

A classroom based intervention in conflict affected Poso, Indonesia: synthesising lessons learned from research and practice

Dessy Susanty, Mark J. D. Jordans, Rima Irmayani & Wietse A. Tol

This paper describes lessons learned from a classroom based intervention, which was implemented in the post conflict area of Poso, Indonesia. These lessons are drawn from qualitative research and a randomised controlled trial in the area, as well as data from our own programme monitoring and evaluation. We describe these lessons learned from a socio-ecological perspective, making recommendations to strengthen the classroom based intervention's connection with critical mental health and psychosocial issues relevant at individual, family and wider community levels. Lessons learned include: the need for further adaptations to address local somatic expressions of psychological distress; consideration of changes at the cognitive level; a need for gender specific activities; engaging families in school based interventions; and addressing the damage to the wider social fabric, including at peer level. The engagement of trained paraprofessional health care is also discussed as an essential consideration.

Keywords: classroom based intervention, communal violence, psychosocial and mental health intervention

Introduction: background

Armed conflicts continue to threaten a vast number of children across the world, especially in low and middle income countries (LMICs). Risser (2007), described the large impact of armed conflicts on children across Southeast Asia, including the negative consequences on physical health, psychosocial wellbeing, access to education and families'

Keys implications for practice

- Adapt interventions to address local expressions of distress and consider gender differences.
- Interventions need to be complemented with more focused treatment interventions and highlight stronger incorporation of the family.
- Any wider damage to the social fabric should be also addressed.
- Can be delivered by paraprofessionals with little formal mental health training.

livelihood and assets. A recent meta-analysis of epidemiological studies, among children exposed to armed conflict globally, revealed a high prevalence of psychological distress and mental disorders. Although this body of literature has significant methodological limitations (particularly the likelihood of conflating distress and disorder), pooled prevalence of posttraumatic stress disorder (PTSD) symptoms across 17 studies was 47% (95% CI: 35–60%), for depressive symptoms was 43% (95%, CI: 31–35%) (four studies) and for anxiety symptoms was 27%. (95% CI: 21–33%) (three studies) (Attanayake, McKay, Joffres, Singh, Burkle & Mills, 2009).

Different intervention programmes have been developed and implemented to meet conflict affected children's needs. School

based interventions are a promising approach, as the school is viewed as a non stigmatised setting for children where a larger number of children in need of support can be reached relatively easily (Jordans, Tol, Komproe & de Jong, 2009).

This paper describes lessons learned during a classroom based intervention (CBI) to reduce psychological distress among school children who were exposed to communal violence in Poso, Indonesia. Lessons learned are based on findings of several studies, including qualitative research (Tol, Reis, Susanty & deJong, 2010a); results from a cluster randomised trial of the intervention (Tol, Komproe, Susanty, Jordans, Macy, & de Jong, 2008; Tol, Komproe, Jordans, Gross, Susanty, Macy, & de Jong, 2010b), a mixed methods study aimed at developing function impairment measures (Tol, Komproe, Jordans, Susanty, & de Jong, 2011); as well as systematic programme monitoring and evaluation (Jordans, Tol, Komproe, Susanty, Vallipuram, Ntamatumba, . . . & de Jong, 2010a; Jordans, Komproe, Tol, Susanty, Vallipuram, Ntamatumba, & de Jong, 2010b; Jordans, Tol, Susanty, Ntamatumba, Luitel, Komproe, & de Jong, 2013a). Details on the results of these studies are briefly summarised below, but for more detailed data, methods and results earlier publications referenced should be consulted. Our key aim in this paper is to reflect on these findings with a bird's eye view and provide recommendations with particular relevance to practitioners.

The CBI was part of a larger psychosocial and mental health care package for children, which was implemented in Burundi, Indonesia, Nepal, Sri Lanka and South Sudan (Jordans et al., 2013a). In Indonesia, the project was implemented in collaboration between ChurchWorld Service (CWS) Indonesia and HealthNet TPO. It started in September 2004, ran up to 2008 with funding from Plan Netherlands, and subsequently continued with funding from USAID up to 2010.

