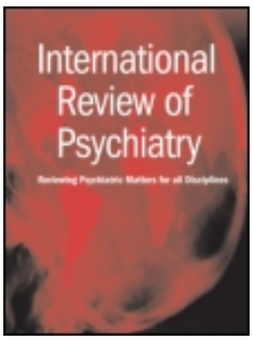

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Responding to the needs of children in crisis

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Abstract
This paper explores the issues confronting service providers setting up child and family mental health programmes in conflict, post conflict and disaster areas. Drawing on clinical experience and research in humanitarian settings, it calls for greater attention to the child's perspective, their individuality and the cultural, social and political context in which they live. It argues that those concerned with the psychopathology of children in crises should widen their frame of reference beyond narrowly defined traumatic reactions to include other mental health and psychosocial issues, including the current problems of daily life and the needs of children with pre-existing psychiatric disorders. It recommends culturally valid means of assessment, the creation of age-appropriate services and training for primary healthcare workers. Children's mental health needs in crises are varied, complex and intimately connected with their needs for security, food, shelter, education and family connection. This requires holistic, rights-based approaches that can access resources to address basic needs, advocate for security and protection, and recognize and address the needs of the more vulnerable children. This is the approach recommended by the Inter Agency Standing Committee Guidelines for Mental health and Psychosocial Support in Emergency Settings.

Introduction

In Kosovo in the spring of 1999 13-year-old Arlinda and 12-year-old Dita were rounded up by paramilitary forces along with 17 members of their extended family and driven at gunpoint out of their house and into the street. After two hours of harassment they were all pushed into the corner of a garden under a hazelnut tree. 'My aunt was on the path in front and one of the soldiers pushed her down and shot her. My cousins all started crying and he looked at them, looked back at my aunt and started shooting again. Then he dropped his gun, took another from another soldier and started shooting at us. I slid down the wall. Bullets hit my leg twice then they stopped shooting. Someone made a noise because they had difficulty breathing. They started shooting again.' Arlinda put up her arm to protect herself. Bullets shattered it. Another hit her back. 'After a while they stopped.' Arlinda remembers the silence. When she lifted her head and looked round she could see one of her brothers with half his head shot off and her neighbour's son with his face destroyed. Her grandmother was dead. Five children including Dita's brothers, Agron and Arben, and a sister Diana, had survived and lay bleeding among the bodies of seven women and seven children, until another military unit arrived, gave them first aid and transferred them to hospital. They stayed there for the next three months, visited once by their two surviving fathers who had left the house to hide elsewhere, thinking their absence would make their families safer from attack.

I was asked to see the children just after they were discharged from the hospital. At that point they had convinced themselves that both their mothers were alive and my first task was in supporting the fathers in telling them the truth. This truth was only accepted once DNA testing had been done on the identified remains and a funeral had been held. My second was helping Dita's father get in touch with Diana, injured in the stomach and being tube fed in a hospital in Belgrade. My third was to work with other agencies to get the children a medical evacuation for orthopaedic care unavailable in Kosovo. Through all of this my main preoccupation was how to accompany the children through the very different ways in which they chose to handle their grief. All the children were grieving. Each had their own way of coping. Six-year-old Arben kept himself very busy, so busy he sometimes found it hard to sit still. He was adamant he did not want to discuss what had happened. Twelve-year-old Agron had told the whole tale to a journalist on the first day. Now he preferred to think about the future. Dita was very sad and quiet. She preferred not to talk about it.

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Arlinda often felt sick, she had little appetite, and the pictures and memories of what had occurred often filled her mind. One day she asked me to go outside with her so that she could show me what had happened. The other children had no wish to revisit or discuss past events at this point, nor did I push them to do so. All of them wanted to look at old photographs of their families and talk at length about their mothers and happier times in the past.

After a few months, they were evacuated to the United Kingdom where the two older girls received treatment for their extensive physical injuries and where social services continued to provide practical and emotional support. They also began school and the slow process of integrating into a new society. In 2003 Arlinda rang me to ask me to accompany all of them to Belgrade where they were the key witnesses of the first war crimes trial to prosecute a Serbian soldier for involvement in war crimes in Kosovo. Three of the children chose to testify in closed session. As always they had their individual ways of dealing with stress. Agron slept a lot. Diana spent every spare minute in the hotel pool and learnt to swim in three days. In boring moments while we sat in waiting rooms and corridors, we played endless games: travel scrabble and increasingly foolish games of consequences. My ability to make Origami paper birds proved as useful as any amount of psychotherapy training. Diana made 50. Throughout it all, including the identification parade and the hours of testifying, the children behaved with courage, grace and composure that was moving and extraordinary. Afterwards all of them told me that their predominant feeling was one of relief. Regardless of the outcome, they were glad that they had come to Belgrade and told the truth. It helped them feel some sense of closure.

'I am so glad I did it,' Arlinda said. 'I stared right at him and he could not turn and look at me. I felt that I was in control. He thought he was in control, that he had killed us and it would all be quiet. But I was able to tell the world what he did, I wasn't afraid of speaking, and he could not stop me.'

