

Children and the Sphere standard on mental and social aspects of health

Jodi Morris, Mark van Ommeren, Myron Belfer, Shekhar Saxena and Benedetto Saraceno¹

Most of the world's children live in resource-poor countries where people are at a relatively high risk of exposure to catastrophic situations arising from conflict and natural disasters.² Given the potential social, psychological and psychiatric consequences of exposure to disaster, mental health and psychosocial support programmes are increasingly part of humanitarian aid. A minimum standard on mental and social aspects of health is included in the recently revised Humanitarian Charter and Minimum Standards in Disaster Response (Sphere Handbook) (Sphere Project, 2004). Most recommendations for mental health and psychosocial interventions in guidance documents are based on expert opinion rather than research. Consequently, interventions are being implemented without full understanding of their potential benefit or harm. This paper offers a child-focused review of the evidence for each of the interventions described as indicators for the Sphere standard on mental and social aspects of health. It suggests some, but limited, support for each of them. However, the evidence base needs substantial strengthening.

Keywords: children, disaster response, mental health, psychosocial interventions, review

Introduction

Almost one-half of the population of the 49 poorest countries in the world are younger than 18 (United Nations Population Division, 2005). These children³ are much more likely to be exposed to armed conflict and catastrophic situations arising from natural disasters than children living in high-income countries. Accumulating evidence suggests that not only in Western settings (Barenbaum, Ruchkin and Schwab-Stone, 2004), but also in non-Western contexts, children exposed to catastrophic events are at heightened risk of symptoms of depression and anxiety (including post-traumatic stress symptoms), behavioural problems, diminished cognitive functioning, and a host of other non-clinical mental, physical and social signs of distress (Loughry and Eyber, 2003; Lustig et al., 2004; Machel, 1996). In response, mental health and psychosocial support programmes designed to prevent and treat psychological and social disturbances among children exposed to disasters are a rapidly increasing part of international humanitarian aid.

Many governmental and non-governmental organisations (NGOs) have developed guidance (IFRC, 2001; WHO, 2003; World Bank, 2004) and manuals (IFRC, 2003; Action Aid India, Oxfam India and NIMHANS, 2002; UNICEF, 2004) for intervention. Most recommendations in documents and manuals are based on expert opinion, because practice has preceded research. Consequently, interventions are being implemented without full understanding of their potential benefit or harm to different groups.

This paper offers a child-focused review of the evidence for the intervention indicators described in the Sphere minimum standard on mental and social aspects of health (Sphere Project, 2004) for use in acute emergencies. This piece of policy was chosen for review because the *Sphere Handbook* presently represents, across disciplines, perhaps the most widely distributed, basic humanitarian aid text (Van Dyke and Waldman, 2004, p. 25). The Sphere Project was launched in 1997 by a group of influential international NGOs in response to apparent inadequate humanitarian aid provision during the 1994 Rwanda crisis (Walker and Purdin, 2004). The *Sphere Handbook* aims to reflect the collective opinion of experts from hundreds of NGOs and thousands of aid workers by outlining minimum standards for humanitarian aid. The book includes four technical chapters covering key sectors (water, sanitation and hygiene promotion; food security, nutrition and food aid; shelter, settlement and non-food items; and health services) based on the principles and provisions of international humanitarian law (Salama, Buzard and Spiegel, 2001; Sphere Project, 2004). The *Handbook* also contains: a Humanitarian Charter (describing core principles for humanitarian action and the right of disaster-affected populations to life with dignity through protection and assistance); and a 'standards common to all sectors' chapter detailing eight core standards relevant to all sectors (Sphere Project, 2004).

When the early versions of the *Sphere Handbook* were published in 1998 and 2000, mental health and psychosocial support was not included because of a perceived lack of expert consensus on what should be incorporated on mental health.⁴ However, a minimum standard on mental and social aspects of health (within the chapter on health services) has been included in the revised (2004) *Sphere Handbook*. The standard states that '[p]eople have access to social and mental health services to reduce mental health morbidity, disability, and social problems' (Sphere Handbook, 2004, p. 291), which is consistent with the 1966 United Nations International Covenant on Economic, Social and Cultural Rights that articulates 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. The *Handbook* describes 12 intervention indicators for this standard.

The Sphere standards were intended to be universal and applicable to any operating environment. However, in the pre-ample of the *Handbook* it is explicitly stated that in practice, not all standards and indicators are attainable in every single context. Recognition that the appropriateness of the indicators need to be considered in light of the particular cultural and social context was reinforced by an analysis of the Sphere standard on mental and social aspects of health based on qualitative social science literature (Batniji, van Ommeren and Saraceno, 2006). The mostly anthropological and sociological literature emphasises that social structures in disasters are complex, diverse and in flux. This literature, although generally supportive of the type of interventions in this Sphere standard, warns against presuming the universal appropriateness of interventions (Batniji, van Ommeren and Saraceno, 2006).

The Sphere standards were written to be applicable to general populations but with appropriate attention to vulnerable groups, including, specifically, children. However, as far as we know, there has been no child-focused literature review of any Sphere standard. This is a gap given that children's problems after emergencies and their ensuing needs for intervention differ from those of adults.

Research on interventions

Most research on interventions has been conducted in the West and has concentrated on clinical treatment. Generally, these interventions concentrate on individuals or sub-groups displaying signs of distress or symptoms and use methods that are primarily intra-psycho in nature, such as cognitive restructuring and emotional processing of the traumatic event. The strategy of employing psychological, symptom-focused interventions in emergencies has been criticised by some who claim that it fails to capture the social and cultural consequences of exposure to catastrophic events or appreciate children's resilience or indigenous ways of coping, and that it presumes that Western constructions of personhood are universal (Bracken and Petty, 1998; Summerfield, 2000). Indeed, Slovenian mental health workers engaged with Bosnian child refugees have suggested that most of the mental health needs of an affected population may be addressed by non-mental health interventions that attend to basic needs, restoration of the rule of law, safety, security and human rights (Kos and Derviskadic-Jovanovic, 1998). An additional concern is the feasibility and sustainability of highly technical psychopathology-focused interventions in low-income countries. Often these interventions are designed to be implemented by highly trained professionals and most countries ravaged by war or other humanitarian disasters do not have the human resources to widely implement highly technical, manual-based treatments.

Intervention indicators of the Sphere standard on mental and social aspects of health

The Sphere standard on mental and social aspects of health—largely based on a World Health Organization document (WHO, 2003)—uses the term 'social intervention' to describe those activities that primarily aim to have social effects, and 'psychological intervention' for interventions that primarily aim to have a psychological or psychiatric effect (Sphere Project, 2004). This distinction was made with the explicit acknowledgment that social interventions usually have secondary psychological ramifications and that psychological interventions may have secondary social consequences.

