



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation¹
(Tip: Click on the binocular icon to search this document)

**Clinton Global Initiative University 2008 Meeting
Working Session: Global Health
The Overlooked International Emergency:
Mental Health in Post-Crisis Communities
Clinton Global Initiative University
March 15, 2008**

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

FRANKIE BEVINS: We're going to go ahead and get started here to stay on schedule. If you guys can all grab a seat? Alright. Welcome back. I think most of you were probably in this room this morning. So, we're back this afternoon with another fabulous panel. Just one last reminder, you all know how this works but please remember to submit your questions that you may have for the panel in general, or specific panelists, during this first half hour, alright.

So, as you all know, we're here to talk about mental health in crisis— emergency in post-crisis regions. In the wake and in the midst of so many tragedies around the world right now: war in Afghanistan; Iraq; the recent earthquakes in Kashmir; in Peru; the conflict in Sudan; 9/11; extremely pertinent here, Katrina; it's incumbent upon us to think about how we can help these populations heal— how we can help them recover and get back on their feet. This entails both physical and mental health. The physical wounds are visible— the mental ones, not so visible. As most of you are aware, mental health is often overlooked and under-talked about.

That's why I'm extremely excited to be here today with our panel of dedicated experts. So without further ado, I'm going to turn it over to them. With a quick introduction— first off, we have Mindy Kronberg, who is here as the assistant

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

clinical professor of psychology at Louisiana State University Health Sciences Center.

We have Daryl Paulson, who is the author of the recent book, Haunted by Combat: Understanding PTSD in War Veterans Including Women, Reservists, and Those Coming Back from Iraq.

We have Shin Takeda, Founder and Creative Director of the Aja Project, and our moderator, Dr. Kathleen Allden, who is the Medical Director at the International Survivors Center in Boston and also serves on the faculty at the Dartmouth Medical School. Dr. Allden.

KATHLEEN ALLDEN, M.D.: Thank you, Frankie. Thank you everyone for coming. This is really heartening for me to see so many people interested in global mental health. It's always been the poor cousin or the ugly stepsister in the field of global health. However, we've made a lot of progress over the last decade. So this is a very exciting area. And I think you'll find today's panel very rewarding.

I'm going to ask each one of our panelists to begin by giving us just a very brief thumbnail sketch of their work, so you can have an idea about what they're doing on a day-by-day basis. So please make it brief, just to give our students an idea. We'll start with Mindy.

MINDY KRONBERG: Okay. I'm a clinical psychologist. I work for LSU, and my focus is on trauma. I also have a

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

specialty in infant mental health, and I work closely with first-responders. Since Katrina, we've been working onsite in police stations, fire stations, and in schools in New Orleans, St. Bernard and Plaquemines Parish.

DARYL PAULSON, PH.D.: I'm Daryl Paulson, and I actually have a different thing. I am CEO and president of BioScience Laboratories, but I do counseling for traumas as just a favor for what I went through when I was in Vietnam. It was just horrible and the trauma of Vietnam is present in the traumas of the latest wars.

SHINPEI TAKEDA: My name is Shinpei Takeda, and I'm the founder and the creative director of the Aja Project. It's an organization that works with the refugee youth— working with photography and media arts.

So I have a project in refugee camps in Thailand. And also, we work with internally displaced people in Columbia— in Bogotá. And also in San Diego, we work with recently-resettled refugee young people from Iraq and Afghanistan, in which they use photography as a way to tell and talk about their stories and how they came from Iraq, how they arrived here, how they feel now. And we also use these images taken by these children, and we put them all over the place— in the neighborhood, in the United Nations' buildings, and stuff like that.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

KATHLEEN ALLDEN, M.D.: And I am a psychiatrist. I wear two hats— probably several more— but I have a foot in human rights, as well as another foot in humanitarian assistance. There's a great deal of overlap in these two fields. And you'll probably learn that during your discussions. My clinical work has been with survivors of torture and severe forms of human rights abuse. I've run two different clinical programs for those individuals in Boston. One was the Indo-Chinese Psychiatry Clinic. And my most recent program, the International Survivors Center, sadly that program is coming to an end.

