecution and Trauma (ADAPT) model offers a unifying, conceptual framework to underpin policy and practice in the field.

Keywords: Adaptation and Development after Persecution and Trauma (ADAPT) model, conceptual framework, mental health and psychosocial support

Introduction

Over the past few decades, the field of post conflict and refugee mental health has made major strides, with a growing consensus emerging in terms of the formulation of policy, programming and research priorities (van Ommeren, Saxena & Saraceno, 2005; Inter-Agency Standing Committee, 2007; Sphere Project, 2011; Allden et al., 2009; Tol et al., 2011). The Adaptation and Development after Persecution and Trauma (ADAPT) model provides a conceptual framework to underpin existing policies and practices, by demonstrating links extending across the continuum of adaptive and maladaptive psychological responses to mass conflict, and the range of programmes (psychosocial, mental health) needed to support communal and individual recovery (Silove, 1999; 2004; Silove & Steel, 2006).

Principles underpinning the ADAPT model

The ADAPT model postulates that stable societies are grounded on five core psychosocial pillars that are fundamentally disrupted by mass conflict. These core pillars are: (1) Safety/Security; (2) Bonds/Networks; (3) Justice; (4) Roles and Identities; and (5) Existential Meaning. Repair of these pillars is considered essential to restoring communal mental health and psychosocial recovery.

This model draws on a number of key principles:

1. The traumas and stresses associated with mass conflict are multiple, often occurring concurrently or sequentially, and convey complex meanings to the survivor and community. Assessing the contextual meaning of trauma, therefore, is essential to understanding the overall impact of these events on mental health and adaptation.
2. At each of the intervening steps leading from trauma to psychopathology there is potential for positive adaptations, depending on the availability of resources (intra-personal or interpersonal) that can

be mobilised to meet these challenges (Hobfoll et al., 2012). It is important, therefore, to avoid assuming a simplistic deterministic model (i.e. that trauma always leads to posttraumatic stress disorder (PTSD)).

3. The boundary between normative and maladaptive psychological response is indistinct and fluid, varying in time, context and culture; identifying a mental disorder related to trauma and stress at one point in time does not mean that the condition is fixed or immutable.

4. The social world mirrors and interacts with the personal/psychic world, creating a process of recursive, or looped, feedback. A post conflict environment is one of rapid and, at times, unpredictable change, therefore requiring a repeated process of re-appraisal in order to understand the dynamic interaction between the individual, the group and the evolving eco/social context.

5. Recovery is an active process: individuals and their collectives have a natural drive to mobilise their own resources, striving to survive and adapt, and to rebuild the damaged ADAPT pillars. When progress in this recovery process is slow or obstructed, the reasons are often structural, rather than inherent to the individual, group or culture.

6. Posttraumatic growth and positive change are possible, even in the most adverse circumstances. Survivors can learn invaluable lessons from their experiences, gaining insights and motivation to achieve a higher order of adaptation for themselves and their communities. At the same time, psychological growth and maladaptive responses are not mutually exclusive; it is common to observe a complex mixture of both elements among individuals and collectives in their immediate and longer term responses to conflict and persecution.

7. In post conflict populations, there will always be a subpopulation with pre-existing or new onset mental disorders (such as psychosis, or severe mood disorders) of the type observed across all societies (Silove Ekblad & Mollica, 2008). Those persons with the most severe disorders, such as psychosis, are at grave risk of neglect or abuse in unstable, conflict affected settings (Silove et al., 2000). Attending to the needs of the severely mentally ill is as much a human rights imperative as focusing on traumatic stress reactions (noting that the two domains of mental disorder frequently overlap) (Lund et al., 2012).

Pillar 1: Safety and Security

A schematic outline of the key elements of the ADAPT model is provided in Table 1. Pillar 1 (Safety/Security) is presented first because of its fundamental importance to recovery. In conflict affected settings, populations are exposed to repeated or prolonged threat, thereby living in states of pervasive insecurity with a varying capacity to exert control over the situation. There is evidence, from a range of societies exposed to conflict, that prevailing conditions of terror increase the rates of posttraumatic stress reactions (Steel et al., 2009). As such, the prevalence of PTSD symptoms in a conflict affected population can be regarded as a barometer of the extent of threat and insecurity the community is experiencing.

