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ARMED CONFLICT AND THE MENTAL HEALTH OF CHILDREN

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Introduction

Armed conflicts, defined as 'any organised dispute that involves the use of weapons, violence, or force, whether within national borders or beyond them, and whether involving state actors or nongovernment entities' (Kadir et al., 2018: 2), are said to impact one in ten children worldwide with estimates of around 230 million children living in areas affected by conflict (UNICEF, 2015). In this chapter, we will explore the impact of armed conflict on children's mental health briefly, outlining community-based and trauma-based psychosocial interventions. We conclude by offering a critique of Western-focused psychosocial interventions, highlighting the importance of culturally responsive interventions, which take on board, locally socially constructed ideas of healing and trauma.

Armed Conflict and Children's Mental Health

Armed conflicts impact on children directly, for example, through death, injury, illness, hunger, trauma, increased violence, including sexual trauma, separation from parents, and impacts on mental health but can also impact on children indirectly. Indirect effects can be a lack of access to medical and education services, poor living conditions, disrupted social orders, and unsafe environments. Moreover, armed conflicts can mean that many children will have to leave their home and seek sanctuary in another part of the country (internally displaced) or seek refuge in another country (refugees and asylum seekers). Armed conflicts also involve children because they can become involved in the fighting themselves, either as 'child soldiers' or as porters and cooks for armed groups. It is said that the

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impact on children of armed conflicts can continue throughout the life-course and impact on life chances (Kadir et al., 2019).

Exposure to trauma from armed conflict is said to lead to several mental health issues in children including post-traumatic stress disorder (PTSD), depression, anxiety, and suicidal thoughts (Dimitry, 2012). The prevalence of PTSD in children, for example, was found to be 23%–70% in Palestine and 10%–30% in Iraq, whilst in Rwanda, it was estimated to be between 54% and 62% after the 1994 genocide (Dimitry, 2012). The literature highlights how armed conflict can lead to prolonged stress responses in children, resulting in toxic stress, with Feldman et al. (2013) identifying changes in cortisol and salivary amylase in children, because of war stress. This may be exacerbated for children who are in extremely difficult circumstances because of gender (girls), unaccompanied children (who have lost or been separated from their parents/carers), or children with disabilities (Ataullahjan et al., 2020).

Research demonstrates, for example, that in Syria, an estimated 30% of children experienced toxic stress due to the unstable environment (Raslan et al., 2021); this manifested itself in nervousness, nightmares, sadness, and aggression, as reported by their parents, increased bed-wetting at night, and during the day, and many became mute or developed speech issues such as stutters (McDonald et al., 2017). This prolonged exposure to toxic stress and cortisol activation is said to disrupt their developing neuro-endocrine-immune response and, in some instances, physiological development (Franke, 2014). Continual multiple causes of trauma and toxic stress, therefore, have been highlighted, as not only having an immediate impact but also life-long impact on children's socio-emotional and mental health development and increased risk of several chronic physical and mental health difficulties in later life (Franke, 2014; McDonald et al., 2017).

The number of children involved in armed conflict as 'child soldiers' is increasing (United Nations, 2018). Many of these children perpetrate violence themselves and, at the same time, are subjected to violent acts, including torture and rape (Betancourt et al., 2020). Research has indicated that both shorter-term and longer-term mental health issues, amongst this group of children and former 'child soldiers', are worryingly high. However, not all 'child soldiers' report long-term mental health issues, and this may be a result of the level of trauma that they were exposed to, as well as other factors, such as stigma and levels of community and family reintegration (Betancourt et al., 2020). Su et al. (2021) in their longitudinal study found that children who were 'soldiers' in Sierra Leone during the civil war were more likely to report mental health issues, including PTSD, as well as hyperarousal, and difficulties in controlling emotions, if they had experienced higher levels of war trauma, including the perpetration of violence, being a victim of violence, and the loss of loved ones. They highlight that this has important implications for interventions in low-resource countries and that 'child soldiers' who report elevated levels of war involvement should be prioritised in relation to interventions.