I have done a great deal of overseas work with refugees as well— Cambodian refugees before they returned to Cambodia, Burmese refugees along the Thai-Burma border. I've also worked in Africa and Sierra Leone, Northern Uganda, refugee camps in Kenya and, more recently, in Rwanda. My work overseas has been in training and technical assistance to non-governmental agencies.

I also was a co-author of UN Standards on Medical-Legal Investigation of Torture and Other Cruel and Degrading Punishments. And I do a fair amount of medical-legal expert testimony in human rights, as well as asylum.

So we have a very broad spectrum of experiences up here on the panel and very exciting to get started. I am going to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

take the liberty, being your moderator, to make a few comments as we get started, because this is a topic about which many people don't know much about.

Why is mental health important? Early on in our field, people would say, "What are you going to do? Do psychoanalysis in a refugee camp? That's preposterous." This is preposterous, but here is why mental health is important—because it's about suffering. Now, as humanitarians, we're concerned about suffering, of course. And that's why we want to do something.

But also, and perhaps equally importantly, is the disability that mental health disorders cause within traumatized populations. It is well-known and documented in psychiatry and research that mental health disorders have a significant impact on social functioning. What is social functioning? Going to school, taking care of your family, going to work, rebuilding your society— all of these things are social functioning. Social functioning can be so dramatically impaired by emotional distress and psychiatric disorders that this has been increasingly researched.

In the 1990s, there was a study put out by the WHO called the Global Burden of Disease, where finally, disease was looked at, not in terms of only its mortality rates, but in its morbidity rates as well. And there's a new calculus now for

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

looking at disability, in terms of adjusted life-years. And this study revealed startling results. And you have this on your informational sheet on your tables there— that mental health disorders cause a tremendous global burden of disability. And these studies that were performed on general populations around the world have pretty huge implications for post-conflict regions and traumatized populations, because if most of our disability is going to be due to mental health disorders in the coming years, if you extrapolate these numbers to traumatized populations and they're trying to rebuild their own countries, it has really remarkable implications. So, mental health is important from the economic development point of view as well. Social capital has to be restored. So, as people are interested in international development post-conflict reconstruction, mental health is pretty important.

So, how do we approach it? This is such a huge topic, as you can tell from our panelists— everything from working with kids in Louisiana here post-hurricane Katrina to working with vets coming back from war, to working with refugees in San Diego and in Columbia— internally displaced people. What do you do, and where do you begin?

So a model has emerged, in terms of policy and strategies for intervention. Best practices are being defined

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

increasingly. And I'll just say briefly, and then we'll go to our panelists to help flush this out.

If you think of a pyramid, and the tip of that pyramid, you have the smallest population, but of the very most highly traumatized individuals. These are the people who are at high-risk. These are people who have had such a bad experience. They're suicidal. They're psychotic. They may have had pre-existing mental illnesses, such as schizophrenia. In a post-conflict context or post-disaster conflicts, these people need a tremendous amount of help. Often times, they don't get it. But these are the high-risk cases. They need one-on-one curative intervention. And if you take a public health approach, the levels of intervention will be curative, preventative, and then health-promoting. So the tip of that pyramid requires curative.

The middle layer are those people at-risk— former child soldiers, people who have experienced rape, people who have experienced atrocities during genocide within their own family. These are very highly impacted people, but there's some that's basically still functioning, at-risk though, for developing a significant mental disorder without the proper supports. And they need preventative measures. And we'll hear our panelists talk about that.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And then, the bottom layer of that pyramid, which is the biggest section of the general community that's impacted by the war or disaster, and they're getting by. Maybe they're somewhat less impacted, but they're still experiencing emotional pain as a result. And what you do for them, you provide community-based supports. And we're going to talk about that.

So that's the model of intervention. That's where policy is moving. So, I want to begin today by flushing these things out with our panelists. I can give you some examples myself, but I think we'll begin with talking about high-risk. And as I mentioned, let me just give you a couple brief examples to just make sure you know what I mean.

High-risk individuals need curative programs. You have a torture survivor who's been imprisoned for several years—tortured repeatedly. This individual may have brain-damage from beatings to the head and starvation. They need one-on-one therapy as well as, perhaps, even medications. The program I ran in Boston, this is what we did, as well as concrete social services. There's a program at the Burma border that I've worked extensively with training indigenous medics to provide one-on-one counseling.