Much debate, in the recent past, has focused on whether or not the construct of PTSD has any legitimacy as a psychiatric condition, particularly when applied across

Table 1. The ADAPT model: principles and implementation

ADAPT Pillar	Informing principles	Adaptive–normative response	Maladaptive response	Psychosocial response	Clinical principles
Safety/Security	Sense of safety is pivotal to mental health. Posttraumatic stress reaction is a normative survival response to threat, which can become dysregulated.	*Collective:* Preparedness to respond to danger and ensure the security of group. *Individual:* Normative defensive response.	*Collective:* Hypersensitivity to threat cues in environment resulting in over-reactivity of the group to perceived threat. *Individual:* post-traumatic stress and other anxiety symptoms leading to PTSD and comorbid disorders.	Restoration and maintenance of safety and security are fundamental to hastening natural recovery. Normalisation of acute stress response, stress management in non-pathologising framework. Provide protection for vulnerable groups.	Creating therapeutic environment that encourages sense of security, underpins all interventions. Emergency clinical services for those with complicated acute reactions. Medium term specialist services for those with chronic PTSD and comorbid disorders
Bonds/Networks	Bonds and networks are essential to human functioning	*Collective:* Group mourning, remembrance rituals. *Individual:* Culturally sanctioned normal grieving	*Collective:* Incapacitated by unmitigated losses, historical dislocation, overweening preoccupation with past. *Individual:* Prolonged grief complicated by depression, somatic complaints and other comorbid disorders.	Restoring families, other bonds and networks. Psychosocial programmes for vulnerable groups: widows, orphans.	Focus on grief is central to virtually all therapeutic interventions. Selective/specific therapy for complicated grief, focusing on loss and attachment issues.
Justice	The sense of injustice is a universal response to human rights violations.	*Collective:* Anger and sensitivity to further injustices. Striving to promote justice. *Individual:* Need for acknowledgement of past suffering; sensitivity to further acts of injustice.	*Collective:* Mistrust, resentment, unresolved sense of grievance. *Individual:* Range of outcomes including anger, resentment, mistrust and paranoia.	Multisectoral approaches to acknowledging and mitigating sacrifices of the past; programmes to achieve transitional and restorative justice.	Explicit recognition of the injustices experienced and the legitimacy of anger. Ensuring that principles of justice, respect, recognition and empowerment are intrinsic to all interventions.

Table 1. (Continued)

ADAPT Pillar	Informing principles	Adaptive–normative response	Maladaptive response	Psychosocial response	Clinical principles
Roles and Identities	Roles and identities inevitably challenged by mass conflict and displacement.	*Collective:* Adapting to new cultures, mores and norms while preserving core elements of traditional values/culture. *Individual:* Forging new or hybrid identities that support adaptation.	*Collective:* Clash of cultural mores and norms and sense of continuity, marginalisation. Intergenerational conflict. *Individual:* Marginalisation, withdrawal, anomie, complicated by depression and other morbid outcomes.	Multisectoral interventions to achieve integration of displaced persons, provision of opportunities (work, education) and assistance with acculturation.	Supporting role transitions and forging of new or hybrid identities while valuing established traditions.
Existential Meaning	World views and belief systems fundamentally challenged by conflict and displacement.	*Collective:* Re-establishing institutions and practices that confer meaning (religious, spiritual, social, cultural, political). *Individual:* Revising/renewing/confirming beliefs and values and/or finding new avenues for expression.	Community: Fragmentation, loss of coherent narrative and guiding principles. *Individual:* Alienation, in extreme cases leading to depression, suicidality.	Policy explicitly acknowledges and responds to broader existential issues and need to respect values/beliefs among populations exposed to conflict. Overcoming discrimination and promoting rights to exercise and practice belief systems. Sensitive acculturation programmes.	Explicit recognition and incorporation of existential issues in all therapy, recognising the primacy of the individual in forging new or adapted systems of meaning.

cultures (Silove, 1999). By adopting an evolutionary perspective on the traumatic stress reaction, it is possible to understand how a normative universal response to threat can become dysregulated under adverse eco/social conditions (Silove, 1998). Within that conceptual framework, the intrusion of trauma memories is regarded as a survival mechanism designed to prepare the person for future encounters with the same or related threats (Silove, 1998). Avoidance of threat cues existing within the environment enhances the survivor's capacity to avoid ongoing or recurrent dangers, while arousal phenomena such as hypervigilance, exaggerated startle and heightened physiological reactivity prepare the person to mount defensive flight or fight responses.

In some, the traumatic stress response can become dysregulated, meaning the survivor reacts to a range of environmental cues that are not inherently threatening (Silove, 1998). A range of pre-existing and surrounding traumatic factors contribute to risk that the traumatic stress reaction will become chronic and disabling (Brewin et al., 2000). The post traumatic environment is particularly relevant, especially when survivors are exposed to a constellation of adversities, such as: ongoing conditions of threat, uncertainty about the future, lack of control over their lives, and an absence of social support or resources to achieve recovery (Silove, 2002; Hobfoll et al., 2012).