This paper draws on all relevant bodies of literature, including case studies, ethnographic research and the general developmental psychology literature, to evaluate interventions for potential help or harm. Each Sphere intervention indicator (whether applicable to all age groups or specifically for children) is listed followed by a review of the literature obtained through PsychInfo and PubMed database searches. Keywords describing extreme stressors (conflict, disaster, earthquake, flood, refugee, trauma, violence, war) were matched with additional keywords (adolesce*, child*, intervent*, psycho-social) to narrow search results.⁵ Search queries were complemented by an examination of all article titles from 2000–04 in the following journals: *American Academy of Child and Adolescent Psychiatry*; *American Psychologist*; *Child Development*; *Developmental Psychology*; *Disasters: Journal of Disaster Studies, Policy, and Management*; *Journal of Child Psychology and Psychiatry*; *Journal of Traumatic Stress*; *Journal of Refugee Studies*; and *Social Science and Medicine*. Articles were chosen for review if they addressed any of the intervention indicators in the Sphere standard on mental and social aspects of health.

Sphere key indicators for mental and social aspects of health

Social intervention indicators

1. People have access to an ongoing, reliable flow of credible information on the disaster and associated relief efforts

Providing information following disasters is believed to diminish distress by reducing rumours, speculation and misinformation. A secondary benefit is that it helps to build trust between the community and relief workers. Although a literature base exists for risk communication among adult populations (for example, Peters, Covelto and McCallum, 1997), to our knowledge no research has been conducted on the impact of mass communication of disaster information directly to children, even though various methods, including television, have been used (Klingman, 2002). Rather than concentrating on direct communication with children, more of a focus has been placed on using schools and parents to relay disaster information, likely because they are already trusted sources. There is some evidence that parents providing information can reduce distress in adolescents. For instance, Farwell (2001), utilising a qualitative research methodology, found that the family was the framework that adolescent Eritrean refugees looked to for information. Similar findings were reported in the 1950s among US parents who were interviewed about their communications with their children following a tornado (Siber, Peery and Bloch, 1958).

Despite limited empirical research, the policy of providing disaster information to children appears to be widely accepted within the mental health community. For instance, many professional organisations recommend that parents supply developmentally appropriate information to their children after traumatic events. Typically, though, no further guidance is offered to parents on what is developmentally appropriate. Again, the research in this area is limited, although psychological theory and case reports suggest that younger children require more concrete clarification of disaster events (Pynoos and Nadar, 1988).

Recent research intimates possible risks in disaster communication with children, as US children's level of exposure to the media after a 1995 disaster was correlated with trauma symptoms (Pfefferbaum et al., 2001). This finding may be relevant to children in resource-poor countries, where children also have access to media, especially radio.

2. Normal cultural and religious events are maintained or re-established (including grieving rituals conducted by relevant spiritual and religious practitioners). People are able to conduct funeral ceremonies

Participation in cultural and religious events is believed to create increased structure and predictability in children's lives, as well as facilitate use of traditional coping resources, thereby reducing distress (Stichick, 2001). There is some support for this notion in the qualitative research literature. For example, ethnographic research by Eisenbruch (1991) found that unaccompanied adolescent Cambodian refugees in Australia showed less distress than a similar group in the US. Eisenbruch's explanation for the difference is that there was less pressure on the adolescents to abandon their culture and more

encouragement to participate in traditional ceremonies in Australia than in the US. Eisenbruch noted that the adolescents living in the US often expressed a yearning to partake in traditional Buddhist ceremonies and felt that traditional religious beliefs and access to rituals could combat their painful feelings and bad memories of past atrocities. Honwana (1997) in a qualitative study of post-war healing strategies in southern Mozambique found that children's participation in burial services was an important part of their post-war recovery. Children who were perceived to be acting strangely, such as being overly aggressive, were invited to participate in them, which in turn appeared to decrease their aggressive behaviour. To our knowledge, no quantitative research conducted in low-income countries has focused on these issues. However, a longitudinal study comparing US children who attended a parent's funeral with those who did not may be informative. The study found that children who attended a parent's funeral reported 50 per cent fewer psychological symptoms than children who were not present (Fristad et al., 2000–01). This research does not suggest that children should be forced to participate in grieving rituals, merely that involvement may be beneficial.

3. As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities

Schools and recreational activities are common in many emergencies to support children's social and psychological well-being by enabling them to establish, or re-establish, routines and a peer network, to distract children's minds from the surrounding suffering, to accord some respite to parents, and to offer a protective environment. In addition, for those children who were in school before the disaster, recommencing school sends children the message that they are expected to resume their normal roles as students, providing positive expectations for adaptation (Vernberg and Vogel, 1993). Recognising the importance of routines, Omer and Alon (1994) have proposed the 'continuity principle', which stipulates that throughout all stages of a disaster, interventions should aim to preserve and restore continuities disrupted by the event. According to this principle, the more an intervention is based on a child's existing (unharmful) individual, familial, organisational and communal routines (for instance, school, recreational activities and relationships), the more effective it will be in counteracting the disruptive effects of a disaster.

The importance of establishing schools and recreational activities is widely recognised. For example, the United Nations Children's Fund (UNICEF) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) developed the 'school in a box' programme (a pre-packed kit that contains basic school supplies such as exercise books and pencils) in Rwanda to facilitate the speedy establishment of schools in an emergency context (UNICEF and UNESCO, 1994). Despite widespread acceptance of the importance of initiating formal or informal schooling soonest, little empirical research has been done on the bearing that emergency education has on children's well-being. Instead, most research has focused on evaluating specific intervention programmes conducted within schools (Agger, 2004; Woodside, Santa Barbara and Brenner, 1999), rather than on education as an intervention in itself.

The few studies that have examined the impact of emergency education on children's well-being have primarily concentrated on children's perceptions of the value of education in facilitating their adjustment. For instance, when Eritrean refugee youths were interviewed about their intervention suggestions, they stressed the importance of the continuity of education (Farwell, 2001). Likewise, a qualitative analysis of interviews with Chechen adolescents attending an emergency educational programme in Ingushetia found that they felt that it helped to reduce humiliation and stigma, enriched social support networks and provided safe space (Betancourt, 2005). However, because the programme implemented differed from the type of education they received before their displacement, the schools were perceived as 'not normal'. Thus, the structure of the programme clashed with the adolescent's desire for predictability and normality. This finding could indicate that educational programmes may be most effective in facilitating adjustment if they emulate, to the extent possible, the type of education received prior to the disaster.

In summary, although the research is limited, initial findings on emergency education are consistent with expert opinion, and suggest that resuming education likely benefits children. However, we note potential risks highlighted in the literature, namely that schools may be used to recruit children into conflict (Sesnan, 1998), that corporal punishment and sexual abuse may increase due to teacher stress (Nicolia and Triplehorn, 2003) and that schools can be misused to promote ethnic conflict (Dengi-Ségui, 1997).