If you take an example of at-risk population, I can give you an example in Northern Uganda— a former child soldier

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

program where these individuals were given skills-based training— how to herd goats, given goats to begin new herds with, some of the young people were taught tailoring. It improved not only their self-esteem but their position in the community and their ability to support themselves— very effective program.

And an example of health promoting in a traumatized community, Northern Ireland, for example— I visited and consulted with a program in Belfast that was a peace-building initiative for families affected by the troubles. And it was for promoting peace within that context. So those are some of the examples of programs within those various levels of the pyramid.

So let's begin by asking our panelists if they could give us some feedback on that. And I'd like to begin with, let's say, the top-level there of intervention on the one-on-one basis. And I'd like to turn the discussion to Daryl with his experiences with veterans.

DARYL PAULSON, PH.D.: Well, let me take this down when I came back from Vietnam. I came back, and I was 21. And I went to talk to some people in a bar, because I could talk now, and I could go to a bar. They wouldn't even talk to me. And I did this probably about two or three people, and I started to think, "What is going on? What's going on?"

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And when we took the bus to the airport, I remember some guy said something about baby-killers or something. And I wondered, "What are they talking about? I'm not a baby-killer." And even before that, I remember landing on the plane. We came in to El Toro Marine Base— I was a marine— and I thought, "Wow, this is going to be good. I survived Vietnam." And I went like this and walked out of the plane. And there's three people that were standing there. And they were giving us doughnuts and things like that— and milk. And they were wives of military people. And I just lost it. Something had really happened right then, and it proceeded.

When I went to school— well, this was probably about three months later. I went to school, and they would have protests. And I would get so upset— protesting me? And then, I'd sit there, and I just couldn't find myself. And I quit talking about Vietnam right then and drank, and drank and drank. It was just horrible. It was just horrible.

KATHLEEN ALLDEN, M.D.: I think that's a good description of why an individual needs personal attention— one-on-one attention after coming back from war. I don't know what the sounds effects are.

[Laughter]

We're entering his war zone, I'm afraid.

SHINPEI TAKEDA: A little traumatized.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

KATHLEEN ALLDEN, M.D.: Yes. [Laughter] Okay. So let's continue along with our model, but I think many of us are aware of what the VA offers or doesn't offer about what our veterans need.

I want to then take the discussion to Shin, because Shin is working in what we call psycho-social programming, where it takes on the task of addressing youth who are at-risk. So, Shin, would you describe some of that?

SHINPEI TAKEDA: I guess I can start from also I point-of-view. I was not much different from where you guys are, and I started this organization when I was about 21-years-old. And I didn't set out to do, to be honest, mental health work [laughter]. I thought it was cool to take photographs with kids in refugee camps. And it was fun; they have fun.

So, sometimes these terminologies- I'm not saying anything contradictory to what we're talking about. These terminologies can be very overwhelming, but I think it's also important to keep those theoretical framework, but also, they're human. Daryl may be a high-risk victim, perhaps, but he's Daryl- he's human. So I think it's so important to create that relationship, and that, when you set out to do this work, not forget about that portion.

So one of the work I do is working with refugee kids, and they take photographs. And what does that have to do with

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

mental health or psycho-social work? We have an assignment, and they take photographs.

For a case of a re-settled refugee in San Diego from Iraq, we asked him to take photographs of your feelings about old home. So they go home and take photographs of their carpet they brought from Iraq. Or they take a photograph of their old photos from Iraq. And then, they write about it— how do they feel about it? And then, we talk about, "Okay, tell us about how you felt when leaving there." So they take photographs and recollect their memories. And then, tell us, what does it feel like now? What is your new community? And so, they take photographs of their new community— new place.

And then, tell us about yourself ultimately. So they do a self-portrait work. So what we do is, we ask them to tell us who you are, but through a very non-threatening way. So they do that in the photographs.

And then, we take this image and make them large and put them in their neighborhood. And then, so they feel that their stories are validated. They know that they're important. So that's the kind of work we do. And that's one of the, I think, community-based intervention approach. I think it's interesting.