The search for justice can be therapeutic for the victims. It can also provide the basis for reconciliation with those once associated with the perpetrators. Arlinda told me that she had changed her mind about Serbs as a whole. Much to her surprise, she had enjoyed herself some of the time in Belgrade. 'Before this happened we never hated them. Afterwards I was really angry, I really hated; but now I really appreciate what they have done.' All the children had been touched by Serbian human rights activists' efforts on their behalf, and the genuine friendliness of the security guards taking care of them. 'It does not matter where a person is from; it's about who they are inside. But I do still have a problem with trust.'

Arlinda and her family are some of the many children who have taught me about how children will respond to crises and what they need: That political, social and cultural literacy is essential and that to help any child in crisis one needs to understand the child's world and their perspective upon it. That even in the face of one disaster, children in the same family will respond differently and have different needs. That one's primary role may be to facilitate and support honest family communication and that while grief may be devastating, it is not a mental illness, and that the retelling of the trauma story is not always essential for recovery. Some children need to talk, some don't, but whether they wish to talk or not, symptomatic relief can help, and exposure may or may not be helpful. The timing and level of such exposure should be determined by the child. Finally it is almost always a combination of psychological and non-psychological interventions that address issues of care, shelter, family connection, justice and reconciliation that may in the long run be most helpful to the child.

This paper draws on clinical experience and research over ten years of setting up child and family mental health and psychosocial programmes in conflict, post conflict and disaster areas to expand upon all of these issues.

Stereotypes and realities

There is a stereotype still prevailing in the media which is that the majority of children exposed to terrifying events will be 'traumatized' and that the trauma will have long term debilitating consequences. Attached to this stereotype is a treatment model advocating the necessity of early 'clinical intervention' usually in the form of some kind of trauma counselling, involving expressive therapies, including some form of debriefing in order to prevent long term psychological problems (Pynoos & Nader, 1993). One consequence of such stereotypes is that in post-disaster situations donors and humanitarian agencies have prioritized trauma identification and treatment programmes for children over other psychosocial programming. In the immediate aftermath of the tsunami in Sri Lanka and Aceh numerous international NGOS offered trauma counselling with little consultation with those they were there to assist and little coordination with each other (Shah, 2006) (Van Ommeren, Saxena, & Saraceno 2005). This is problematic in a number of ways. Such programmes often do not use culturally validated means of assessment. They make use of practitioners with very brief training and limited experience. They use treatments with a

limited evidence base, and may unnecessarily pathologize normal reactions to abnormal events, but make little attempt to address other mental health and psychosocial needs. Finally, they often fail incorporate the views and wishes of the survivors and fail to integrate into existing healthcare systems or to provide a sustainable response to the disaster (Silove & Zwi, 2005).

There is a growing consensus in the research literature that the majority of children exposed to traumatic events do not develop traumatic disorders except after multiple traumas or a history of anxiety (Copeland et al., 2007) and that rates of self recovery are high (Stallard, Keeler, Angold, & Costello 1999). This is born out by clinical experience in the field. A survey of children presenting to a newly formed child and adolescent service in Kosovo found that although stress-related problems were the most common single psychiatric diagnosis in the first year post conflict (21%); children with no psychiatric problems were the most common presentation of all (34%). Such children were often referred by humanitarian agencies concerned that exposure to traumatic events might cause pathological problems in the future. A similar proportion (36%) presented with no psychiatric diagnosis in the second year. This group contained within it many children with behavioural problems related to the changing social environment. By this stage problems such as bedwetting (15%) and mental retardation (12%) outnumbered stress-related problems, which had fallen to 4%. The Kosovar survey also highlighted the significant number of children and young people with other forms of serious psychopathology such as neuro-developmental problems (Jones, Rrustemi, Shahini and Uka, 2003). Studies from post-tsunami Asia found similarly low rates of traumatic stress disorders although eating and sleeping problems were pervasive, as was fear of the sea in the first year after the disaster. The greatest problem affecting children was loss of close relatives and subsequent institutionalization (Carballo, Heal, & Horbaty 2006).

Recent research done on children in Lebanon similarly found that in the long term post-traumatic stress disorder (PTSD) was not the main concern. Follow-up of 143 children found that PTSD, major depression, overanxious disorder, and separation anxiety disorder, were not uncommon in war affected children in first months after exposure to a stressor. 24.1%, 23.6%, 24.9% and 17.9% respectively. However, rates of self-recovery were high and the prevalence of PTSD, depression, overanxious disorder, and separation anxiety decreased to 1.4%, 5.6%, 5.6% and 4.2% after one year. Significant predictors of continuing problems at one year after war trauma were pre-trauma disorders, psychosocial stressors within the child's family (physical abuse and family conflict), and direct witnessing of war events such as injury and destruction of homes (Karam et al., 2000). Similar predictors of continuing post-war emotional distress were found in a study of children exposed to conflict in post-war Bosnia. Qualitative work revealed that habituation and the meaning given to experiences such as bombing (who was doing it and why) mediated the direct effect of exposure to such events; and that many children found physical abuse and family breakdown far more disturbing than war itself (Jones & Kafetsios, 2003).

