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COMMENTARY TO SPECIAL ARTICLE

The ADAPT model: bridging the gap between psychosocial and individual responses to mass violence and refugee trauma

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Commentary on: KE Miller & A Rasmussen (2016). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology and Psychiatric Sciences* 1–10.

In the Special Article on refugee and post-conflict mental health by Miller and Rasmussen (2016), the authors proposed an expanded model concerning the determinants of mental distress, focusing particularly on post-traumatic stress disorder (PTSD) and depression. We identify three core assumptions in their exegesis which we believe understate the dynamic interactions between the collective and the individual human psyche in determining the course of adaptation in the sequence of unfolding experiences that characterize the lives of refugees. These assumptions include that: (1) trauma, like a physical injury, has a linear relationship with mental disorder; (2) past trauma and ongoing stressors are distinct constructs rather than part of a continuum of experiences that interplay in a dynamic manner, linking past, present and future; and (3) it is legitimate to objectify these events as isolated occurrences without taking into account their subjective meaning (both individual and collective) or the continuing abstracting process that humans engage in to assess the implications of the succession of events and conditions they live through in order to bring coherence and organization to experience, the quintessential characteristic of the human psyche. From an evolutionary point of view, the latter process is vital to mounting corrective actions in an ever changing ecosphere, a sequence of adaptations that promote survival. The integration of past, present and anticipated future experiences is a human characteristic intrinsic to all theories of human development and learning. Assuming that the human psyche responds primarily to immediate stresses, without that response being heavily influenced by past experiences, particularly of a highly threatening nature, flies in the face of all notions of development and adaptation.

We have formulated and partly tested the Adaptation and Development after Persecution and Trauma (ADAPT) model (detailed hereunder) with the aim of locating refugee mental health within an adaptational framework that highlights the ever-changing ecosocial context which acts as a moderator and gestalt of the foreground sequence of experiences ranging from traumatic events to post-traumatic stressors; how the individual integrates and responds to these experiences is in turn is grounded in biological, psychological, social, cultural and existential aspects that have enduring although not immutable characteristics. In the remainder of the commentary, we outline the key tenets of the ADAPT model and early empirical findings that appear to support the relevance of the framework to refugee and post-conflict mental health.

The ADAPT model (Silove, 2013) offers an integrated framework aimed at linking a wide array of psychosocial factors or determinants (using these concepts as dynamic and ever-changing phenomena) to a diverse range of mental health outcomes of relevance to populations exposed to mass conflict and displacement. The model postulates that, from an ecosocial perspective, the effects of conflict and displacement can be organised according to the impact on five interrelated psychosocial domains or pillars that under normal conditions, underpin stable societies. These psychosocial domains comprise safety and security; the integrity of interpersonal bonds and networks; access to justice; ability to pursue roles and maintain identities; and freedom to pursue activities that confer meaning (in the spiritual, religious, cultural, or political spheres). Sequential changes in the ADAPT domains reflect the continuum of experiences of

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refugees as they progress through the phases of social disruptions spanning periods of conflict and persecution, displacement and resettlement. Trauma exposure and ongoing stressors represent the more concrete and proximate experiences or conditions that punctuate and shape the ADAPT pillars, the interaction determining individual and collective responses, which may be adaptive or pathological. In that sense, the backdrop of the ADAPT psychosocial pillars form an ever-changing gestalt that moderates and in turn is influenced by the 'foreground' events and conditions (measured as trauma, stress and adversity) in determining mental health outcomes. A framework that explicitly acknowledges the constant mirroring effects of the eco-social sphere and the individual psyche, assists in bridging the artificial divide between a clinical/individual focus, the emphasis being on conceptualizing these differences along a fluid continuum rather than as reified, categorical distinctions.

A core postulate of the ADAPT model is that the psychosocial pillars identified overlap and interact, the greater the undermining of several pillars, the more likely that foreground experiences (cumulative trauma and stress) will lead to adverse mental health outcomes. Further, the range of mental reactions (normative and pathological) is extended beyond the conventional categories of depression and PTSD; the complex interaction of different types of trauma and stress against the background of varying degrees of disruption of the psychosocial pillars, produces a variegated and overlapping constellation of symptoms (for example, explosive anger, prolonged grief, complex-PTSD and separation anxiety), a patterna commonly observed among refugees.

In that sense, the ADAPT model attempts to rescue the notion of trauma from the misattribution that the events are akin to objective 'injuries' to the psyche, a mechanistic perspective that encourages the notion that outcomes, such as PTSD, are static illnesses. ADAPT model attempts to re-infuse meaning into events, living conditions and psychological response as they are experienced and understood within a specific psychosocial and cultural context both at a collective and individual level. The framework re-instates the notion that humans attempt to ascribe meaning to events and the contexts in which they occur, in doing so linking past experiences with present conditions and future eventualities. The human psyche may be unique in being able to achieve this level of abstraction which the ADAPT model attempts to reflect, that is, the capacity to organise and synthesise concrete events and everyday experiences into their meaning domains represented by the five broad psychosocial domains. Of necessity, such an organisation is not perfect, encapsulating somewhat diverse phenomena that overlap with other pillars. Together, however, the pillars are designed to represent universal experiences of refugees, offering an intuitive and meaningful overview not only to professionals but to the survivors themselves (Silove, 2000; Silove & Steel, 2006).

