

Psychosocial interventions for children in war-affected areas: the state of the art

Brechtje Kalksma-Van Lith

In this article the literature on psychosocial assistance to children in war-affected areas is reviewed. Two main types of interventions are identified: the curative approach and the developmental approach. The effectiveness of each of these approaches is discussed.

Keywords: protective factors, psychosocial wellbeing, social context, curative approach, developmental approach

In the past decades, the effects of war on the psychosocial wellbeing of children and our responsibility to protect children from these effects have become widely recognized in the international (humanitarian) field. The UN report on the promotion and protection of the rights of children (Machel, 1996) made an important contribution to this recognition by pointing out the psychosocial and social needs of children, and the urgency to integrate these into all aspects of relief work within a framework of culturally appropriate concepts and traditions.

Generally, two approaches to psychosocial interventions with regard to children in war-affected areas have emerged. At one end of the spectrum we find interventions from a curative point of view, aimed at psychosocial and psychological treatment of individual, or small groups, of war-affected children. The approach is strongly trauma oriented, helping children deal with the

stressful experiences they survived. At the other end, we find an approach that is more preventative in nature. Rather than focusing on past experiences, interventions address the consequences of war and its present challenges. They aim to help children develop healthily within their social context and to protect them from future mental and social disorders.

The two types of responses and their variations have been described and reviewed by many authors and organizations. Paardekooper (2002), for example, makes a distinction between a *psychodynamic* programme that concentrates on problems related to war and subsequent flight, and a *contextual* programme focusing on the problems that children face in daily life. Jo de Berry (2004) describes a programme by United Nations Children's Funds (UNICEF) and Save the Children in Afghanistan, in which she contrasts *mental health service delivery* with a *community, based psychosocial support strategy*. Along the same lines, Richman (in Loughry & Eyber, 2003) talks about a *specialist approach*, referring to trauma-oriented programmes that focus on treatment of children who are most at risk, and a *primary care approach*, referring to programmes that include all children regardless of their affectedness. Within the primary care approach, services are delivered to the whole community, assuming that this promotes social support to children, which enhances their coping skills. Save the

Children (2004) describes three approaches with regard to programme content.

- *Curative* programmes that address diagnosed psychological effects
- *Preventative* programmes that seek to prevent further psychosocial deterioration
- Programmes that *promote* healthy psychosocial development

In this paper, two different approaches to psychosocial intervention will be distinguished. The choice of terms is based on the distinction within the programme focus. The first type of intervention is called *curative approach*, in line with the term used by Save the Children (SCF). It is primarily concerned with resolving trauma and healing the wounds of war. However, as SCF discerns two additional approaches of 'prevention' and 'promotion', the practice shows an intervention type that combines these approaches, aiming both at preventing pathology and at restoring the social fabric for a healthy psychosocial future. The second approach will therefore be referred to as a *developmental, community based approach*.

It should be noted however that most programmes are not archetypes, but moderate versions, to be found somewhere along the continuum. Many programmes also combine elements of both approaches.

The curative approach

The curative approach is highly trauma oriented, focusing on the effects and symptoms of disproportionate stress situations on children. Response from a curative angle is based on psychotherapeutic approaches related to Western mental health concepts (Lowry in: Barenbaum, Ruchkin & Schwab Stone, 2004) such as post traumatic stress disorder (PTSD) (Allwood, Bell-Dolan & Husain, 2002), which single out individual or small groups of children and focus on

confrontation of experience to help them deal with mental and social disorders as a result of war. This approach generally implies the involvement of mental health specialists, such as psychiatrists, psychologists and creative therapists.

As curative programmes focus on mental health, they include a variety of methods such as: psychotherapy, individual and small group counselling, and creative therapy (Fazel & Stein, 2002). The approach is treatment oriented; it usually aims towards capacitating local (mental health) service providers to deliver therapy to trauma-affected children. Curative programmes, when they are part of an emergency and rehabilitation programme often have a clearly demarcated ending, although the 'long-term' nature of these interventions is sometimes difficult to match within a concise time frame.

The developmental approach

The developmental approach towards psychosocial intervention sees people as part of a wider social fabric of relationships and structures. Child development – and hence children's reactions to trauma and crises – is seen as determined by relationships within family and environment. There is a constant interplay and exchange between the child's internal, psychological development and its external, social environment.

This approach does not focus on the symptoms and disorders of children, but on their ways of coping with stress situations, and the after-effects of trauma. The most important concepts within this approach are resources and protective factors. The resources that may help a child to deal with trauma and crises are dependent on culture and local context, as well as individual circumstances. Protective factors are factors that shield children from the worst effects of

stress, such as a stable emotional relationship with a parent or caregiver, social support within and beyond the family, an emotionally positive, open, guiding and norm-oriented educational climate, cognitive competence, and a positive sense of self-esteem (Tolfree, 1996).

Programmatic response is geared towards promoting coping skills, and to restoration of normal life. Family and community relations are regarded as key factors that enhance children's coping potential (Summerfield, 1999; Stichick Betancourt, 2001; Loughry & Eyber 2003). This approach emphasizes children's capacity to be involved in the design of programmes that are beneficial to them.