The setting: CBI implementation in a conflict affected area in Indonesia

The CBI was implemented in Poso district, Central Sulawesi province, where the outbreak of communal conflict between Christian and Muslim groups took place due to a myriad of political and economic inequalities, tension related to migration policies and a weak legal system. During the conflict, people were exposed to various violent acts, such as groups of people attacking and burning villages, slashing family members or relatives, killings and bomb explosions. It led to the displacement of more than 110,000 people, the demise of 700 people and segregation of communities along religious lines (Brown, Tajima, & Hadi, 2005). A qualitative study was aimed at examining psychosocial problems related to the conflict and ways to deal with those problems from the perspective of the affected population. This was done through interviewing key informants (including children) in the community, conducting focus group discussions with children, teachers, parents/caretakers, and having semi-structured illness narrative interviews with affected children and parents/caretakers of affected children (Tol et al., 2010a). The findings revealed psychosocial concerns due to the conflict, including poverty, trauma (in Bahasa Indonesia) and a range of fears (from startling responses to violence related stimuli, such as bamboo fires producing sounds reminiscent of gunfire, to increase of generic fears of the dark or demons), perceived morally inappropriate behaviours (use of drugs, early sexual relations, school truancy, disobedience to parents and elders, use of abusive language), inter-religious tensions and somatic problems. People commonly described their trauma in a broad category of distress after upsetting events, and emphasised somatic sensations such as trembling, fever, a drop in body temperature, headache, sweating, lead up to heart attack, being easily shocked, and loss of concentration or general mental ability. These

problems were commonly treated by the traditional healer using allopathic medicine, prayer (mantra) and massage. Traditional healers (particularly massage therapists), parents, teachers and religious leaders were all people who had a role in reducing conflict related, psychosocial problems. Health practitioners, on the other hand, were scarcely involved in treating both psychosocial and somatic problems. Additionally, the mental health system was difficult to access; at the time, there was only one psychiatric who stayed in the province capital, about 4–5 hours' drive from the area of conflict.

The intervention

For complex emergencies in low resource environments, it is commonly recommended to have multi-sectoral and multi level approaches implemented in accessible areas (e.g., community or school based). Such programmes may address multiple types of needs, ranging from children at risk to children with psychiatric symptoms (Jordans et al., 2010a; Inter-Agency Standing Committee (IASC), 2007). This CBI was a selective, preventive intervention that targeted sub groups of children who had shown mild to moderate problems, and were at risk of developing mental disorders. It was part of a multi-layered care package consisting of a variety of interventions. This care package was developed to be consistent with a public health model that covered prevention, treatment and maintenance interventions (National Research Council and Institute of Medicine, 2009). The first layer comprised of interventions targeted at the general population, in order to prevent psychosocial problems in healthy, albeit potentially at risk, populations (e.g. interventions to promote adaptive adjustment and community resilience, or universal prevention). The second layer contained interventions that targeted sub groups of the population at risk of developing mental health and psychosocial problems, or that demonstrated

mild problems (e.g. focused interventions to reduce psychological distress, or a combination of selective prevention). The third layer comprised interventions that targeted treatment of sub groups with severe mental health problems (e.g. psychosocial counselling aimed at reducing severe psychological distress, suicidal risk and other high risk behaviours, or low intensity treatment) (Jordans et al., 2013a).

The CBI was selected, as it was a group preventive intervention that could be facilitated by trained paraprofessionals within a school/community setting. The group intervention was preferred because the group could be a place for children to learn new strategies, coping and problem solving skills, and also to teach and support each other. Moreover, children would see that everybody might have problems and they were not alone (Jordans, Komproe, Tol, Susanty, Vallipuram, Ntamatumba, & de Jong, 2010b). The CBI was aimed at decreasing distress symptoms and strengthening protective factors, including improved social support, hope and coping methods. The CBI's structure was based on concepts of creative expressive and cognitive behavioural therapy. The creative expressive elements encouraged children to be involved in cooperative games, structured movement, music, drama and dance. The cognitive behaviour therapy elements provided space for children to ventilate past traumatic distress events through drawing and drama, and gain psycho education related to their distress. Groups of children attended the 15-session intervention, three times a week, in the classroom, for five consecutive weeks. Each week had specific themes across sessions: information, safety, and control in week 1 (sessions 1 to 3); stabilisation, awareness, and self-esteem in week 2 (sessions 4 to 6); the trauma narrative in week 3 (sessions 7 to 9); resource identification and coping skills in week 4 (sessions 10 to 12); and reconnection with the social context and future planning in week 5 (sessions 13 to 15).