KATHLEEN ALLDEN, M.D.: This is a good example of constructing a narrative and meaning from one's own life

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

experiences. And this is something Daryl has written about in his book. And we'll come back to it later, because what a personal experience of trauma means to the individual, and then, one's own personal trauma story are very important in how one reacts to it.

But I want to go to Mindy first, because Mindy has a broad array of programs and experiences that she's involved with. But, Mindy, I'd like you to focus on the community-based psycho-educational mental health-promoting activities that you do first, for us to follow along and providing our students with this model.

MINDY KRONBERG: What we realized after the hurricane— and probably many of you in the audience can speak about the hurricane, as well as me, or any of us, because you went through it— but we realized that people did not know what was going to happen afterwards— how people were going to respond. We work with students going back into schools. We realized very quickly that people were not going to come to us. They were busy rebuilding houses. These people needed mental health, but we were going to need to go into the community.

We also realized that in the center of the community are schools. You can't have a community— you can't have families come back without schools. So, the first people who came back were the first-responders, and they were living on a

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

cruise ship. They were by themselves. As soon as we can get the schools open— Jefferson Parish, I believe, opened first. And then, St. Bernard Parish opened very soon after that in November. So, when the schools opened, we realized that was the place to come in and to teach the community, to teach the teachers, and to teach the parents. And we started with psycho-education. We let them know about what to expect for themselves, as well as the students— what they could do for the students to help them.

And, one of the things I wanted to talk about— we're focusing on policy. We started talking about the young children too. We're talking about overlooked victims. And like I said earlier, I work with children age zero to five. And, a lot of people don't know that they could use therapy. I'm an infant mental health specialist. I learned that in graduate school. I was lucky enough to apply to a school that was focused on trauma. I work under Dr. Joy Osofsky who's an infant mental health specialist. But I had never heard about it in undergrad. I didn't know it existed.

So we were able to educate the community that the babies that were six months— that were two and three— would need some, not psychoanalyst— not lying down on the couch— but telling people what to expect for themselves in different ages and how to help them.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

KATHLEEN ALLDEN, M.D.: There's something that's coming across in the descriptions that I hope you're picking up on. When you're working in mental health and psycho-social assistance, it's multi-modal, multi-dimensional, multi-disciplinary. And I want our panel to take this up, because this is a very important theme. You can't work as an individual isolated psychiatrist, or psychologist or social worker. You have to work as part of a network.

For example, in my clinical program in Boston, we had psychiatry, social work, bi-cultural mental health counselors. Basically, we had to find everything from a place for an individual to live, food for the family, dishes, blankets, medications, primary health care, psychological help—everything from top to bottom. You find this in refugee camps as well, where you take a camp that has a wonderful community mental health program.

You noticed in our presentation this morning, there were two lost boys from Sudan in that crowd. Well, I visited that camp, both before they were re-settled and after they came, I met them here. This camp had a very unique community-based mental health system that did a lot of outreach, made home visits, provided medications to people with mental illness, but did a lot of concrete social services as well for families experiencing domestic violence and needing special

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

material assistance as well, so multi-dimensional, multi-disciplinary.

And I want to expand on this with our panel. Let's begin with Daryl again, because Daryl was the one that I'd like him to flush out more about the personal narrative. And then, we'll move on to our other discussions. But I would like you to mention that.

DARYL PAULSON, PH.D.: Yes. I think it is critical, first of all, instead of being stuck in the physical area, to open up and have an inner and an outer me, and an inner and an outer everything else, because they definitely relate and make sense.

But I didn't have this when I came back from Vietnam. I remember that I just started drinking, and drinking and drinking, and just tightening up my being. And one night when I tried to go to sleep, my heart just took off, and I had a panic attack. I never had one of them in my whole life. And I was terrified; I thought I was dying. So I got in my car. I drove to the student health department. And the guy, he came down, "What's wrong?" Well, I said, "I don't feel good. I'm dying or something." So he listened to me. He said, "Nah, nothing's wrong. Go home." So I went home, and I was wound up and I laid down, and I breathed, and I could hear my heart— I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

could just feel it and I just sit and wait and wait— what's going to happen now? What's going to happen?