A key responsibility for leaders in the mental health field is to apprise policy-makers, responsible for relief and resettlement programmes, of the importance of establishing environmental conditions of safety, stability and predictability in order to achieve mental health recovery for those exposed to conflict and displacement. Services can assist in normalising the process of recovery by educating the population about the expectable shortterm responses to trauma, and by building the capacity of personnel to provide culturally appropriate stress management techniques that are applied in a non-pathologising framework. Protection of vulnerable groups, such as women who have suffered rape and/or are at risk of domestic violence, unaccompanied minors, returned child soldiers, members of religious minorities, amongst others, not only has an immediate social function, but also assists in off-setting the risk of chronic PTSD reactions. At a clinical level, emergency mental health services should give priority to those with complicated traumatic stress reactions (the suicidal, severely depressed, those who are not able to care for themselves or their dependents, or who are showing maladaptive behaviours such as aggression and/or excessive alcohol/substance use) (Silove et al., 2004).

Finally, there is a minority of survivors whose PTSD reactions (usually comorbid, or existing along with other disorders) follow a chronic course. It is essential, in the medium term, to identify these survivors (who are often hidden from view) in order to provide clinical interventions to help to avert the risk of long term disability.

Pillar 2: Bonds and Networks
Communities exposed to mass violence and displacement invariably suffer extensive losses, both material and personal. Yet, until recently, the study of grief has been subordinated to the focus on PTSD in the post conflict field (Momartin et al., 2004, Morina et al., 2010). Grief varies from a normative response to a chronic, dysfunctional reaction associated with comorbid disorders, such as depression. More generally, restoring the integrity of interpersonal bonds and wider social supports is vital to promoting recovery

from a wide range of emotional disorders following exposure to conflict.

Attending to the repair of Pillar 2 (interpersonal bonds) therefore, should be a major focus of relief efforts, specific activities including programmes to re-unite families and pre-existing networks, and to re-integrate disrupted communities whenever possible. Culturally sanctioned mourning and remembrance rituals may also assist the process of normal grieving. Dedicated psychosocial programmes may be necessary to support those who have suffered the most egregious losses, such as widows and unaccompanied minors, whose grief reactions may be complicated by the social vulnerabilities they face as a consequence of their isolated status. Further evidence is needed to support early research findings that cognitive behavioural therapies for those disabled by prolonged grief can be applied across cultures (Wittouck et al., 2011).

3. Pillar: Justice

Insufficient attention has been given in the past to the sense of injustice as a psychological (as opposed to a human rights or legal) construct. Yet, clinical experience teaches us that persisting preoccupation with cumulative injustices of the past can play a central role in maintaining psychological symptoms following exposure to persecution and human rights violations (Silove, 1999; Rees et al., 2013). Anger is the normative emotional response to injustice, a reaction that in many instances is justified and adaptive and therefore, should not be labelled as deviant (Rees et al., 2013). In some survivors, however, a pattern of explosive anger can evolve, with attacks being triggered by minor events (Hinton et al., 2003; Brooks et al., 2009). The social consequences of this pattern can be severe, with anger induced acts of aggression becoming

ill-directed, resulting in adverse impacts on the person, the family and the community at large (Rees et al., 2013).

On a wider social level, post conflict societies face the daunting challenge of restoring a durable sense of justice among communities exposed to prolonged periods of deprivation and human rights violations. Although over 40 truth and reconciliation commissions have been initiated around the world over the past 30 years, evidence is conflicting about the effectiveness of these initiatives in achieving the goal of transitional justice (Clark, 2011; Gibson, 2005). Researchers confront major difficulties in measuring the specific social and mental health effects of these processes given their complexity, the society-wide focus and the absence of controlled conditions necessary to allow for rigorous scientific study.

The limited mental health data available, however, suggest that participating in truth commissions may have little impact on symptoms of PTSD or anger among survivors of political abuse, possibly because in many instances, the principal perpetrators are afforded amnesty or otherwise evade prosecution (Kaminer et al., 2001; Silove & Steel, 2006). Frustration and disappointment, with a failure to achieve social justice in the form of economic opportunities, social stability and good governance, are all shortcomings that are typical of many post conflict societies and that are likely to constrain the effectiveness of truth commissions in achieving their objective of transitional justice. Realistically therefore, the restoration of a sense of justice will be a slow and piecemeal process, best advanced by a multi-sectoral, grassroots and participatory approach. Only when contemporary policies and practices in the post conflict environment are seen to be genuinely reflecting the human rights lessons of the

past, are survivors likely to feel a degree of genuine vindication for their sacrifices.