Each individual session started and ended with structured movements, song and dance. The second part was a central activity (for example, the use of drawing in week 3) that focused on the main theme of that week. The third part was a cooperative game that allowed children to participate, in order to promote group cohesion and social support. The format of each session was: (1) sessions started with a get together around a circular coloured object representing unity and safety, then continued with simple hand/body movements and dancing for warming up and preparation for the next activity; (2) the sessions focused on the central topic of the day, e.g. drawing your own body with the places where you feel; (3) the sessions focuses on the central topic game that allowed children to physically express themselves with gross motor movements and high energy play, and (4) a final get together to calm and sooth children after the cooperative game (Macy, Johnson, Gross, & Brighton, 2003; 2004).

The CBI was facilitated by local community volunteers, who were mostly formal school teachers and Sunday school teachers. They had been trained initially for a period of 2 weeks by master trainers. During the training session, the volunteers were given a chance to role play in facilitating each session. The volunteers implemented the first series of CBI under supervision, before a subsequent formal evaluation was conducted to ensure that they had mastered the required skills. Continuous supervision throughout the programme was provided to ensure quality control and care for caregivers. During a supervision visit, the supervisor also provided further on-the-job training to volunteers, in order to assist them to improve their performance.

A rigorous evaluation was implemented to assess outcomes of the CBI. This evaluation was done in the form of a cluster randomised controlled trial with children aged 7–15 from 14 randomly selected schools (seven schools for treatment condition $n = 182$, seven

schools for waitlist control condition $n = 221$). From these schools, 495 children were screened for exposure to communal violence events, psychological distress (PTSD symptoms and anxiety) using standardised checklists. The checklists were adapted for use in Poso through systematic translation (including blind back translation), focus groups and piloting. Some measures were developed locally through qualitative research because a standard version did not seem culturally sensitive (e.g. somatic trauma symptoms, function impairment). Children were screened into the CBI if they had experienced one or more potentially traumatic events, or if they scored above (predetermined) cut off points on either the PTSD or anxiety symptom checklist. Although criterion validation of these checklists indicated a need for higher scores than standard cut off scores in western populations to identify probable disorder, and were adjusted to fit with the selective preventive intervention aims (including children with broader psychological distress), however, in order to prevent over inclusive screening and fitting the secondary prevention character of the intervention, the original cut off scores for an inclusive screening process were retained. Four hundred and three children, who had screened positive, were subsequently assessed before, 1 week after, and 6 months after treatment. Children who were screened negative for CBI were offered youth group intervention as part of the first layer of the care package. Outcome measurements were aimed to cover symptom reduction (PTSD, depression, anxiety, impairment in daily tasks) and strengthening of protective factors (hope, coping, social support). A potential gender effect on the treatment outcomes was also assessed. The results showed that the CBI moderately reduced PTSD symptoms and function impairment for girls and helped maintain hope for both boys and girls, but did not reduce traumatic stress related somatic symptoms, depressive symptoms, or anxiety symptoms for either gender (Töl et al., 2008). Also, positive coping

and social support showed higher improvements in the treatment group, as compared to control group. Contrary to our expectations, an increase in social support through play was associated with smaller reductions in PTSD symptoms (Tol et al., 2010b).

Discussion: lessons learned for practitioners

Despite the positive outcomes that the CBI reduced PTSD symptoms and function impairment for girls, maintained hope for boys and girls, and increased positive coping and social support for boys and girls, the CBI did not resolve all forms of psychological distress. Therefore, we describe some lessons learned based on our experiences implementing the CBI. Lessons learned are based on the conducted research (Tol et al., 2008; Tol et al., 2010a; Tol et al., 2010b; Tol et al., 2011) as well as systematic programme monitoring and evaluation (Jordans et al., 2010a; Jordans et al., 2010b; Jordans et al., 2013a).

Adapting the intervention to address local expressions of distress

The CBI included some body focused activities, for example the drawing of a *'body map'*, in which children were asked to locate strong feelings they experienced. This activity was overall greatly enjoyed by children (as shown by the monitoring and evaluation data), thus indicating the potential for integrating more such activities. CBI also included structured movements and dance in the opening and closing activities, but these may not have been sufficiently targeted to the local expressions of trauma related somatic distress that may be related to depressive or anxiety symptoms, such as headache, sweating leading to heart attack, being easily shocked and a lack of concentration. Therefore, further adaptation to address such local somatic expressions, specifically related to expressed forms of distress, for instance through focused psycho