Mental Health and Psychosocial Support Interventions

Inter-Agency Standing Committee (IASC) (2016) guidelines for mental health and psychosocial support (MHPSS) in emergencies highlight the importance of creative expressive, psychoeducational, and cognitive behavioural strategies to support children's mental health in armed conflict situations. There is a growing body of evidence on MHPSS interventions and practice in conflict settings, particularly in sub-Saharan Africa, although these are not always adequately documented (Kamali et al., 2020). In relation to psychosocial and trauma-based interventions, the focus tends to be on supporting resilience, management of stress, and conflict resolution, as well as trauma-focused cognitive-behaviour therapy and psychotherapy. Mindfulness-informed interventions are also popular and focus on improving wellbeing and decreasing stress (Franke, 2014). Other therapies, which focus on decreasing heart and respiratory rates, as well as breathing techniques and guided imagery, have also shown to reduce toxic stress (Franke, 2014). Narrative Exposure Therapy and meditation-relaxation were also found to improve recovery rates for PTSD (Catani et al., 2009). In the Narrative Exposure Therapy, children gave a detailed account of their biography, with the traumatic experiences recorded into a coherent narrative by a therapist, enabling them to relive the emotions. With the meditation-relaxation intervention, children went through six sessions involving assessment, participation in psychoeducation, followed by breathing, meditation, and relaxation exercises, led by counsellors (Catani et al., 2009). Moreover, in the Democratic Republic of Congo, a 15-session, group-based, culturally adapted Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) intervention was found to be effective in reducing post-traumatic stress and psychosocial distress among 50 former 'child soldiers' and other war-affected boys in a randomised controlled trial (McMullen et al., 2013).

There are a limited number of community-based interventions that have been empirically evaluated, with most of the peer-reviewed literature mainly focused on school-based interventions (Betancourt et al., 2013). A greater focus on the evaluation of interventions that strengthen community and family support is, therefore, required (Jordans et al., 2016). Nonetheless, 'Child Friendly Spaces' (CFSs) are often highlighted by humanitarian organisations as being key to supporting children's psychosocial wellbeing in armed conflict settings. CFSs are 'safe' community-based spaces where children can engage in 'normal' fun activities such as play, arts and crafts, drama, and have opportunities to make friends. These activities are normally facilitated by trained practitioners often from the child's own community. Since 2011, 'Syria Relief' operates CFS through school platforms to address children's exposure to toxic stress (Raslan et al., 2021). They work with trained psychologists, counsellors, case managers, social workers, and caregivers to provide group and individual support using a four-tiered approach namely: (1) provision of clothing, food, hygiene packs, and financial vouchers for vulnerable children and families; (2) community engagement through psychosocial support (PSS) activities and awareness campaigns on the importance

of MHPSS, identification, and referral of at-risk children; (3) non-specialised support activities, often implemented directly at the schools, including guided art, sport, play, peer interaction, and skills-building activities; and (4) specialised focused services and treatment (Raslan et al., 2021). Another example of the implementation of CFSs is by 'BRAC', in partnership with the LEGO Foundation, Sesame, and UNICEF, who have been implementing the Humanitarian Play Labs, an MHPSS model in Rohingya refugee camps in Bangladesh since 2018 (Frounfelker et al., 2019). The CFSs provide safe spaces for children aged 0–6 years to access free and structured play and learning activities with adult supervision. The model combines play and PSS to address the mental health needs of children, delivered by trained paraprofessional play leaders, and has been lauded for its novel approach in humanitarian settings (Frounfelker et al., 2019).