As for recreational activities, few studies have systematically assessed the beneficial impact that resuming recreational activities has on children's adjustment following traumatic stress. The importance that they play in fostering children's social, emotional and cognitive development, however, is largely recognised, and they are often a component of intervention strategies in resource-poor countries. For example, Wessels and Monteiro (2003) describe a psychosocial programme implemented in Angola that involved recreational activities such as drama and football. The entire programme was evaluated using qualitative and quantitative indicators and positive outcomes were found, including improved conduct at school, less evidence of war-related games and toys, decreased isolation, violence and aggressive behaviour, and increased school attendance. The practice of restoring normal recreational activities for children is consistent with the aforementioned continuity principle (Omer and Alon, 1994).

4. Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities

Anecdotal reports from humanitarian agencies suggest that children benefit from active participation in common interest activities, including relief efforts. Child participation in community activities is believed to help them develop a sense of efficacy and agency in otherwise disempowering circumstances (Klingman, 2002). For example, youths aged 12–18 assumed an active role in developing community projects in Sri Lanka in 2002, such as constructing schools and re-establishing bus services (Hart, 2002). Although no formal studies were conducted, programme staff (anecdotally) noted increases in children's self-esteem and psycho-emotional well-being. Child participation programmes, such as the one described above, have been developed by various agencies and are being

implemented in various emergency settings around the world. While participatory programmes are gaining support in the humanitarian aid community, to our knowledge no controlled research has taken place.

5. Isolated persons, such as separated or orphaned children, child combatants, widows and widowers, older people or others without their families, have access to activities that facilitate inclusion in social networks

Many key processes in child development proceed through and because of social relationships (Garbarino and Kostelny, 1996; Vygotsky, 1978). Moreover, a large body of research suggests that social support provides a buffer against psychological distress for children in emergency environments (Llabre and Hadi, 1997; Kliwer et al., 2001). A review of risk factors for psychological distress among children exposed to traumatic stressors found that disrupted social networks were among the strongest predictors (Pine and Cohen, 2002). Thus, an empirical rationale exists for interventions that help to facilitate children's inclusion in social networks.

The theoretical literature also underlines the importance of social relations. Contemporary developmental theorists, drawing on the ecological theory of Bronfenbrenner (1979), suggest that social networks exist at a variety of levels, including family, community and society, and that a sense of social connectedness at each of these levels provides a protective function for children (Lerner and Castellino, 2002). Consequently, children not only need supportive individual relationships with family members and peers but also they benefit from feeling connected to community institutions such as schools or religious groups. The importance of community cohesion is also highlighted in the adult literature on social capital, within which some studies propose that a strong sense of connection with neighbours is associated with better mental health outcomes (Ziersch et al., 2005).

With regard to how to involve vulnerable groups in social networks, recommendations drawn from case studies of children exposed to political violence suggest that activities should be available to as many members of a community as possible (Zur, 1990). When programmes are designed for particular groups, such as widows or orphans, they often serve to 'label' them, which may cause further marginalisation (Zur, 1990). Although inclusive activities and programmes may be ideal, there are particular situations justifying targeted schemes. For instance, Machel (1996) proposes that special educational classes may be necessary for former child soldiers who may have fallen behind in their schooling. Placing former child soldiers with children at their educational level would frequently mean that they would be in classes with much younger children, which may be humiliating. Machel recommends establishing special classes for former child soldiers with the goal of integrating them into regular classes as soon as possible.

6. When necessary, a tracing service is established to reunite people and families

Family tracing services reduce the risk of prolonged family separation, thereby helping to maintain family relations and support. The importance of quickly reunifying families is strongly supported by theory and research, suggesting that, in most cases, the needs

of children are best met through the constancy, continuity and stability of family relationships (Ainsworth et al., 1956; Bowlby, 1988). Although there is strong backing for reuniting families, little published research has examined the efficacy and outcomes of tracing programmes per se, despite the fact that their actual procedures and practices have significant implications for children. One exception is a study by Charnley and Langa (1994), which involved interviewing Mozambican children and families that had participated in a tracing and reunification programme. They discovered that the initiative was successful in reuniting families. The study found little evidence that placement of children in unrelated substitute families leads to maltreatment, but it did uncover problems associated with residential placements, including overcrowding, which had negative effects on the children's emotional and physical health.

While there is general support for family tracing and reunification programmes, the literature has highlighted some concerns. For example, Bonnerjea (1994), in a review of tracing programmes and children's rights, notes, *inter alia*, the issue of considerable lag time between separation and reunification. In the interim, children may have developed new attachments and found substitute parental figures. Reunification can thus involve another case of separation for the child. Bonnerjea (1994) argues that this second separation may be difficult for very young children who have limited memories of family and home or who are reunited with distant relatives.

Both qualitative and quantitative research conducted with adult refugees intimates that the reunification process can be difficult after prolonged separations and in some cases, increases distress (Rousseau et al., 2004). For instance, measures of pre and post distress levels among Taiwanese citizens who were given the opportunity to reunite with their family in mainland China after four decades of separation indicated that some individuals developed psychiatric complications, mainly depression, after the visit (Tseng et al., 1993). No similar research has been conducted with children, but studies of family reunification following prolonged hospital stays and foster home placements may be informative. For example, early research conducted by Robert and Joyce Robertson found that children who had been separated from their mother due to lengthy hospitalisation and who had formed an attachment to a substitute mother, were distressed after reunifying with their biological mother (Alsop-Shields and Mohay, 2001). Likewise, children reunited with a biological parent after living in foster care demonstrated heightened behavioural problems post reunification (Taussig, Clayman and Landsverk, 2001). This research does not suggest that reunification should be avoided, merely that the process can cause distress, which needs to be considered.

7. Where people are displaced, shelter is organised with the aim of keeping family members and communities together

As noted above, interventions that focus on keeping families together as a means of minimising psychological distress are strongly supported by both the theoretical and research literature. More specifically, attachment theory suggests that humans have a biological instinct to seek proximity to attachment figures during times of high stress and that the comfort and soothing provided by an attachment figure can offer a sense of security and diminish distress (Bowlby, 1980). The importance of maintaining connection

to attachment figures in times of crisis is also empirically supported. For example, children who were evacuated during the Second World War bombings of London showed more distress than those who stayed with their parents and were directly exposed to the war (Foster, Davies and Steele, 2003; Freud and Burlingham, 1943). Similarly, a study of young children exposed to war in Eritrea, found that children who lived in orphanages showed more signs of emotional distress five years later than those who lived in a refugee camp with one or both parents (Wolff and Fesseha, 1999).

8. The community is consulted regarding decisions on where to locate religious places, schools, water points, and sanitation facilities. The design of settlements for displaced people includes recreational and cultural space

Consulting community members about decisions provides a sense of agency and control over their environment and helps to ensure local relevance and sustainability of programmes. Research suggests that children also benefit from participation in decisions that affect their lives. For example, Wolff and Fesseha (1999) compared the mental health of war orphans living in two different orphanages in Eritrea, one in which the children were expected to participate in its activities and another where the director made all of the decisions and daily routines were determined by explicit roles and schedules. They found that children in the first institution showed fewer behavioural symptoms of emotional distress than those living in the second. The importance of involving children in decisions is also stressed in human rights documents, such as the 1989 Convention on the Rights of the Child, which states that children have the right to express their views on all matters affecting them, with due weight given to their age and maturity.