A separate prospective study from Lebanon followed war orphans for a period of five years and also found that while stress-related problems decreased, impulse control problems and attention deficit disorders increased over time from 1.7% one year after trauma to 10% four years later (Cordahi-Tabet et al., 2002a, 2002b). It might appear from these results and the above mentioned post-war rise in behavioural problems in Kosovo, that externalizing behavioural difficulties may be a more significant post-conflict problem for children than internalizing emotional problems. The connection with family conflict and abuse suggests that they may be responses to changing family structure and accompanying changes in patterns of discipline and responsibilities rather than directly related to traumatic events.

What this suggests is that those concerned with psychopathology in children in crises should widen their frame of reference beyond narrowly defined traumatic reactions. They should be particularly alert to socially isolated children, children who have suffered losses of close relatives, those who have pre-existing problems or vulnerabilities in their families or themselves, and they should be aware that crises present an opportunity for families who have children with pre-existing pathology such as mental retardation, to access services that did not previously exist. Meanwhile, the majority of resilient children also have psychosocial needs which are almost certainly best understood by listening to the children themselves.

How can we assess children's needs in crises?

Figure 1 illustrates a pragmatic approach to conducting needs assessments of children in crisis situations. They are in keeping with the newly drafted Inter Agency Standing Committee Guidelines for Mental Health and Psychosocial Response in Emergency Settings (Inter Agency Standing Committee, 2007) which emphasize the need for a coordinated process that avoids multiple assessments and that engages the community in ownership of the process.

Unfortunately very little ethnographic work is done with children in emergency situations and

Summary of steps in emergency needs assessment

- Review available literature: WHO Atlas, local mental health studies, ethnographic and cultural material
- Coordinate with other local and international agencies responding to the crises, both to share existing information and resources and to conduct joint needs assessments
    - Ethnographic methods: ask children and caretakers!
    - Age and gender segregated focus groups
    - Key informant interviews
- Combine with psycho-education about emergency (e.g. explanation of earthquake/tsunami, mine awareness education)
- Quantitative surveys using culturally validated instruments
- Share results and proposed actions with children, caretakers and their community

Figure 1. Summary of steps in emergency needs assessment.

the quantitative surveys are often focused on pathological symptoms using unvalidated symptom checklists (Gupta, 1997). Back translation is not a sufficient means of validation; it is often done by university-trained translators who do not come from the same cultural world as the children. The symptom focus of many checklists does not allow children to express lack of well-being in non-symptomatic ways or to identify their perception of the source or significance of symptoms such as sadness, nightmares, hyperarousal or lack of energy (Jones & Kafetsios, 2005). Furthermore, a focus on pathology prevents children from expressing other psychosocial needs or protection concerns.

We have found that structured age- and gender-specific focus groups with 6-10 children, in which each child is given an opportunity to address particular themes, work well. The group context provides mutual support for shy children, and allows articulate children to model for those lacking confidence. Careful semi-structured questioning in go-rounds prevents any one child dominating the group and allows less confident children to speak. If children initially appear simply to copy each other's responses, further gentle probing usually brings out the individual child's experience. The group form makes it possible to combine the needs assessment with simple psychosocial health messaging such as mine awareness, or clear age-appropriate explanations about the particular disaster, and advice as to what to do to stay well. For children who appear to have concerns or difficulties expressing themselves, or have more to say, follow-up in-depth interviews are conducted.

What bothers Kurdish children most:

- Violence in the camps
- Discrimination by teachers and authorities because they were IDPs
- Environmental hazards
- The necessity to work
- Being confined and early marriage for girls
- Lack of safe space to play
- Lack of clean water
- Poverty

Kurdish children's worst fears and worries:

- Being bitten by scorpions and snakes
- Being blown up by a mine
- Failing in school and being beaten by parents
- Djinns (ghosts)
- New conflict

Figure 2. The fears and concerns of IDP Kurdish children in northern Iraq, 2003.

What are children's concerns?

The here and now

When children are given the opportunity to freely express their main concerns, what comes up is often much more related to the here and now than to previous experiences of trauma: For example Figure 2 illustrates the main concerns, fears and worries of 76 internally displaced Kurdish children, interviewed in Northern Iraq in 2003, most of whom had been living in temporary camps or shelters for all of their lives (Jones, 2005).

Main worries and concerns of returning refugees and ex-combatants, post conflict in Sierra Leone 2004

- Poverty and unemployment
- Divorce, abandonment or death
- Traumatic memories of the war
- Forced recruitment
- Substance abuse
- Foster care
- Early marriage/early delivery

Figure 3. Main worries and concerns of returning refugees and ex-combatants, post-conflict Sierra Leone, 2004.

Cluster bombs were a continuing hazard and every child knew of others who had been injured. The hardship, restrictions and overwhelming sadness caused by living as an internally displaced person (IDP) are summed up by this teenage girl who had lived in a 'temporary' tented encampment for more than 3 years.