education on those expressions and how those expressions may relate to fear, sadness or trauma, as well as adding body focused activities (e.g. stress management techniques) could be considered. Staples and colleagues (2011) evaluated a mind/body programme for children in Gaza. The programme consisted of psycho education on mind/body connections, drawings of their feelings and problems as well as a genogram (intergenerational family maps that uses symbols to describe relationships, major events and dynamics within a family), and numerous techniques using breath and body. Each session started with a slow, deep breathing meditation followed by checking participants' feelings, how they used the techniques, and ended with the same breathing exercises. Every time a new technique was introduced to participants to try, they were invited to share what they experienced and how the techniques had helped them cope with their feelings or situations. This open trial study involved 129 children who were assessed before first session, after the last session, and at 7 month follow-up. This approach has not been rigorously evaluated, but initial results indicated a reduction in PTSD and depressive symptoms. That this, and other body focused techniques, may prove helpful to address somatic experiences associated with conflict experiences were also revealed by the participants in the qualitative study.

Considering gender differences in appropriate interventions for boys and girls

The efficacy study of CBI found that girls benefitted more from the intervention than boys. This finding is consistent with another CBI study in Nepal (Jordans et al., 2013a). This result leads to the view that upcoming empirical investigations should continue to examine the effects of gender, and perhaps evaluate the efficacy of gender specific activities. Boys and girls are different in the ways

in which they express and deal with emotions. Ogrodniczuk and colleagues (2001) examined the relationship of patient gender and outcome for two-forms (interpretive, supportive) of short-term individual psychotherapy. The results showed that female patients preferred a more collaborative and personal relationship with the therapist and benefitted more from problem solving and interventions that underscore the influence of external circumstances for current difficulties. While male patients preferred a more neutral relationship with the therapist and benefitted more from interventions that encourage introspection and examination of uncomfortable emotions.

The CBI can be adjusted as a mental health promotion intervention, and complemented with more focused treatment interventions

Improvement in social support, hope and coping methods were hypothesised to lower PTSD symptoms. We expected that increases in protective factors, due to the CBI, would be associated with reductions in psychological distress. However, the CBI evaluation findings revealed the opposite. Increases in positive coping methods were not in turn related to reductions in psychological distress. Improvements in social support through play were associated with *smaller* reductions in PTSD symptoms. We concluded that it might be difficult to apply the CBI for two of the stated aims; i.e. as preventive intervention (aimed at strengthening protective factors) and as a treatment intervention (aimed at reducing psychological distress). Hence a suggested adaptation is to retaylor CBI more as a universal prevention (given that evaluations in other countries showed more consistent effects for the preventive aim showing improvements in coping, pro social behaviour, social support and hope) (Tol, Komproe, Jordans, Ndayisaba, Ntamatumba, Sipsma, . . . & de Jong, 2014; Tol, Komproe, Jordans, Vallipuram,

Sipsma, Sivayokan, & de Jong, 2012; Jordans et al., 2010a), to be implemented in conjunction with more focused treatment interventions that can effectively address more severe psychological distress and mental disorders.

Although the CBI included cognitive and behaviour elements (e.g., psycho education, discussion of trauma events through drawing, etc.), these apparently were not sufficiently effective to reduce trauma related, psychological distress.

Individual or group cognitive behavioural therapy (CBT) with a trauma focus has been recommended for PTSD symptoms by the World Health Organization's mental health Gap Action Programme (mhGAP) (Tol, Barbu, & van Ommeren, 2013). Preliminary findings have also shown promising results for CBT to treat PTSD symptoms in adults, in other parts of Indonesia. A quasi-experimental (unpublished) study of CBT was conducted with adults affected by an earthquake in Air Tawar, in West Sumatra (Erwina I, unpublished data, 2010). The study, which involved 39 participants in the intervention group and 39 participants in the control group, found PTSD symptoms were significantly reduced for participants who received CBT, but not in the control group. Additionally, a study done by Smith and colleagues (2007) concluded that effects of individual, trauma focused, CBT were partially mediated by changes in maladaptive cognitions, as predicted by cognitive models of PTSD. In the study, CBT was conducted for treating children and young people (aged 8–18 years old) with PTSD. The study found participants who received CBT showed significantly greater improvement in symptoms of PTSD, depression and anxiety, with significantly better functioning, with such gains maintained at a 6 month follow-up. Therefore, replacing CBI with CBT as a treatment intervention for more severe problems, such as PTSD and depression, could be a promising direction.