Psychological and psychiatric intervention indicators

1. Individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community

Psychological first aid refers to non-intrusive emotional support, assistance in covering basic physical needs, protection from further harm, and when appropriate, providing or mobilising social support (NIMH, 2002). Within adult populations, there is some evidence that psychological first aid can reduce distress and prevent the development of psychiatric disturbance (Foss, 1994). One difficulty in evaluating the efficacy of psychological first aid is that operational definitions often differ from publication to publication. For instance, whereas some consider critical stress debriefing to be a form of psychological first aid, most see these two interventions as distinct, noting that the key difference between them is that the former emphasise expression of thoughts and feelings about the event, whereas the latter underscores basic, non-intrusive emotional and practical support (see, for example, NIMH, 2002; Raphael, 2000).

Unfortunately, no empirical research has focused specifically on the effectiveness of psychological first aid (as defined by the US NIMH) among children and adolescents,

although research on other types of interventions may be informative (Wraith, 2000). For instance, research has suggested that group-based treatments, which by their nature provide a source of peer support, can be effective in reducing distress in children exposed to extreme stressors (Goenjian et al., 1997; Paardekooper, 2002). Future research may help to determine whether it was the social support provided by the group, or other components of the interventions, that were instrumental in alleviating distress.

The research literature also points to ineffective and possibly harmful early mental health intervention practices. While very limited, there is some evidence that interventions that underline emotional expression are less effective than programmes that emphasise practical support and problem-focused coping skills. For example, Paardekooper (2002) tested the effectiveness of two intervention programmes versus a control group in reducing mental health symptoms within a group of Sudanese refugee children. She found that children who participated in an intervention programme that concentrated on problem-focused coping skills (such as problem solving) demonstrated fewer behavioural problems and post-traumatic stress disorder symptoms and experienced fewer daily hassles than children in an intervention programme that underscored emotion-focused coping skills (such as emotional expression through art and sculpting). Problems with interventions that stress emotional expression through talking may especially manifest in cultures where such cures are not normative. For instance, in southern Mozambique, talking about a traumatic situation is believed to encourage the reappearance of bad spirits (Honwana, 1997). Klingman (2002), noting that intervention strategies frequently oscillate between a focus on problems of daily living and exploration of traumatic experiences, accentuates that creating a safe environment and strengthening the child's sense of safety and trust must take first priority. In the acute aftermath of disasters, intervention strategies that centre on the problems of daily living tend to be safer than those that highlight working through traumatic experiences.

2. Care for urgent psychiatric complaints is available through the primary health care system. Essential medications consistent with the essential drug list are available at primary care facilities

WHO stresses the importance of integrating mental health care into primary health, because management and treatment of psychiatric complaints in primary care enables the largest number of people to gain access to services (WHO, 2001). Some countries, such as Guinea-Bissau, Lebanon and Sri Lanka, have responded by developing programmes that integrate child mental health assessment and treatment into primary care (de Jong, 1996; Fayyad, Jahshan and Karam, 2001; Nikapota, 1991). Unfortunately, most accounts are descriptive and little systematic evaluation of the effectiveness of these programmes has taken place. For example, Pillay and Lockhat (1997) describe a programme in which primary care nurses in South Africa were trained to screen for mental disorders in children and adolescents and to refer cases to the community psychiatric nurse for treatment. However, as acknowledged by the authors, no evaluation of this approach has taken place.

In terms of medication, there has been little empirical investigation in childhood of pharmacological agents for treatment of psychiatric complaints following traumatic events

(Pine and Cohen, 2002). Tricyclic antidepressants, which are on the WHO Model List of Essential Medicines, have not been shown to be efficacious in tackling prepubertal depression and have been only moderately effective in relation to adolescents (Murray, de Vries and Wong, 2004). Use of selective serotonin reuptake inhibitors (SSRIs) for treating depression in children is controversial (Whittington et al., 2004).

3. Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided. Basic needs of patients in custodial psychiatric hospitals are addressed

Children with mental disorders are routinely underserved, a point particularly true in developing countries (WHO, 2005). Often they stay at home because many schools will not accept children with special needs (Fayyad, Jahshan and Karam, 2001). Because of a lack of appropriate mental health services in the community, children with a severe mental disorder may end up in custodial settings such as institutions for the mentally retarded, mental hospitals or orphanages (Pluye et al., 2001). It is extremely important to remember the needs of children in institutional environments to ensure that they are protected and receive ongoing care during an emergency, when people in custodial settings are at elevated risk of life-threatening neglect (van Ommeren et al., 2003). The Sphere standard highlights the basic needs of patients in custodial hospitals but should be rewritten to cover the basic needs of any mentally ill adult or child living in any type of institutional environment.

Those with pre-existing conditions often have pressing mental health needs in an emergency. This is evidenced by the fact that individuals with pre-existing mental health conditions are the first to seek help from mental health services set up in the near aftermath of an emergency, as observed among children in Kosovo and adults in East Timor (Jones et al., 2003; Silove et al., 2004).

Regarding the danger of premature discontinuation of treatment, research suggests, not surprisingly, that children who terminate psychological treatment prematurely achieve worse clinical outcomes than those who complete them, controlling for pre-treatment dysfunction (Kazdin, Mazurick and Siegel, 1994). Unfortunately, little research has focused on premature termination of psychotropic medications within child populations. However, in adults, premature discontinuation is associated with an increased risk of psychiatric relapse (Altshuler et al., 2001).

4. If the disaster becomes protracted, plans are initiated to provide a more comprehensive range of community-based psychological interventions for the post-disaster phase

As for the most effective way to meet the mental health needs of children, there is strong support in the theoretical literature for comprehensive community-based systems of care (Pumariega, Winters and Huffine, 2003; WHO, 2005). Community-based programmes typically emphasise the importance of the child-family unit in the care process, the integration of disparate agencies and interveners into a contextual approach, and the significance of home-based care. Little research has examined the outcomes of such programmes in developing countries, although the few studies conducted on

community-based psychological support programmes for children in the general population in emergency settings are promising. For example, Dybdahl (2001) tested a psychosocial programme in Bosnia and Herzegovina that consisted of providing psychosocial assistance to mothers and promoting enriching, stimulating interaction among them and their pre-school aged children. She found that mother–child dyads that participated in the intervention programme experienced better physical, cognitive and mental health outcomes than a randomised control group that only received medical care. Likewise, there has been promising research support for community-based group interventions in low-resource countries. For instance, Layne et al. (2001) revealed support for a school-based trauma/grief-focused group intervention for war traumatised Bosnian adolescents, Goenjian et al. (1997) provided evidence of support for a community-based psychotherapy intervention for Armenian adolescents, and Paardekooper (2002) highlighted support for a community-based mental health group intervention for Sudanese refugee children.