> I am 13. I wake at seven, eat breakfast and do my jobs like washing the floor and doing the dishes. Then I collect wood, every other day. It's a long walk to find any. It can take four to five hours and is very hard. When I get home I am so hot so I wash my face but the water is hot as well and it is not refreshing. Ice is very expensive. I may help with the cooking. Then there is nothing to do so I just sit around. We cannot go out. I have never been to school. I cannot read or write. My elder sister went until sixth grade. She speaks Arabic and Kurdish. My brother is in second grade. I feel very sad. (Teenage girl, Takya camp, 2003)

For some the restriction, boredom, and limitations of their lives resulted in suicidal feelings:

> If life went on like this I would not want to live. (Teenage girl, Police Machinery Building, 2003)

Boys who had more chance to go out and were almost invariably working were similarly sad:

> I would like to die. I don't have anything to do when I am not working. My life is too hard, I just want to die. I have thought of it [suicide] a couple of times. I don't do it because it would upset my parents and I know they need me. (Teenage boy, Takya, 2003)

Focus groups conducted with approximately 60 returnees and ex-combatant children in Kailahun Eastern Sierra Leone in 2004 revealed similar concerns about life in the here and now (Jones, 2004).

Poverty and unemployment were the biggest worry in all groups, in both genders and both ages, as figure 3 illustrates. Children particularly discussed its impact on their hope of schooling and their fear that they would not be able to continue studying. Loss of a parent through death, abandonment or divorce was the most upsetting event for children. More than 70% of the children in every group were affected in this way.

Orphans and vulnerable children

The disruption of war and displacement appeared to have created particularly vulnerable and fluid family structures in this area and children frequently moved from one carer to another with little attention to their best interests. In the small boys' group it was notable that the children who were whipped were all in divorced families. Beating was the main form of chastisement in Kailahun district and was largely regarded as acceptable by parents and children alike.

> My mother and father divorced in 2002. I live with my father who has a second wife. When we are home she overworks me and stops me studying, she does not give me enough food because I am not her biological child, then she sends me to take food to her boyfriend and beats me when I refuse. Then when father comes she complains about me and he beats me for making false allegations against her – when I say she has a boyfriend – he does not believe me but it's true. Sleep does not come at all; I eat, but just enough to make life go on. I don't want food. (12-year-old boy, primary school, Kailahun)

> When the war came we fled to Guinea where my mother got sick. She went to the hospital but they could not treat her and she died. When my mother died my father rejected me and my elder sister and so we came to be with our grandmother, but she too died, so we went to stay with our auntie. But there is not enough food. So sometimes we go to our extended family and help with the swamp (rice) and they give us food. (11-year-old girl, primary school, Kailahun)

Fostering is encouraged by humanitarian agencies seeking non-institutional solutions for separated children or by village families who send children to relatives in town to assist school attendance. Child welfare committee members, teachers, and the children themselves frequently raised the problem

of what could be called the 'Cinderella syndrome' where the foster child is made to work, kept from school, treated differently from the related child, and often severely beaten. There is no fairy godmother.

In this context the more recent direct experience of war (which ended in 2002) had also marked these children. The majority had lost at least one close relative in the conflict. More than 50% of the boys had been abducted and served in one fighting force or another. Girls who had suffered similar experiences were excluded from the internationally established demilitarization and reintegration schemes because at that time their needs went unrecognized.[1]

> When the war came we were all captured: father, elder brother and grand father were all killed. I saw them being killed by the SLA. I was six years old. The SLA kept me for four years, they did not make me do anything, I was too little. But I saw many people killed. So many people killed. They captured people and put them in a house and put it on fire. Another relative, a woman, they boiled palm oil and put it in her ear. They let me go two years ago. Because of all the bad events when I go to sleep I am frightened. I remember them killing people and burning houses. I have nightmares every week. Only at night, in the day I am alright. I can do my schoolwork, although I am sad. (10-year-old girl)

Refugee children from the conflicts in Congo, Rwanda and Burundi interviewed in Uganda in the summer of 2006 expressed almost identical concerns, again stressing worries over poverty, how to access or continue schooling and the difficulties of being fostered as their main concerns (Jones, 2006). Children in child-headed households were even worse off, complaining of being without care, and difficulties such as managing their monthly World Food Programme rations. As hungry teenagers they succumbed to the temptation to eat all the food provided in the first week and then went hungry. Such unaccompanied children are particularly vulnerable. For example in one focus group of five children, each had witnessed one or both parents' death, suffered nightmares all the time, worried all the time about work, money and food, which made it hard to concentrate at school. All lacked any positive views of the future or any clear ambitions for their lives.

Paying attention to context

Both the nature of the event and the socio-cultural political context in which it occurs will affect the way children and young people respond, (and the degree of media attention and humanitarian support they receive). Arlinda's experience as a civilian in Kosovo quoted at the outset occurred in a relatively short conflict very different from the prolonged conflicts in many parts of Africa. These have produced large numbers of young ex-combatants with significant substance abuse problems and problems of reintegration into families that did not necessarily want them home. In contrast it is surviving teenage girls who were most severely affected by the recent earthquake in Pakistan. With the destruction of their home, villages, the sudden loss of their families and removal to a camp environment girls faced a much more restricted and confined life than boys, were denied access to school, forced into early marriage and expected to take on parental roles as caretakers of younger children.