From a clinical perspective, the ADAPT model allows for a systematic examination of the transition points along a continuum progressing from normative responses through to states of distress and to frank mental disorder. For instance, it is postulated that exposure to systematic human rights violations such as politically motivated murders, rape, torture, common experiences for refugees, fundamentally challenges the sense of injustice (ADAPT pillar 3), which, in the absence of redress and other exacerbating factors, may result in persisting feelings of anger, which, under certain circumstances can become pathological (Rees *et al*. 2013; Tay *et al*. 2015*c*). At the individual level, the person may develop symptoms consistent with intermittent explosive disorder, whereas at the collective level, these reactions may increase risk of family conflict and domestic violence (with risk of transgenerational impacts), and wider ranging social consequences (Rees *et al*. 2013). This example, indicates how the ADAPT model encourages integration of the background gestalt of the changing ecosocial context and the foreground experiences of trauma and stress; between the psychosocial impact of the refugee experience and individual psychological responses; and between the latter and the wider familial and social impacts of past trauma, the longer-term effects that are critical to efforts of social stabilization and peace-building.

Given that the ADAPT model draws heavily on existing observations (clinical, theoretical and scientific), a large number of studies have tested discrete aspects of the framework, for example, the impact of life threatening events (pillar 1) and traumatic loss (pillar 2) and mental health outcomes. However, it is only recently that research has been conducted that explicitly tests all pillars of the framework simultaneously. We have included an operationalised index of ADAPT in the comprehensive Refugee Mental Health Assessment Package developed and validated among West Papuan refugees, other components including trauma events, ongoing stressors and a range of mental disorders (Tay *et al*. 2015*b*). In a series of modelling analyses, the composite ADAPT index proved to play a key role in the pathways leading to several pathological outcomes including PTSD (Tay *et al*. 2015*a*), complicated grief (Tay *et al*. 2015*d*) and adult separation anxiety (Tay *et al*. 2016). In a key analysis, we could not achieve convergence for the conventional model in which the quantum of trauma and adversity lead to PTSD, either directly or indirectly. Only when the ADAPT index was included, did the model

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converge producing a good fit and demonstrating a direct effect of the index on ongoing adversity as well as a moderating effect on trauma exposure. Several ongoing studies examining the ADAPT measure in a further sample of West Papuans residing near the border of PNG, and among displaced refugees from Myanmar in Malaysia, will shed further light on these theoretically supported relationships.

An important issue is whether the ADAPT model can make a contribution to the treatment of refugees. Mounting evidence indicates that trauma-focused psychological treatments (such as Narrative Exposure Therapy are effective in treating PTSD (Neuner *et al*. 2010). Broader approaches, such as the Common Elements Treatment Approach, offers a flexible and personalised approach in treating a range of symptom constellations based on a trans-diagnostic framework (Murray *et al*. 2014). Other transdiagnositc and psychosocial treatment approaches (e.g., Problem Management Plus by World Health Organization) (Dawson *et al*. 2015) have shown promise in treating symptoms of common mental disorders in conflict-affected settings (Rahman *et al*. 2016).

However, extant clinical and psychosocial approaches focus primarily on the amelioration of mental health symptoms, even though it seems likely that many indirectly involve issues relevant to the ADAPT pillars. We have developed an explicitly experiential psychosocial intervention (Integrated ADAPT Therapy, IAT) that focuses more directly on the meaning of the continuum of changes experienced by refugees, organised according to the constituent five pillars. We postulate that an explicit understanding of the pillars and their flexible application within the culture and context, can assist refugees in four possible ways. First, it provides a conceptual framework to bring some coherence to the sense of chaos that many refuges experience. Second, the pattern of distress/social dysfunction identified and its correspondence to the undermined pillars of the ADAPT model can provide a platform for self-help and targeted interventions with the aim of assisting survivors in strengthening their coping skills and capacities for change and adaptation. Third, by focusing on resilience and adaptation, it is assumed that the resulting improvement will mitigate mental health symptoms without the need for a specific focus on complex comorbid diagnoses. Fourth, from a public mental health perspective, IAT has the potential to be applied as a preventative or health promotion approach for use with appropriate modifications across a range of sectors in refugee communities. In its early proof of concept and piloting phase, we have contextualised the universal pillars within the culture and specific environments of a range of refugee groups. Our preliminary observations suggest that IAT resonates strongly with the lived experiences of refugees in a range of settings and has promise in reducing distress, bringing coherence to the sense of chaos and increasing adaptive capacities of refugees with varying levels of distress. Our ultimate goal is to produce a genuinely translational epidemiology model in which community-wide problems identified in community surveys (explosive anger, grief, alienation) are understood within the ADAPT framework, prompting interventions (self-help, community mobilization, external support) that assist in repairing the ADAPT pillars both at the broader eco-social and intra-psychic levels, an approach that ideally will be integrated into public mental health and psychosocial support programs for refugees.

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