Levels of evidence

The objective of this paper was to examine research evidence for the Sphere standard for mental and social aspects of health as it applies to children and adolescents living in low-resource countries. As recommended by Spiegel et al. (2001), we apply an evidence-based grading system to summarise the proof. Overall, there was no evidence to suggest that any of the interventions are inherently harmful to children, although in a couple of cases, caveats were noted. Yet, none of the interventions met commonly recognised standards for substantiation of effective treatment, which generally involves randomised control trials. This may be largely due to the nature of numerous Sphere interventions. For example, many of the social interventions are extremely difficult to assess using experimental methodologies. However, most psychological and psychiatric intervention strategies may be evaluated in trials. Although evidence from randomised control trials was sparse, for most of the interventions there was some research supporting the benefit of the intervention for children. Table 1 summarises the strength of the research evidence for each intervention based on the following classification scheme (adapted from Cooper, 2003):

- 1 = at least one randomised controlled trial or good systematic review;
- 2 = at least one study using a quasi-experimental design;
- 3 = at least one observational study; and
- 4 = anecdotal evidence (that is, no research evidence exists but the practice is supported by expert opinion, including the observations of relief workers and mental health professionals).

As one can see from Table 1, two of the interventions met level 1 evidence, two met level 2 evidence, five met level 3 evidence, and three met level 4 evidence.

Table 1 Levels of evidence for Sphere standard recommendations

| Recommendation | Level of evidence | References |
|--|-------------------|---|
| People have access to an ongoing, reliable flow of credible information on the disaster and associated relief efforts. | 3 | Farwell, 2001; Siber, Perry and Block, 1958 |
| Normal cultural and religious events are maintained or re-established (including grieving rituals conducted by relevant spiritual and religious practitioners). People are able to conduct funeral ceremonies. | 3 | Eisenbruch, 1991; Honwana, 1997 |
| As soon as resources permit, children and adolescents gain access to formal or informal schooling and to normal recreational activities. | 3 | Farwell, 2001; Betancourt, 2005 |
| Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities. | 4 | Hart, 2002 |
| Isolated persons, such as separated or orphaned children, child combatants, widows and widowers, older people or others without their families, have access to activities that facilitate inclusion in social networks. | 1 | Pine and Cohen, 2002 |
| When necessary, a tracing service is established to reunite people and families. | 3 | Charnley and Langa, 1994 |
| Where people are displaced, shelter is organised with the aim of keeping family members and communities together. | 3 | Freud and Burlingham, 1943; Foster, Davies and Steele, 2003 |
| The community is consulted regarding decisions on where to locate religious places, schools, water points, and sanitation facilities. The design of settlements for displaced people includes recreational and cultural space. | 2 | Wolff and Fesseha, 1999 |
| Individuals experiencing acute mental distress after exposure to traumatic stressors have access to psychological first aid at health service facilities and in the community. | 4 | No specific studies—expert opinion |
| Care for urgent psychiatric complaints is available through the primary health care system. Essential medications consistent with the essential drug list are available at primary care facilities. | 4 | Pillay and Lockhat, 1997 |
| Individuals with pre-existing psychiatric disorders continue to receive relevant treatment, and harmful, sudden discontinuation of medications is avoided. Basic needs of patients in custodial psychiatric hospitals are addressed. | 2 | Kazdin, Mazurick and Siegel, 1994; Kazdin, 1990 |
| If the disaster becomes protracted, plans are initiated to provide a more comprehensive range of community-based psychological interventions for the post-disaster phase. | 1 | Dybdahl, 2001 |

Notes

1 = at least one randomised controlled trial or good systematic review.

2 = at least one study using a quasi-experimental design.

3 = at least one observational study.

4 = anecdotal evidence (that is, no research evidence exists but the practice is supported by the opinion of experts, including relief workers and mental health professionals).

Other factors to consider in implementing interventions

Although there is no evidence that any of the interventions recommended by Sphere are intrinsically harmful to children, there is mounting proof that certain intervention practices commonly implemented in the field are potentially harmful, such as single-session debriefing programmes in the immediate aftermath of trauma (Rose, Bisson and Wessely, 2002). We note that many interventions for children contain components of debriefing methods but are not labelled as debriefing interventions per se. For example, many psychosocial intervention programmes include activities that encourage the children to draw or 'act out' their trauma using drama skills. These interventions are sometimes called 'ventilation' techniques and their effects may be similar to those that prematurely emphasise the verbal retelling of a trauma (Paardekooper, 2002). A sense of safety is considered to be a crucial component in the recovery from traumatic stress, and prematurely encouraging the processing of traumatic events is seen as harmful (Herman, 1992), especially when individuals trained to reduce potential heightened anxiety are not present. Interventions during the acute stage of a disaster should emphasise safety whether it is through the re-establishment of routines and structures, or the provision of social support and nurturance.

In addition to the issue of timing, correctly identifying the segment of the population to target for intervention is essential. Again, there is risk of harm if an intervention is directed at the wrong population segment, such as applying symptom-focused intervention techniques universally to the population at large. For example, Wraith (2000) describes a school intervention where all children were debriefed after the death of three pupils in a transport accident regardless of whether they knew the victims or witnessed the incident. Some of the children who were asymptomatic before the debriefing reportedly emerged from it frightened and clingy, and developed nightmares and reactive separation problems. Thus, it may be best not to intervene psychologically with children unless they are showing considerable symptoms of distress, given that children's understanding of events is largely shaped by the reactions of adults and children around them (Klinner et al., 1986).

Conclusion

Children's needs tend to be different from those of the members of other age groups. This creates the possibility that general standards can be inappropriate or even harmful to children. However, the present review suggests that this does not seem to be the case for the Sphere standard on mental and social aspects of health. Nevertheless, although there is some support for the standard's specific intervention indicators in terms of their applicability to children, the evidence base at this point requires substantial strengthening. Future, well-designed research may help to determine with more certainty the extent to which the approach as well as the specific interventions proposed by Sphere are effective for children.

A limitation of the review presented here is that it does not seek to identify essential interventions that may have been missed in the Sphere standard on mental and social

aspects of health, such as specific considerations in helping separated infants and toddlers. Moreover, some psychosocial interventions are covered in other Sphere standards, rather than in the standard considered above. For instance, the need for psychosocial stimulation for undernourished infants is covered in the Sphere standard on severe malnutrition.