In the recent conflict affecting south Lebanon the most significant psychosocial issue after families had returned to their homes was the fear of unexploded ordnance. Some 6000 munitions a day had fallen on the area for 34 days, 10% were unexploded. As a result, parents were reluctant to let children out of their sight to play and children felt nervous of renewed conflict, bored and confined. The priority was to create safe play spaces which could also be places where informal education and life skills training could begin.

What emerges from all these assessments is that, firstly, context matters. Each disaster and war is different and within one conflict children may have very different experiences one from another. They need to be asked directly what their concerns are. Secondly, children's mental health needs and problems are varied, complex and intimately connected with their social and practical needs for security, food, shelter, education and family connection. This requires a holistic, rights-based approach that can both access resources to address basic needs, advocate for security and protection, and recognize and address the needs of the more vulnerable children (or refer them to other agencies with appropriate resources).

How should we respond?

Answering that question requires addressing a number of key issues.

Appropriately defining childhood and youth

Firstly, the construction of who is a 'child' is extremely variable around the world. In many low and middle income countries adolescence as a protected period of 'childhood' is non-existent or shortened: the majority of children in the world are

engaged in the household economy from young age, usually through the care of younger siblings, the gathering and preparation of food, the collection of water and the herding of livestock. More formal work may also begin early, whether for infant coffee pickers in Guatemala, brick makers in Pakistan or child carpet makers in Kabul. Girl children in many areas are still not regarded as worth educating and remain vulnerable to forced marriage and early childbearing. In addition, in some traditional societies 'youth' begins at puberty with circumcision in both sexes and initiation into adult life and responsibilities, and continues until parents are dead. Conflict and disasters increase the likelihood of all the above.

The greater impoverishment of families means a greater necessity for children to work – they may become the main breadwinner – or to marry early. Disrupted infrastructure, means roads and bridges to schools are destroyed, school buildings are targeted or become barracks for the military and education is less available. War also means the forced abduction of children as young as four into various armed forces where they are subject to abuses such as those described above. In the longer term, such disruption can result in schools, including primary schools often containing youths into their twenties trying to catch up on missed schooling.

All of which raises the question as to whether the traditional age divisions of the mental health services in high income countries are appropriate for services developed in such contexts where there are minimal or absent social and psychiatric services of any description. There is a growing consensus that health services would do better to construct services for children (under 12) and young people from 12 to 24 thus encompassing the vulnerable period in its entirety and increasing the chance of relevant holistic service provision.

Recognizing different understandings of psychopathology

Secondly, as stated in the introduction, there are different understandings of psychopathology. It is clear that almost all societies recognize something resembling the severe mental disorders, often in the form of a 'catch-all' group, such as 'out of head' in Sierra Leone or 'Gila' in Indonesia. These terms encompass anyone neglecting themselves and acting strangely. They thus include sufferers of epilepsy and those with mental retardation. In rural areas particularly, such disorders are variously ascribed to the effect of evil spirits/witchcraft/and/or disordered family relations. Sufferers are heavily stigmatized, and usually treated traditionally with minimal effect. They are vulnerable to abuse, rejection or isolation and confinement even when young.

However, the understanding of the less severe 'common mental disorders' is different. Post-disaster problems of sadness and fear are not necessarily regarded as mental illness consequent on life events (Jones, 2004). The help-seeking behaviour may be different. For example, poil-heart, the Creole term for heavy heartedness in Sierra Leone, is described in the following way by an adolescent girl in Kailahun:

> Someone who is poil-heart is in a group but she's withdrawn from it, she suffers from something and does not pay attention. If she has a baby she is confused and can neglect the baby. When she or he imagines what happened she cries all day and cannot sleep or eat. She tries to work but it is no good. When she is at school her concentration is poor.

This problem, which from its detailed description would appear to resemble depression, is not seen as a problem that requires professional medical assistance, either allopathic or indigenous. The treatment for poil-heart was described by the same girl as follows:

> . . . If my friend was poil-heart I would go to her and talk with her to encourage her. If there was a football game I would encourage her to go. If lonely I would ask her problems and exchange ideas. If she told me she could not sleep or was afraid I would take her to my bed and share it. One should hear the problem, explain it and solve it.

Western therapeutic efforts should take care to identify and support positive and constructive approaches such as this, rather than undermining them through identifying them as pathology in need of medical intervention, thus deskilling those who may feel they are able to help.

That is not to say that the pathological potential consequences of a problem such as childhood sexual abuse should be ignored because they are not recognized or acknowledged by that society. For example, rape and sexual assault of girls and women was a major problem in the conflict in Sierra Leone, and continued after the war, but was often not brought to the attention of any services, as it was regarded as neither a legal nor medical issue, but something to be resolved by payment between families. The presence of international agencies began changing attitudes to this issue and more families began bringing victims forward for medical and legal support. Figure 4 illustrates the multifaceted approach such cases might require.