Mental health and psychosocial programmes can play an active role in promoting an ethos of justice by ensuring that human rights issues are central to all relevant activities. Although scientific evidence is essential in guiding the technical aspects of programmes, and donors may give primary emphasis to these aspects, it is also vital that leaders in the field emphasise the central importance of promoting a culture of justice and human rights that afford survivors and their communities a sense of acknowledgement, dignity, respect and empowerment.

Pillar 4: Roles and Identities

Mass violence and displacement invariably impact on established roles within the family and the society, disruptions that demand active accommodation and adaptation. The threat to these roles within the family and society, in turn, intersects with broader issues of identity, particularly in relation to culture, ethnicity, and nationality.

Unstable conditions can persist for long periods for survivors of mass conflict, interfering with the person's capacity to re-establish a coherent and durable sense of identity, and/or to find consistently meaningful roles. These challenges are evident when refugees are sequestrated in settings of prolonged statelessness, confined in refugee camps or detention centres, or are compelled to live as asylum seekers in societies that are hostile to their presence (Silove, 2002). Unemployment on its own, particularly in settings of underdevelopment and lack of social support, is strongly associated with impaired mental health (Karsten & Moser, 2009). Marginalisation, prejudice and discrimination within settings of displacement can also add to the sense of ambiguity or disorientation and a lack of

belonging that most refugees experience (Noh et al., 1999). Identity confusion can contribute to a range of adverse psychological and psychiatric outcomes (withdrawal, isolation, depression) that will have negative social consequences, including personal disengagement, family difficulties, deviant behaviour and an overall sense of alienation, in which the person loses any sense of belonging or function (Zhao & Cao, 2010).

In more favourable circumstances, refugees who are offered appropriate opportunities are able to adopt new roles and identities through access to education, professional advancement and other pursuits. As is well known, persons of refugee background have risen to positions of prominence in resettlement societies, and their progeny often have prospered, adopting hybrid identities that blend elements of the home and adopted culture (Kirmayer, 2006). The preservation of collectivist/interdependent family and communal structures can be adaptive, buffering individuals against the stress of competition in the (sometimes) individualistically oriented cultures of resettlement countries.

The implications for policy are self evident: it is essential to safeguard and promote the rights of survivors of conflict and refugees to pursue education, work and other opportunities by actively removing barriers to their participation. Family based, psycho-education programmes can be effective in facilitating role transitions, adaptations that include changes in gender roles, rights and status, and in parental expectations and approaches to child-rearing. It is inevitable that the clinician will need to grapple with the personal and practical challenges the survivor confronts in forging new roles and a sense of identity. It is also essential for clinicians to establish a close collaboration with psychosocial programmes and agencies

that assist survivors to pursue education, vocational training, employment and other activities that provide practical support, in order to re-establish meaningful roles and a sense of mastery over life.

Pillar 5: Existential meaning

All individuals require a coherent narrative – whether implicit or explicit – in order to make sense of their lives. Conflict and displacement represent a major disruption to the sense of continuity of life, compelling survivors to re-appraise, and at times, to revise fundamentally their world views and systems of belief. Communities from traditional backgrounds grounded on a single, dominant system of beliefs often find themselves resettled in pluralistic societies, in which a multiplicity of faiths, lifestyles and world views co-exist. There are inevitable challenges in reconciling past customs and mores with those encountered in the new society, an issue that may lead to inter-generational tensions. Ideologically committed refugees, who have been engaged in the struggle to free their homeland, can experience intense feelings of isolation and powerlessness after relocating to a distant resettlement country.

Understanding the existential challenges confronted by persons exposed to conflict and persecution is vital to forging a comprehensive approach to psychosocial recovery, mental health and resettlement (Kinzie, 1989). Policymakers need to understand the extent to which the history of human rights violations has challenged the systems of meaning of populations exposed to conflict, and the sensitivity of survivors to further disruptions. In countries resettling refugees, it is vital to adopt policies and practices that champion the principles of multiculturalism, encouraging all sectors of the society to accommodate a multiplicity of world views within a pluralistic society. Training and awareness raising among service providers, including mental health professionals, is important to sensitise professionals to the existential challenges confronting refugees in their efforts to accommodate to the culture, values and systems of meaning of the mainstream society in the resettlement country. Existential issues are invariably central to the conduct of psychotherapy (Kinzie, 1989). For example, therapists need to develop the capacity to engage with militants who tend to downplay their own suffering in favour of their central commitment to the wider political cause.