The review suggests that even effective interventions can be harmful if applied at the wrong time (that is, too early) or are targeted at the wrong segment of the population. Because of these concerns, some researchers are emphasising a systematic process approach to intervention rather than focusing on specific intervention techniques (Richman, 1996; Stichick, 2001). For example, Shalev, Tuval-Mashiach and Hadar (2004) recommend that during the acute stage of a disaster, the community should direct the intervention and it should concentrate on meeting basic needs, providing social and instrumental support and reducing secondary stressors. The role of mental health professionals should be limited to offering support to non-professional helpers and facilitating access to community resources (Shalev, Tuval-Mashiach and Hadar, 2004). Only if children have not responded to these non-clinical intervention efforts, should clinical care be implemented.

Although not specifically framed from this perspective, the Sphere standard adopts a similar approach, as the majority of the recommendations focus on mobilising community and social resources. Psychological or psychiatric interventions need to be available to and accessible by only a fraction of the population with severe mental health needs. Such an approach does not attach potentially stigmatising labels to affected populations and values local resources and forms of understanding.

Correspondence

Jodi Morris, PhD, Technical Officer, Mental Health: Evidence and Research Team, Department of Mental Health and Substance Abuse, World Health Organization, Avenue Appia, 20, 1211 Geneva 27, Switzerland. Telephone: +41 22 791 37 29; e-mail: morrisj@who.int.

Endnotes

¹ Jodi Morris is a Technical Officer at the World Health Organization (WHO), Geneva, Switzerland; Mark van Ommeren is a Scientist at WHO, Geneva, Switzerland; Myron Belfer is a Professor of Psychiatry at the Department of Social Medicine, Harvard University, Cambridge, MA, US; Shekhar Saxena is the Coordinator of the Mental Health: Evidence and Research Team at WHO, Geneva, Switzerland; and Benedetto Saraceno is the Director of the Mental Health and Substance Abuse Department (MSD) at WHO, Geneva, Switzerland.

² Declaration of interest: Mark van Ommeren was involved in drafting the Sphere standard on mental and social aspects of health.

³ Consistent with the 1989 Convention on the Rights of the Child, in this paper a child is considered a person younger than 18. We use the term adolescents only when specifically referring to the latter subgroup. It is acknowledged that definitions of childhood vary across cultures.

⁴ Nan Buzard, Project Manager, Sphere Project, personal communication, October 2002.

⁵ Stars indicate that the ending can vary (for instance, adolescence and adolescents).

References

- Action Aid India, Oxfam India and NIMHANS (National Institute of Mental Health and Neuro Sciences) (2002) *RIOTS: Psychosocial care for children*. Books for Change, Bangalore.
- Agger, I. (2004) *School-based psychosocial programs for children: Guidelines for initiation of programs*. Report of the Danish Red Cross. Danish Red Cross, Copenhagen.
- Ainsworth, M., M. Boston, J. Bowlby and D. Rosenbluth (1956) 'The effects of mother-child separation: A follow-up study'. *British Journal of Medical Psychology*. 29(3-4). pp. 211-224.
- Alsop-Shields, L. and H. Mohay (2001) 'John Bowlby and James Robsertson: Theorists, scientists, and crusaders for improvement in the case of children in hospital'. *Journal of Advanced Nursing*. 35(1). pp. 1365-2648.
- Altshuler, L. et al. (2001) 'The impact of antidepressant discontinuation versus antidepressant continuation on 1-year risk for relapse of bipolar depression: Retrospective chart review'. *Journal of Clinical Psychiatry*. 62(8). pp. 612-616.
- Barenbaum, J., V. Ruchkin and M. Schwab-Stone (2004) 'The psychosocial aspects of children exposed to war: Practice and policy initiatives'. *Journal of Child Psychology and Psychiatry*. 45(1). pp. 42-62.
- Batniji, R., M. van Ommeren and B. Saraceno (2006) 'Mental and social health in disasters: Relating qualitative social science research and the Sphere standard'. *Social Science and Medicine*. 62(8). pp. 1853-1864.
- Betancourt, T.S. (2005) 'Stressors, supports, and the social ecology of displacement: Psychosocial dimensions of an emergency education program for Chechen adolescents displaced in Ingushetia, Russia'. *Culture, Medicine and Psychiatry*. 29(3). pp. 309-340.
- Bonnerjea, L. (1994) 'Disasters, family tracing and children's rights: Some questions about the best interests of separated children'. *Disasters*. 18(3). pp. 277-283.
- Bowlby, J. (1988) *A Secure Base: Parent-Child Attachment and Healthy Human Development*. Routledge, London, and Basic Books, New York, NY.
- Bracken, P.J. and C. Petty (1998) *Rethinking the trauma of war*. Free Association Books, New York, NY.
- Bronfenbrenner, U. (1979) *The ecology of human development*. Harvard University Press, Cambridge, MA.
- Charnley, H. and J. Langa (1994) 'Community-based interventions for separated children in Mozambique: The family tracing and reunification program'. *Community Alternatives. International Journal of Family Care*. 6(1). pp. 115-131.
- Cooper, B. (2003) 'Evidence-based mental health policy: A critical appraisal'. *British Journal of Psychiatry*. 183(2). pp. 105-113.
- de Jong, J.T.V.M. (1996) 'A comprehensive public health model programme in Guinea-Bissau: A useful model for African, Asian, and Latin American countries'. *Psychological Medicine*. 26(1). pp. 97-108.
- Dégni-Ségui, R. (1997) *Report on the situation of human rights in Rwanda*. Report submitted by Mr René Degni-Ségui, Special Rapporteur of the Commission on Human Rights, under paragraph 20 of resolution S-3/1 of 25 May 1994. <http://unjobs.org/archive/7817451397008065087199790908702094800819930>.
- Dybdahl, R. (2001) 'Children and mothers in war: An outcome study of a psychosocial intervention program'. *Child Development*. 72(4). pp. 1214-1230.
- Eisenbruch, M. (1991) 'From post-traumatic stress disorder to cultural bereavement: Diagnosis of South-east Asian refugees'. *Social Science and Medicine*. 33(6). pp. 673-680.
- Farwell, N. (2001) "'Onward through strength": coping and psychological support among refugee youth returning to Eritrea from Sudan'. *Journal of Refugee Studies*. 14(1). pp. 43-69.
- Fayyad, J.A., B.A. Jahshan and E.G. Karam (2001) 'Systems development of child mental health services in developing countries'. *Child and Adolescent Psychiatric Clinics of North America*. 10(4). pp. 745-762.
- Foss, O.T. (1994) 'Mental first aid'. *Social Science and Medicine*. 38(3). pp. 479-482.
- Foster, D., S. Davies and H. Steele (2003) 'The evacuation of British children during World War II: A preliminary investigation into the long-term psychological effects'. *Aging Mental Health*. 7(5). pp. 398-408.