Sexual assault in Sierra Leone

GB was an eight-year-old girl who was raped by her neighbour while alone in her house. Her mother took her to the pediatric ward in the field hospital run by an INGO. She was referred to the author because of persistent generalized body pains worse in her sacral area and arms and legs. She was increasingly reluctant to walk and her mother carried her everywhere. No organic cause could be found. GB retold the story of assault and how the perpetrator had pinned down her arms and covered mouth. She complained of pain, weakness, persistent nightmares of the assault, continuing fear of perpetrator. Her parents were divorced and her father wished the perpetrator to be forgiven and to avoid court. Mother wished GB and herself to move to another area. GB wanted the man punished. She was treated with gentle mobilization, dream scripting and play therapy. Repeated family meetings were held in coordination with the child protection agencies resulting in a consensus to pursue relocation and prosecution. GB's nightmares and limb pains decreased and she became fully mobile allowing discharge home. At home she weakened again and was taken to the religious healer, but he had no effect. Gentle mobilization was restarted and she made progress to full recovery. She continued to have individual counselling from one of the psychosocial agencies who are also helping with legal support to bring the perpetrator to court.

Figure 4. Sexual assault in Sierra Leone.

Treating the family as a whole

At 14 Fatima was the oldest of seven children. She lost her parents in the Pakistan earthquake of 2005 and moved to an army-run displaced persons camp. She became the main caretaker for her younger brothers and sisters and was nominally the responsibility of her aunt and uncle. An informal school was begun in the camp by UNICEF and Fatima wanted to attend. The children and their aunt all attended a children's grief support group set up in the primary healthcare clinic in the camp. When it was explained that all the children would also benefit from the activities and distraction provided by the school, aunt and uncle appeared to agree. However, although all the younger children were allowed to go to the informal school, Fatima was still prevented from going. On every visit a different excuse was given: her aunt was sick, there were other children to care for, she was a girl and too old for school. Finally when the aunt was encouraged to join an income-generating sewing machine programme, Fatima was permitted to go to the child support programme.

Figure 5. Treating the family as a whole.

Taking a holistic approach

Thirdly, there is the question of who is the target of treatment and support. In most low and middle income countries, in the absence of any sort of welfare provision the extended family and the local community play a significant role in the child and young person's life. Programmes which target children on their own without supporting or addressing the needs and concerns of their carers and communities will usually fail. Figure 5 illustrates the importance of addressing all the needs in the family, not just those of the child.

One way of illustrating how to construct a holistic response to children's needs is illustrated in Figure 6.

The pyramid both illustrates the proportion of those in any conflict- or disaster-affected population likely to be suffering serious mental disorders, and the way mental health and psychosocial support in emergencies can be provided in a layered system of complementary supports to address the complex needs of different groups (Inter Agency Standing Committee, 2007). This integrated holistic approach is particularly significant for children, as they cope best with disaster when their immediate family is coping well and their needs are addressed.

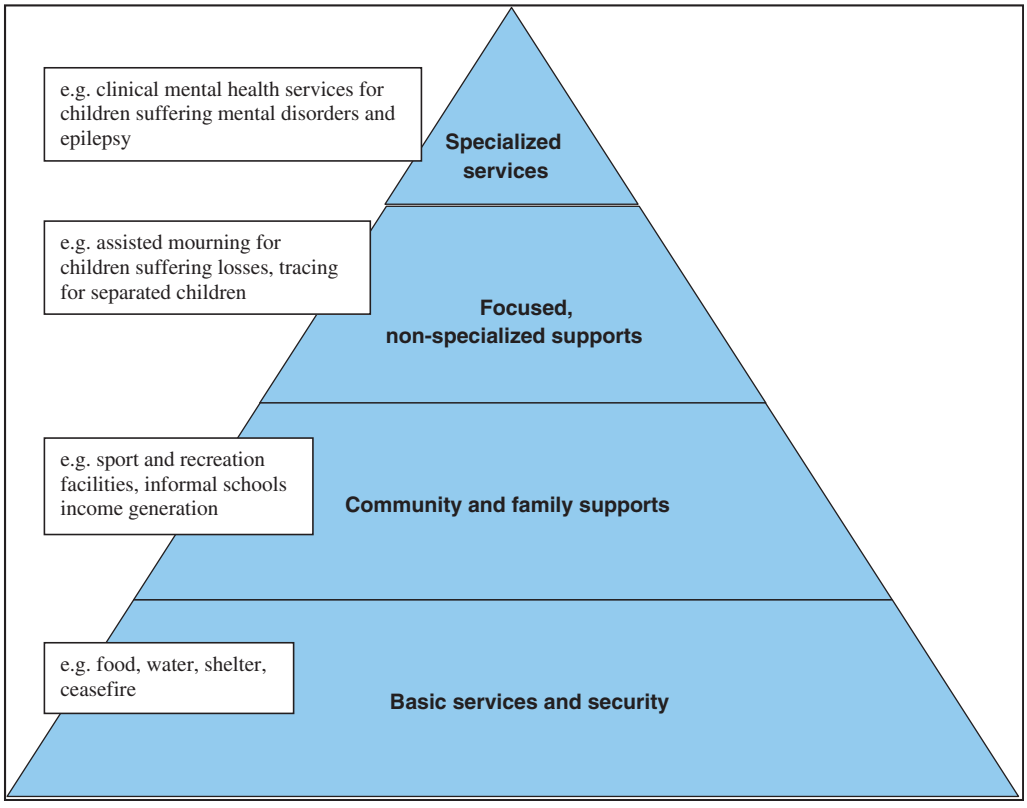

Figure 6. Pyramid illustrating proportions of those with mental health and psychosocial needs in an emergency and suggested forms of intervention.