And then, nothing happened until the next day I went to school. It happened in accounting class. I couldn't believe it. I couldn't believe it. I had to get out of the class. So I got out of the class, went to the doctors. Well, he looked at me and said, "Nothing wrong. What's your problem?"

Well, this had gone on, and on and on, probably about ten times, five times, something like that. And he finally gave me a tranquilizer. And boy, I was out of it— I was just gone. It didn't seem to really help, because when I drove to my town from the university's town, I had another panic attack. But this time, it was full circle. It was the real panic attack. I thought I was dying.

KATHLEEN ALLDEN, M.D.: I want to interrupt Daryl right now, because he's giving us an example of how the medical system doesn't know what to do. And I want to move onto Mindy, because she works within a very complex mental health system that has come up with scores of ideas about what to do. So due to limitation of time, I want to move onto some of those responses, Mindy, about the multi-disciplinary approaches that you've taken here in New Orleans.

DARYL PAULSON, PH.D.: So, then I—

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

KATHLEEN ALLDEN, M.D.: Can we move onto Mindy, though?
I'd like her to answer that question.

MINDY KRONBERG: I think you're giving a wonderful example of how you actually feel after a trauma. And people have the need to tell the story— to talk about it. But we have psychologists, psychiatrists and social workers. We also work closely with pediatricians. I work with adults, but mostly with children. So we work closely with pediatricians— get referrals. And we work as a community without many distinctions. Often there's a distinction between the psychologist and the psychiatrist. One of the things we did was that we realized we had to meet the need. And the need wasn't always sitting behind a desk, either dispensing medication for psychiatrists or— is this where you're going?

KATHLEEN ALLDEN, M.D.: Yes. You said precisely what we're looking for— this multi-disciplinary approach. And we only have a couple minutes left.

But, Shin, has some important things to say about two matters that relate. And I'd like his comments on the cross-cultural matters that come up, as well as the stigma and how to work within communities without using the terminology, per se, of mental health. And, Shin, could you give us some of your ideas on that?

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

SHINPEI TAKEDA: Sure. First of all, I'm from Japan. And just to make us aware that this idea or the word mental health, we still don't have a translation for that. So, I think it's also important for us to know that this terminology and some of the terminology we're using is very based on the world view of more or less western world, I think. So in places like Thailand, her experience was— it was difficult for me to explain that. But for us, it was important to just talk about more tangible results— education— they will learn photography, they will learn writing skills. So that was the way we approached it.

And also the stigma portion is also very important. I think it's not something that we can fix. And I think that's a very important thing. It's not a problem that needs to be fixed, but I think it's something that requires a long time of support and care from the community.

KATHLEEN ALLDEN, M.D.: Well, I'll say one more thing and then, we'll conclude, because we only have about a minute and a half left.

When working cross-culturally, you have to be very much in partnership with the individuals in the country or the particular ethnic group with whom you're working, because you don't know the questions to ask. We only know what we, as western-trained researchers, or scientists or professionals,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

have been taught. We have to work in partnership with our colleagues as equals.

So, in sum, I hope you've been able to get a flavor of how complex this field is. And we've only touched the surface—the wide array of programs that are available and those that really do need to be developed within each unique cultural, political, geographical context.

I want to thank our panelists for helping the audience get a picture of this very new and developing field. Thank you. [Applause]

FRANKIE BEVINS: All right. Thank you all. You guys know the drill. So now we're going to turn to our tables and discuss among yourselves. The questions are very similar to those in the morning. So just again, spend a brief five-minutes or so pulling out the nuggets of what you got from the panelists.

Going over that, we had a broader range. We had personal experience. We had more of a clinical outreach approach. We have theoretical frameworks. And, of course, we have Shin's project, which is on-the-ground outreach with children.

So, feel free to take that as a platform—jumping off and thinking. Also, while it's outside the confines of this particular panel, we're all very aware that this issue has hit

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

home in a big way on university campuses recently with suicides, violence, and other unfortunate outcomes. So, feel free to think about that framework as well.

Table facilitators, please try and enter the themes and ideas immediately, so that our theme team can capture them over the entire course of the half-hour. And participants, again, try and think of really tangible things that you, we, universities can do on campuses. So with that, get started.

[END RECORDING]