The search for meaning is a core task for refugees, even though some may find it difficult to articulate the dilemmas they face, particularly where language is a barrier to communicating the complexity of the constructs involved. The practitioner can support and resonate with the existential uncertainties survivors confront, even though resolution of the underlying issues is a deeply personal matter that ultimately rests with the individual. Many refugees achieve a positive existential accommodation and adaptation but some will experience a profound sense of alienation that can dominate the clinical picture, contributing to clinical presentations of depression, drug and alcohol abuse, somatoform complaints and suicidality.

Implications and applications of the ADAPT principles

For clarity, the five psychosocial pillars of the ADAPT model are described independently, although in reality they form interdependent components of the foundations needed to restore stability to conflict affected societies. The ADAPT model shares, with other contemporary frameworks, several key elements that are essential to

understanding the psychosocial response of survivors of mass violence. These include: recognition of the importance of the eco/social environment to recovery; the need for a culturally and contextually sensitive understanding in judging the border between normative and pathological reactions to stress; and the importance of supporting a balance of interventions (psychosocial, mental health) in a manner that provides an integrated approach to promoting communal and individual recovery (IASC, 2007; de Jong, 2002; Miller et al., 2006).

As an awareness-raising tool, the ADAPT framework is readily communicated to a wide audience that extends well beyond the confines of mental health professionals. The psychosocial pillars, and the examples that can be used to illustrate them, resonate with the experiences of individuals and communities that have lived through conflict and make intuitive sense to leaders and workers in relief agencies across all sectors. As such, the ADAPT model offers a concise summary of the key issues that need to be conveyed to a wide range of stakeholders about the challenges that conflict affected populations face, the adaptive changes that are possible for survivors, and the multilevel interventions that promote the process of recovery.

The ADAPT model offers a structure for training of workers in all mental health and psychosocial programmes. Although specific technical knowledge is needed to treat individual forms of mental disorder, it is important for trainees and specialists alike to fully understand the context in which these interventions are applied. Even when treating those with the most severe mental disorders, background issues of safety, family cohesion, justice, roles and identities and a sense of existential meaning are vital in formulating a comprehensive approach to management.

Much of the existing body of epidemiological and psychosocial research undertaken in the refugee and post conflict mental health field can be understood from the vantage point of the ADAPT model. Although no single research study will be able to examine all facets of the model simultaneously, individual elements are amenable to testing. Creative multidisciplinary and mixed methods approaches are needed to advance this process in a field where conventional research designs may be inadequate to capture the full complexity of the influences at play (Bolton, Tol & Bass, 2009; Rees et al., 2013).

The model is also helpful in facilitating communication with policymakers and funders, in that it provides a readily understood, nontechnical set of principles that supports more detailed practical interventions outlined in existing guidelines and consensus statements relevant to mental health and psychosocial programming, training and research (van Ommeren et al., 2005; IASC, 2007; Sphere Project, 2011; Allden et al., 2009; Tol et al., 2011). In essence, the ADAPT model provides answers to the '*why*' underpinning the '*what*' that needs to be done (WHO & UNHCR, 2012). Most importantly, the ADAPT model encourages policymakers and planners to recognise the interaction between past conflict and ongoing social challenges that shape the process of adaptation (individual and collective). It is only within that broader eco/social and historical matrix that the sequential steps in the trajectories, leading from conflict to stress related mental disorder, can be understood in a comprehensive manner.

Importantly, the model promotes creative thinking about the range of strategic interventions that may be offered to foster the dynamic process of recovery and reconstruction after conflict; the overarching goal

being to create conditions that will maximise opportunities for individuals and communities to adapt in a positive manner. In that way, mental health and psychosocial activities can come to be understood as an integrated set of interventions contributing to the process of social stabilisation and recovery, rather than as isolated activities that occupy the margins of the overall relief and recovery effort. In the ideal scenario, all actors in the reconstruction process will embrace a broader psychosocial perspective that recognises that a coordinated, multi-sectoral approach to repairing the ADAPT pillars is essential to promoting psychosocial stabilisation and to offsetting the risk of survivors developing chronic and disabling mental disorders.

Conclusions

The ADAPT model distils the essential principles from existing knowledge and theory to provide the essential building blocks that inform the range of interventions needed to achieve communal recovery following mass conflict. The model is intended to be heuristic; serving as an aid to problem-solving, prompting further thought, analysis and inquiry that ideally will lead to the expansion and revision of the framework – or to its replacement with a more comprehensive model as further knowledge accrues.

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