Addressing the needs of children separated from their families

Another issue is the very varying attitudes to the costs and benefits of institutionalizing or fostering unaccompanied children whose serious psychosocial needs have been illustrated above. While the negative impact of institutionalization has been much studied and discussed in the west and most international organizations oppose institutional solutions, many impoverished families see the placement of their children in charitable religious 'boarding' schools, or with wealthier relatives as a way of improving their children's chances of success in life, in spite of the risk of exposure to abuse. Programmes that target the staff working in such institutions with training and support, to enable productive attachments to form, may be more constructive than confrontation with, or ignoring the system (WHO, 1997). Whether institutionalized or not, children outside their families, such as unaccompanied minors, street children, children working away from home, are particularly vulnerable and need programmes that address their specific needs. Their care in and out of institutions needs careful and consistent monitoring.

An example of an emergency response

In designing an appropriate emergency response, the Inter Agency Guidelines for Mental Health and Psychosocial Response in Lebanon provide one example of a framework that would be appropriate to many crisis situations (Inter Agency, 2006). They were drawn up by a consortium of international organizations and NGOS drawing upon an early draft of the more comprehensive IASC guidelines. They laid out underlying principles of action including: a rights-based, participatory community-based approach that built local capacity, enhanced competence and resilience rather than focusing purely on vulnerability and that emphasized a return to normality:

> . . . by re-establishing family and community connections and routines, strengthening predictability in daily life, and providing opportunities for affected populations to rebuild their lives. For example, schooling for all children should as far as possible be re-established at the earliest stage.

They also emphasized, do no harm:

> . . . Culturally inappropriate methodologies can undermine traditional coping mechanisms,

> and inappropriate exploration of distressing events can leave people more vulnerable.

The Middle East inter-agency guidelines recommended a series of actions to address both the communal non-pathological and the more clinical needs. Those steps relevant to children and youths are summarized below:

I. Address communal non-pathological needs

- Advocate and address protection concerns and basic needs
- Coordinate with other sectors to ensure that humanitarian assistance enhances rather than disrupts psychosocial wellbeing
- Assist mourning
- Establish tracing mechanisms and services for separated children
- Re-establish normal routines including formal and informal schooling
- Provide information to carers and children on the event/current situation/where to get assistance/effective coping mechanisms
- Provide safe places for children and youths for recreational activities
- Support carers: teachers and parents
- Reduce exposure of children to graphic depictions of violence
- Provide life skills and/or vocational training and opportunities for youths and adults
- Refer cases of severe distress to mental health services
- Support and where appropriate train the local community in providing all of the above

II. Relevant psychological care for children in acute distress and with pre-existing mental disorders:

- Psychological first aid for children and youths in acute distress
  - Protecting from further harm
  - Assessing and meeting basic needs
  - Listening but not forcing talk
  - Ensuring connection to parent or relevant carer
- Avoid programming that focuses on a single diagnosis and consider all urgent neuropsychiatric problems
- Inquire about and address the needs of those on long-term medication (for example anticonvulsants)

These guidelines also addressed the question of terminology, stating specifically that:

> Terminology should be used that: is understandable to non-specialists; normalizes reactions to difficult situations; reflects and reinforces the ability of people to deal with and overcome difficult situations; acknowledges and strengthens existing social support mechanisms within families and communities; reflects the collective and structural nature of causes and response to distress. Care must be taken to avoid terminology that could lead to disempowerment and stigmatization of people in distress.

It also provided examples of more appropriate terms as illustrated in Figure 7.

Examples of recommended terms (can be used in place of terms to the right)	Examples of terms that are not recommended to be used outside clinical settings
Distress or stress Psychological and social effects of emergencies	Trauma
Reactions to difficult situations Signs of distress	Symptoms
Distressed children (children with normal reactions to the emergency) Severely distressed children (children with extreme/severe reactions to the emergency)	Traumatized children
Psychosocial well-being or mental health	
Structured activities	Therapy
Terrifying events	Traumatic events

Figure 7. Appropriate terminology to use with children and youths in clinical and non-clinical settings in conflict and disaster situations.

Responding to the needs of more severely disturbed children

Setting up services

One of the main problems with any kind of specialized clinical mental health services is that in most low and middle income countries (LAMI) income countries they are unlikely to be used by any family with a severely disturbed child because of the stigma attached. Family-centred services accessed through either primary healthcare clinics or school-based services are better than age- or disorder-focused services that may be difficult to sustain after emergency funding disappears. A well trained outreach component is essential to help access hidden problems. However, outreach workers, whether teachers or health volunteers, should not be trained in the identification of mental disorders without providing either clear systems or resources for referral or accompanying training in management, otherwise they may undermine local support systems without being able to offer clear alternatives.

For example, in the IDP camps established after the Pakistan earthquake in the Balakot area of the North West Frontier Province (NWFP) most children in need of services were identified and brought to the primary healthcare clinic by female health visitors, who were trained in both identification and continuing support for the family after treatment was initiated by a general practice physician trained in mental healthcare.