- Freud, A. and D. Burlingham (1943) *War and Children*. Ernst Willard, New York, NY.
- Fristad, M.A., J. Cerel, M. Goldman, E.B. Weller and R.A. Weller (2000–01) 'The role of ritual in children's bereavement'. *Omega: Journal of Death and Dying*. 42(4). pp. 321–339.
- Garbarino, J. and K. Kostelny (1996) 'What do we need to know to understand children in war and community violence?' In R.J. Apfel and S. Bennett (eds.) (1996) *Minefields in their hearts: The mental health of children in war and communal violence*. Yale University Press, New Haven, CT. pp. 33–51.
- Goenjian, A.K. et al. (1997) 'Outcome of psychotherapy among early adolescents after trauma'. *American Journal of Psychiatry*. 154(4). pp. 536–542.
- Hart, J. (2002) 'Children's clubs: New ways of working with conflict-displaced children in Sri Lanka'. *Forced Migration Review*. 15 (October). pp. 36–39.
- Herman, J.L. (1992) *Trauma and Recovery*. Basic Books, New York, NY.
- Honwana, A.L. (1997) 'Healing for peace: Traditional healers and post-war constructions in Southern Mozambique'. *Peace and Conflict: Journal of Peace Psychology*. 3(3). pp. 293–305.
- IFRC (International Federation of Red Cross and Red Crescent Societies) (2001) *Psychological support: best practices from Red Cross and Red Crescent programmes*. IFRC, Geneva.
- IFRC (2003) *Community-based psychological support: A training manual*. IFRC, Geneva.
- Jones, L., A. Rrustemi, M. Shahini and A. Uka (2003) 'Mental health services for war-affected children: report of a survey in Kosovo'. *British Journal of Psychiatry*. 183 (December). pp. 540–546.
- Kazdin, A.E. (1990) 'Premature termination from treatment among children referred for antisocial behaviour'. *Journal of Child Psychology and Psychiatry and Allied Disciplines*. 31(3). pp. 415–425.
- Kazdin, A.E., J.L. Mazurick and T.C. Siegel (1994) 'Treatment outcome among children with externalizing disorders who terminate prematurely versus those who complete psychotherapy'. *Journal of the Academy of Child and Adolescent Psychiatry*. 33(4). pp. 549–557.
- Kliwer, W., L. Murrelle, R. Mejia, Y. de Torres and A. Angold (2001) 'Exposure to violence against a family member and internalizing symptoms in Colombian adolescents: the protective effects of family support'. *Journal of Consulting and Clinical Psychology*. 69(6). pp. 971–982.
- Klingman, A. (2002) 'Children under stress of war'. In A.M. La Greca, W.K. Silverman, E.M. Vernberg and M.C. Roberts (eds.) *Helping Children Cope with Disasters and Terrorism*. American Psychological Association, Washington, DC. pp. 359–380.
- Klinnert, M.D., R.M. Emde, P. Butterfield and J.J. Campos (1986) 'Social referencing: The infant's use of emotional signals from a friendly adult with mother present'. *Developmental Psychology*. 22(4). pp. 427–432.
- Kos, A.M. and S. Derviskadic-Jovanovic (1998) 'What can we do to support children who have been through war?' *Forced Migration Review*. 3 (December). pp. 4–7.
- Layne, C.M. et al. (2001) 'Trauma/Grief-Focused Group Psychotherapy: School-based Post-war Intervention with Traumatized Bosnian Adolescents'. *Group Dynamics: Theory, Research, and Practice*. 5(4). pp. 277–290.
- Lerner, R.M. and D.R. Castellino (2002) 'Contemporary developmental theory and adolescence: developmental systems and applied developmental science'. *Journal of Adolescent Health*. 31(6) (supplement). pp. 122–135.
- Llabre M.M. and F. Hadi (1997) 'Social support and psychological distress in Kuwaiti boys and girls exposed to the Gulf crisis'. *Journal of Clinical Child Psychology*. 26(3). pp. 247–255.
- Loughry, M. and C. Eyber (2003) *Psychosocial Concepts in Humanitarian Work with Children: A Review of the Concepts and Related Literature*. The National Academies Press, Washington, DC.
- Lustig, S. et al. (2004) 'Review of child and adolescent refugee mental health'. *Journal of the American Academy of Child and Adolescent Psychiatry*. 43(1). pp. 24–36.
- Machel, G. (1996) *United Nations report on the impact of armed conflict on children*. Hurst & Company, London.
- Murray, M.L., C.C. deVries, C.S. and I.C. Wong (2004) 'A drug utilisation study of antidepressants in children and adolescents using the General Practice Research Database'. *Archives of Disease in Childhood*. 89(12). pp. 1098–1102.

- Nicolai, S. and C. Triplehorn (2003) 'The Role of Education in Protecting Children in Conflict'. *Humanitarian Practice Network Paper*. 42. pp. 1–32.
- Nikapota, A.D. (1991) 'Child psychiatry in developing countries'. *British Journal of Psychiatry*. 158 (June). pp. 743–751.
- NIMH (National Institute of Mental Health) (2002) *Mental health and mass violence: evidence-based early psychological interventions for victims/survivors of mass violence. A workshop to reach consensus on best practices*. NIH Publication No. 02–5138. US Government Printing Office, Washington, DC.
- Omer, H. and N. Alon (1994) 'The continuity principal: A unified approach to disaster and trauma'. *American Journal of Community Psychology*. 22(2). pp. 273–286.
- Paardekooper, B.P. (2002) *Children of the forgotten war: A comparison of two intervention programs for the promotion of well-being of Sudanese refugee children*. Vrije Universiteit, Academic Proefschrift, Amsterdam.
- Peters, R.G., V.T. Coviello and D.B. McCallum (1997) 'The determinants of trust and credibility in environmental risk communication: An empirical study'. *Risk Analysis*. 17(1). pp. 43–54.
- Pfefferbaum, B. et al. (2001) 'Television exposure in children after a terrorist incident'. *Psychiatry: Interpersonal and Biological Processes*. 64(3). pp. 202–211.
- Pillay, A.L. and M.R. Lockhat (1997) 'Developing community mental health services for children in South Africa'. *Social Science and Medicine*. 45(10). pp. 1493–1501.
- Pine, D.S. and J.A. Cohen (2002) 'Trauma in children and adolescents: Risk and treatment of psychiatric sequelae'. *Biological Psychiatry*. 51(7). pp. 519–531.
- Pluye, P., Y. Lehingue, C. Aussilloux, I. Popa, I. and C. Aiguesvives (2001) 'Mental and behavior disorders in children placed in long term care institutions in Hunedoara, Cluj, and Timis, Romania'. *Santé*. 11(1). pp. 5–12.
- Pumariega, A.J., N.C. Winters and C. Huffine (2003) 'The evolution of systems of care for children's mental health: Forty years of community child and adolescent psychiatry'. *Community Mental Health Journal*. 39(5). pp. 399–424.
- Pynoos, R. and K. Nadar (1988) 'Psychological first aid and treatment approach to children exposed to community violence: Research implications'. *Journal of Traumatic Stress*. 1(4). pp. 445–473.
- Raphael, B. (2000) 'Conclusion: Debriefing—science, belief, and wisdom'. In B. Raphael and J.P. Wilson (eds.) *Psychological debriefing: Theory, practice, and evidence*. Cambridge University Press, Cambridge.
- Richman, N. (1996) *Principles of help for children involved in organized violence*. Save the Children, Westport, CT.
- Rose, S., J. Bisson and S. Wessely (2002) 'Psychological debriefing for preventing post traumatic stress disorder (PTSD)'. *Cochrane Database Systematic Reviews*. 2. CD000560. <http://www.update-software.com/abstracts/AB000560.htm>.
- Rousseau, C., M.C. Rufagari, D. Bagilishya and T. Measham (2004) 'Remaking family life: Strategies for re-establishing continuity among Congolese refugees during the family and reunification process'. *Social Science and Medicine*. 59(5). pp. 1095–1108.
- Salama, P., N. Buzard and P. Spiegel (2001) 'Improving standards in international humanitarian response: the Sphere Project and beyond'. *Journal of the American Medical Association*. 286(5). pp. 531–532.
- Sesnan, B. (1998) 'Push and pull: Education for Southern Sudanese in exile: 1986–1996'. In G. Retamal and R. Aedo-Richmond (eds.) *Education as a Humanitarian Response*. Continuum, New York, NY. pp. 59–73.
- Shalev, A.Y., R. Tuval-Mashiach and H. Hadar (2004) 'Posttraumatic stress disorder as a result of mass trauma'. *Journal of Clinical Psychiatry*. 65(1). pp. 4–10.
- Siber, E., S.E. Perry and D.A. Block (1958) 'Patterns of parent-child interaction in a disaster'. *Psychiatry Journal for the Study of Interpersonal Processes*. 21(2). pp. 159–167.
- Silove, D. et al. (2004) 'Indices of social risk among first attenders of an emergency mental health service in post-conflict East Timor: An exploratory investigation'. *Australian and New Zealand Journal of Psychiatry*. 38(11–12). pp. 929–932.