Other forms of community-based interventions include art-based services such as 'Save the Children's HEART' programme in Syria, which supports children to communicate their feelings, through activities such as drawing, music, role-play, and drama (McDonald et al., 2017). School-based activities are also used to support psychosocial wellbeing and mental health. One example of a school-based programme was implemented in the Gaza Strip for Palestinian children. This included teachers, parents, social workers, and counsellors working with children using cognitive-behavioural technique to discuss and work upon traumatic experiences. Other activities also included games, physical activities, and drama to increase self-esteem, wellbeing, relationships, and cooperation amongst children (El-Khodary and Samara, 2020). School-based programmes can also include mentoring, after-school clubs, and use of lay counsellors (Ataullahjan et al., 2020).

Culturally Responsive Interventions: Critique of Mental Health and Trauma Based Interventions

Universal ideas of mental health and trauma, based on Western socially constructed biomedical categories of health and wellbeing, have been critiqued by many social scientists (Torre et al., 2019). The main tenet of the critique highlights that 'mental health' is socially constructed and the 'way in which people express, embody, and give meaning to their afflictions are tied to specific social and cultural contexts' (Honwana, 2006: 150). It is argued that the contemporary western focus on the individual, or person-centred emotions, underpins the increased emphasis on psychosocial interventions, to support mental health in armed conflict and humanitarian non-Western settings. This is seen as problematic for several reasons. First, a focus on individual trauma or emotions may not be recognised by many non-Western societies, who may be more likely to focus on distress, in relation to what has happened to the moral and social order, as opposed to them individually (Kirmayer, 1989). Moreover, the description of communities or individuals as traumatised can in turn undermine agency and result in the community or individual viewing themselves in this way (Armstrong,

2008). Second, the focus on (emotional) vulnerability means that resilience can be ignored (Torre, 2019), which leads to an emphasis on therapeutic medicalised interventions, as opposed to reinforcing existing local support networks and empowering communities. Imposition of Western values of trauma and individual emotions on non-Western societies could be perceived as a form of modern global imperialism, where Western ways of thinking become dominant across cultures.

It is also argued that Western-focused mental health and trauma definitions, which are used by the international humanitarian and aid communities across the globe, lead to the 'psychologisation' of non-Western populations (Enomoto, 2011; Pupavac, 2005) and constitute modern-day 'international therapeutic governance' (Pupavac, 2001), a form of control whereby 'global social risk' is managed to support Western interests. Pupavac (2001) questions the relevance of Western-based psychosocial interventions for war trauma in non-Western countries and highlights the importance of culturally and locally relevant support systems and coping strategies. Moreover, the medicalisation of war trauma is said to lead to the pathologisation of communities and individuals as being 'unable to function', pathologising normal responses to distress. This results in externally programmed 'psychosocial interventions implicitly [denying] the capacity of populations for self-government' (Pupavac, 2001: 365) and undermining responses to conflict, grief, and pain, which may be appropriate to the situation.

Although therapeutic psychosocial interventions are a hegemonic discourse amongst international stakeholders and humanitarian aid workers, there is lack of evidence on which psychosocial interventions work (Torre et al., 2019). For example, the evidence for the success of CFSs is limited due to the poor evaluation design of the interventions (Ager et al., 2013). Whilst some evaluations of CFSs found some short terms benefits, they did not demonstrate any longer-term benefits to the children (Metzler et al., 2019). Furthermore, CFS models have been noted to have a weakness in terms of community engagement (UNICEF, 2018). Torre et al. (2019) claim further that, in many cases, Western psychosocial interventions can do more damage than good and can lead to people claiming symptoms that they do not feel, to fit in with the categories of trauma, which aid agencies support. This was found in Honwana's (2006) work with 'child soldiers' in Mozambique and Angola and describes how returning 'child soldiers' 'quickly understand that their status as victims is crucial to obtaining aid (from non-governmental agencies (NGOs)……and are likely to enhance their victim status in the presence of NGOs' (Honwana, 2006: 15). This resulted in them telling the stories that they believed the NGOs wanted to hear e.g., stories of trauma, helplessness, and need for support to access services such as education and health, as well as other poverty eradication interventions. Torre (2019: 14) argues that there is also very 'little evidence that war-affected individuals in non-Western countries have regarded their mental health as an issue or looked for specific treatment for it en masse' (Almedom and Summerfield, 2004). This is problematic due to increased focus from NGOs on offering these services to local