Short theoretical courses should be avoided and theoretical training should always be combined with continuing on-the-job supervision as there is no substitute for training staff to deal with the reality of the problem as it presents in the clinic, school or home. This also allows for any international trainer to fully understand the communal and cultural context and adapt accordingly.

Figure 8 shows examples of curricula for training primary healthcare workers to address the needs of children in emergencies. A problem-focused curriculum may work better, particularly with non-medical volunteers. Such a curriculum also allows for a more flexible culturally based approach inclusive of the local conceptualizations of problems and solutions.

Therapeutic approaches

The therapeutic approaches adopted for severely disturbed children should draw on the existing evidence base and should avoid treatments for which there is a negative evidence base, such as single incident debriefing (Rose et al., 2002), or which may be culturally inappropriate. For example, a UNICEF-funded study of eye movement desensitization (EMDR) – which has proved effective in western settings – reported that Indonesians in Aceh found the intervention frightening and disliked it as they believed the hand movement indicated that they were being bewitched (Melville, 2003). Unfortunately, the evidence base for treatments for a wide range of problems is still poor for children in LAMI countries, with notable exceptions such as the recent randomized controlled trial comparing creative and interpersonal therapies for adolescent survivors of conflict in Northern Uganda (Bolton et al., 2007).

In LAMI countries the extended family is the major form of social support and whatever treatment method is adopted will usually be delivered in a family context, thus some understanding of family therapy, particularly systemic approaches that engage with the family as a whole rather than singling out the individual child, may be particularly productive and enhance therapeutic compliance. Classroom-based interventions can address the whole group without stigmatizing a few children. Where medication is required, the recommended drugs should be the

Curriculum for training primary health care workers to address the mental health needs of children

- Communicating with children and families
- Grief and loss
- Stress-related responses and disorders
- Behavioural disturbance
- Early child development and developmental disorders
- Mental retardation
- Epilepsy
- Sleep, feeding and elimination disorders
- Sexual and physical abuse
- Severe depression and other severe mental disorders
- Suicide and self-harm

A problem focused approach to addressing children's mental health needs in the PHC clinic

- The withdrawn and isolated child
- The aggressive child
- The child who cannot learn
- The fearful child
- The abused or neglected child
- Bedwetting
- Problems with sleeping and eating
- School problems

Figure 8. Suggested curricula for training primary healthcare workers to address the mental health needs of children.

cheapest generic version and available on the local essential drug list, and mechanisms for proper supervision need to be set up. Usually a combination of approaches is required to address the complexity of biomedical and psychosocial issues that can arise. For example, in the case of conversion disorder following sexual assault described in Figure 4 above, a combination of family therapy, play therapy, problem solving, cognitive behavioural approaches and psycho-education worked well.

Conclusion

This paper has focused on outlining an approach and some underlying principles to responding to the needs of children in crises, looking particularly at those suffering during and in the immediate aftermath of conflicts and natural disasters. The paper has drawn on both the literature, clinical experience and the framework provided by the newly developed IASC guidelines for mental health and psychosocial support in emergency settings. It has emphasized the need for attention to the child's perspective as a starting point and argued for a deep consideration of culture, context and the specific meanings of events, as the framework both for assessment of the problem and response. It suggests that a narrow focus on psychopathology and a narrow definition of what is a child may deny large numbers the support and attention that they require both during and after crises. It points out that the larger part of psychosocial support is provided by non-medical interventions that address both the needs of the child and the family and community in which s/he lives.

However, millions of children in the world live in a state of crisis so permanent and chronic that they generate far less attention than the sudden disasters that attract both media and donors. These long-term chronic crises of hunger, poverty, infectious diseases and lack of education are the target of the Millennium Development Goals which aim among other things to eradicate extreme poverty and hunger, lower child mortality, address HIV and improve children's access to primary school education. Patel and others have highlighted the role mental health interventions such as treating maternal depression would play in achieving these goals (Miranda & Patel, 2005) and a growing number of practitioners, researchers and humanitarian agencies are now paying attention to the mental health needs of children in these silent longstanding emergencies. WHO now recommends that psychosocial stimulation be combined with emergency nutrition programmes as there is clear evidence to show that combined interventions in early childhood promote better long-term cognitive development and better growth (WHO, 2006). There is also evidence that nurturing parental behaviour at this early age may increase the resilience of these children to stress at a later date (Leckman, 2007).

Children who are poorly nourished, under stimulated, lacking in warm relationships and grow up in poverty are more likely to be stunted in growth, more vulnerable to stress and less likely to attend school. If they do, they may well under-perform, contributing to the lack of social capital in that society as a whole and its increased vulnerability to future conflict and disasters whenever they do occur. Thus one of the most significant responses to the mental health needs of children in crises will be to decrease their vulnerability through a holistic approach that addresses their physical and mental wellbeing from the very start of life.

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AGM Edinburgh, July 2003; The Mental Health Effects of War on Children: Experiences from the Balkans: Symposium on Children and Terrorism, Royal College of Paediatrics, Annual General Meeting, York, April 2002.

Note

[1] In Liberia some international non-governmental organizations have begun to address their exclusion from the demobilization process through informal community led processes (Wessells, 2006).

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