Stronger incorporation of the family

An alternative intervention that can be considered to accompany CBI is a parental support programme to strengthen the family's protective function. The family, as the first layer of a child's social ecology, plays a central role in child development and wellbeing (Bronfenbrenner, 1979). The quality of parenting has a significant impact on mental and physical health of the children. Yet, in our care package intervention, family functioning was not specifically targeted. Research in other areas affected by political violence has highlighted the importance of parental functioning for children's functioning (Quota, Punamaki, & El Sarraj, 2005). A previous evaluation of a psychosocial intervention targeting mothers of Bosnian refugees showed improvements of mothers' mental health affected the physical and emotional health of their children. Over 6 months of intervention, young children of mothers in the intervention showed better weight and lower reports of emotional and behavioural problems, as compared to young children of mothers receiving health services alone (Dybdhal, 2001). Another study on a brief parenting psycho education programme in Burundi demonstrated short-term effects in reducing conduct problems among school going boys in a post conflict setting, yet had no effect on depressive symptoms or perceived social support (Jordans et al., 2013b). Both these studies indicate the potential benefit of a stronger family-focused component.

Paraprofessionals can deliver psychosocial interventions with little formal mental health training

It is noted that the CBI was facilitated by community volunteers who were mostly formal school teachers or Sunday school teachers. Although they did not deliver the CBI in the school where they taught, the knowledge and skills that they gained throughout the programme have likely benefitted their approach in dealing with

students' problems in their schools, and the methods of delivering lessons. They were hopefully more aware of, and sensitive towards, their own students. Unfortunately, we did not do a rigorous study on the effectiveness of using the teachers to deliver the CBI intervention, as compared to other facilitators. However, through monitoring we could see that this approach may have had advantages. Further study is needed to assess the comparative benefits of teachers versus other facilitators in implementing the CBI.

The intervention should address the wider damage to the social fabric and be integrated with other post conflict programmes, such as poverty reduction and conflict resolution

Poverty and religious tensions were some of problems that were most strongly emphasised during the qualitative research. Poverty included: difficulties paying school fees and associated stigma, as well as increased perceived economic inequality in conflict affected communities given that some people's livelihoods were more destroyed than others. Inter-religious tensions included: increased sensitivity surrounding teasing and fighting, and children playing separately (e.g. lining up in different lines in gym class) between religious groups, which had not occurred previously. Children expressed fears of moving through areas populated by a different religious group, areas that were now more segregated. Poverty and economic inequality can contribute to mental health problems. Therefore, instead of an exclusive focus on mental health problem, the interventions should also address the wider damage to the social fabric, as described by participants. As CBI was part of a larger psychosocial and mental health care package, one could envision that the first (universal prevention) layer of this package could contain economic reconstruction and conflict resolution activities in family and community settings.

Conclusions

Developing and implementing the CBI appears to have contributed to a reduction in psychosocial distress and strengthened resilience in Indonesia. However, further efforts are required to adapt and improve the CBI programme for this context. This is critical for future implementation in a country that is highly vulnerable to humanitarian crises, particularly within the context of natural hazards (earthquakes, Tsunamis, floods, landslides, storms). We suggest that CBI can be improved by: adapting CBI to highlight the universal prevention elements that more directly address local expressions of distress and be more sensitive to gender differences; complementing CBI with a more focused, specialised treatment intervention (such as CBT) that consider changes in cognition and strengthening a family component. Furthermore, we would recommend that a psychosocial care package would place more emphasis on additionally identified social needs, such as families with limited livelihoods and tensions between religious groups. These lessons learned may guide us to develop more effective interventions to improve children's wellbeing and resilience.

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Dessy Susanty, MPsych, is Psychosocial and Research Consultant at Savica Public Health and Communication Consultancy in Jakarta, Indonesia, previously worked at Church World Service Indonesia. email: dessy.susanty@gmail.com

Mark J. D. Jordans, Ph.D., is Head of Research at Health.Net TPO in Amsterdam, the Netherlands and Senior Lecturer at the Centre for Global Mental Health, King's College London, UK.

Rima Irmayani, MA., is Program Officer at Results in Health in Leiden, the Netherlands, previously worked at Church World Service Indonesia.

Wietse A. Tol, Ph.D., is Dr. Ali & Rose Kawi Assistant Professor in the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA and Program Director of the Peter C. Alderman Foundation, Bedford, NY, and Kampala, Uganda.