populations. Many donors who fund NGOs are based in Western countries and may have visions of what needs to be the focus of humanitarian development initiatives; hence services provided in non-Western countries, for example, may be influenced more by international dictates than local need (Morgan, 2016). The relatively recent focus on armed conflicts as 'psychological emergencies' may be justification for the NGO's presence in armed conflict situations, as well as justification to funders that they are doing something about the issue (Torre, 2019).

Honwana (2006: 4) stresses that for interventions to be effective and sustainable, they need to be 'embedded in local world views and meaning systems'. If mental health definitions are socially constructed, so too is the treatment of distress. In the Africa context, for example, this tends to involve community responses, family support, the role of ancestral spirits, and traditional healing approaches, rather than an over-reliance on individual Western biomedical models (Boyden and Gibbs, 1997; Summerfield, 1999; Honwana, 2006). There is a need for improved cultural understanding and cultural sensitivity about the mental health of children in non-Western refugee contexts to improve the effectiveness and acceptability of tailored intervention programs (Im et al., 2017). As an example, the linguistic barrier between Rohingya terms and Western concepts of mental disorders is an impediment in ensuring delivery of culturally sensitive and contextually relevant MHPSS services (Tay et al., 2019). Culturally grounded interventions can be achieved by engaging with communities to understand perceptions, management, and impacts of mental health within their cultural contexts, taking into consideration, the cultural concept of distress, and integration of existing support systems, encompassing psychosocial, behavioural, biomedical, and traditional and religious approaches (Im et al., 2017). Tailored culturally relevant family-based support is also important, as in many cases, children's distress in conflict settings may be a direct result of the trauma they experience themselves, but also a result of the distress that their caregivers experience, with parental psychopathology being a strong predictor of children's mental health (Eruyar et al., 2018).

Conclusion

Although international humanitarian aid agencies acknowledge the need for culturally sensitive programmes to support children in armed conflicts, there is an over-reliance on Western-influenced trauma-based interventions. This is problematic, we argue, because it can ignore the lived experiences and the cultural context of children, meaning that Western ideas of mental health and trauma become hegemonic in non-Western contexts. Ideas about mental health, distress, and trauma are socially constructed within specific cultural contexts and hence, interventions which aim to support children, should reflect the relevant social context, including traditional and local understandings of distress and healing. Critical Public Health theory and Social Constructionism can also provide conducive theoretical frameworks to locate the issues within, particularly emphasis upon the socio-economic context of suffering, trauma, and grief.

Critical Public Health and Social Constructionist theory, for instance, would emphasise the need for practitioners, to reflect upon hegemonic socially constructed Western discourses, such as trauma and mental health, to critically explore, that what may be taken for granted in one context, may not be the case in another. Context and setting are key to supporting children in armed conflict situations, as contextual cultural factors interplay with mental health, and adaptive mechanisms in a unique manner within these settings. Key consideration should be given to cultural factors to enhance diagnosis and management of trauma in children and reduce the intergenerational transmission of trauma, leading to an improved quality of life, and lessen social suffering. Finally, it is also problematic to infer that everyone within a conflict zone will be traumatised as it can lead to the 'psychologising' of whole communities and obscure evidence of resilience and community agency.

Research Points and Reflective Exercise

Here are some questions for you to reflect upon after reading this chapter:

- How far do you think concepts of trauma are universal as opposed to being culturally specific?
- In what ways can psychosocial interventions better reflect the lived experiences and worldviews of children in armed conflict situations?
- What empirically supported strategies are effective for promoting resilience among children, families, and communities in conflict settings?

Further Resources and Reading

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