- Sphere Project (2004) *Humanitarian Charter and Minimum Standards in Disaster Response*. Sphere Project, Geneva.
- Spiegel, P.B., F.M. Burkle, Jr, C.C. Dey and P. Salama (2001) 'Developing public health indicators in complex emergency response'. *Prehospital Disaster Medicine*. 16(4). pp. 281–285.
- Stichick, T. (2001) 'The psychosocial impact of armed conflict on children: Re-thinking traditional paradigms in research and intervention'. *Cultural and Social Influences in Child and Adolescent Psychiatry*. 10(4). pp. 797–815.
- Summerfield, D. (2000) 'Childhood, war, refugeedom, and "trauma": Three core questions for mental health professionals'. *Transcultural Psychiatry*. 37(3). pp. 417–433.
- Taussig, H.N., R.B. Clyman and J. Landsverk (2001) 'Children who return home from foster care: A 6-year prospective study of behavioural health outcomes in adolescence'. *Pediatrics*. 108(1). pp. 1–7.
- Tseng, W.S., T.A. Cheng, Y.S. Chen, P.L. Hwang and J. Hsu (1993) 'Psychiatric complications of family reunion after four decade separation'. *American Journal of Psychiatry*. 150(4). pp. 614–619.
- UNICEF (United Nations Children's Fund) (2004) *Working with Children in Unstable Situations*. UNICEF, New York, NY.
- UNICEF and UNESCO (United Nations Educational, Scientific and Cultural Organization) (1994) 'The UNICEF–UNESCO TEP Program in Rwanda'. http://portal.unesco.org/education/en/ev.php-URL_ID=14214&URL_DO=DO_TOPIC&URL_SECTION=201.html (accessed 22 November 2004).
- United Nations Population Division (2005) 'World Population Prospects: The 2004 Revision Population Database'. <http://esa.un.org/unpp> (accessed 6 January 2005).
- Van Dyke, M. and R. Waldman (2004) *The Sphere Project Evaluation Report*. Sphere Project, Geneva.
- van Ommeren, M., S. Saxena, A. Lorretti and B. Saraceno (2003) 'Ensuring care for patients in custodial psychiatric hospitals in emergencies'. *The Lancet*. 362(9383). p. 574.
- Vernberg, E.M. and J.M. Vogel (1993) 'Interventions with children after disasters'. *Journal of Clinical Child Psychology*. 22(4). pp. 485–498.
- Vygotsky, L.S. (1978) *Mind and society: The development of higher mental processes*. Harvard University Press, Cambridge, MA.
- Walker, P. and S. Purdin (2004) 'Birthing sphere'. *Disasters*. 28(2). pp. 100–111.
- Wessels, M. and C. Monteiro (2003) 'Healing, social integration, and community mobilization for war-affected children: A view from Angola'. In S. Krippner and T.M. McIntyre (eds.) *The psychological impact of war trauma on civilians: An international perspective*. Psychological dimensions to war and peace series. Praeger Publishers/Greenwood Publishing Group, Westport, CT.
- Whittington, C.J. et al. (2004) 'Selective serotonin reuptake inhibitors in childhood depression: A systematic review of published versus unpublished data'. *The Lancet*. 363(9418). pp. 1341–1345.
- WHO (World Health Organization) (2001) *The World Health Report 2001 – Mental health: New understanding, new hope*. WHO, Geneva.
- WHO (2003) *Mental health in emergencies: Psychological and social aspects of health of populations exposed to extreme stressors*. WHO, Geneva.
- WHO (2005) *Child and Adolescent Mental Health Policies and Plans*. WHO, Geneva.
- Wolff, P.H. and G. Fesseha (1999) 'The orphans of Eritrea: a five-year follow-up study'. *Journal of Child Psychology and Psychiatry and Allied Disciplines*. 40(8). pp. 1231–1237.
- Woodside, D., J. Santa Barbara and D.G. Benner (1999) 'Psychological trauma and social healing in Croatia'. *Medicine, Conflict, and Survival*. 15(4). pp. 355–367.
- World Bank (2004) *Integrating mental health and psychosocial interventions into World Bank lending for conflict-affected populations: A toolkit*. World Bank, Washington, DC.
- Wraith, R. (2000) 'Children and debriefing: Theory, interventions, and outcomes'. In B. Raphael and J.P. Wilson (eds.) *Psychological debriefing: Theory, practice, and evidence*. Cambridge University Press, Cambridge.

- Ziersch A.M, F.E. Baum, C. Maccougall and C. Putland (2005) 'Neighbourhood life and social capital: The implications for health'. *Social Science and Medicine*. 60(1). pp. 71–86.
- Zur, J. (1990) 'Children's experience of war: Report on the psychosocial impact of violence on children in Guatemala'. Cited in M. Loughry and C. Eyber (2003) *Psychosocial Concepts in Humanitarian Work with Children: A Review of the Concepts and Related Literature*. The National Academies Press, Washington, DC. p. 127.