The developmental approach is inspired by research on the psychosocial functioning of children in crisis situations. For example, research in Colombia shows that social support and family cohesion reduced the risk of psychopathology, or distress, in coping with severe violence against family members (Stichick Betancourt, 2004b). A literature study to review stress reactions among children and adolescent refugees revealed that reactions to stress might be mediated by coping strategies, belief systems and social relations (Lustig, Kia-Keating, Knight, Geltman, Ellis, Kinzie, Keane, & Saxe, 2003). For example, in a group of Lebanese children exposed to war and conflict, those whose living situation offered more stability were more deliberate in their conduct. In general, social support and parental wellbeing were identified as key protective factors. In one of the reviewed studies, Mayan refugee children, living in camps in Mexico, identified parents and relatives as primary supports in difficult times. Connection to culture and ideological commitment is also said to act protectively. Tibetan refugee children indicated that factors such as religious belief,

solidarity and active community involvement helped them to cope with stress-related symptoms.

Boothby's study of Palestinian children (Arafat & Boothby, 2003) shows that children are able to clearly identify strengths, coping mechanisms and resiliency that they and their families possess. The stress suffered by the children is accentuated by the feeling that parents can no longer fully meet their needs for care and protection, as caregivers themselves are stressed and frustrated, and therefore lack energy to provide support. Children see parental support and school as important factors to improve their lives. School gives them hope for the future and is regarded as an important social forum. Parents and teachers are committed to support children even though they – mostly the parents – find it difficult to give this support.

Stichick Betancourt (2004a) conducted a study into the role of social support and connection with family, peers and the larger community, as protective factors against internalizing mental health problems of adolescents displaced by the war in Chechnya. His study shows that family, peer and community connection has a positive influence on the mental health and adjustment of war-affected youth, hence being effective protective factors in reducing the chances of internalizing stress. These findings suggest that interventions that do not target youth individually but offer them the opportunity to improve connections within the community – for example through cultural events involving friends, family and other members of the community are quite effective.

As a result of these findings, intervention is recommended that assists children in the development of effective resilience to negative life events, by collectively working with the children, parents and caregivers to

enhance coping skills. Programmes based on a developmental approach usually include:

- restoring a sense of normalcy by offering children opportunities to participate in community-based recreational, cultural, sport and other non-formal activities;
- guidance for parents in the form of material and psychosocial support;
- strengthening the role of schools as multifunctional centres.

Some developmental programmes focus on normalizing and restoring stable living conditions, e.g. rehabilitation of schools, community rites, etc. Other programmes are more specialized, helping groups of children deal with specific situations through various methods, which often include creative means such as drawing and play. Still other programmes focus on children's social environment, supporting and informing parents and teachers to help them support the children. Developmental programmes are future oriented, aiming at structural strengthening of children's psychosocial wellbeing.

A shift in approach

Although some authors and organizations continue to see the urgency of curative interventions (Barenbaum et. al. 2004), there is a recent but significant shift towards the recognition of the need to focus on developmental interventions. Various UN agencies, operating in the field of (psychosocial) interventions depart from this developmental approach. United Nations Children's Funds (UNICEF) (2003), in its evaluation of psychosocial programmes in Indonesia, recommends the strengthening of the community-based social support for children including stable family life. UNHCR (2004) in its Guidelines on Protection and Care for refugee children indicate that the best way to promote the psychosocial wellbeing of children is to support

their families and communities, and points to the role of schools in providing structure and predictability. International humanitarian and development agencies such as Save the Children (1996) and the International Rescue Committee (IRC) (2003) have published similar recommendations.

Several arguments have been put forward on the basis of which it is concluded that a developmental approach leads to the most appropriate types of intervention.

First, there is an increased belief that only a small portion of war-affected communities has serious psychological problems requiring specialised care (Loughry & Eyber, 2003) and that the majority of people should be addressed with programmes that focus on stress resilience. In line with this, Stichick Betancourt concludes that an individual, treatment-oriented approach cannot adequately address the challenge of improving mental health outcomes when enormous numbers of children and families are exposed to violence, loss and displacement (Stichick Betancourt, 2004b).

Second, there is a concern that western disorders may be unfamiliar to non-western children. The curative approach generally implies that western style pathology concepts can be projected and imposed on non-western children, assuming that disorders such as PTSD are not culture and context specific, but universally experienced in a similar way. However, studies have indicated that the way in which children suffer is in fact subject to contextual factors. Several authors argue that western mental health therapy based on trauma and related mental disorders have largely failed in settings with a different cultural context. Bracken, Giller & Summerfield (1995) and Summerfield (1999, 2000), within the context of their work in non-western countries, question the usefulness of the concepts of 'traumatization' and

PTSD. They argue that the focus on the individual is not endorsed in non-western societies and that consequently therapeutic modalities developed in the west are not appropriate for people suffering mental disorders in other parts of the world. Based on his field experience in Mozambique, Boothby (Summerfield, 1999) subscribes to this argument by concluding that western talk therapies failed in unstable and impoverished settings where cultural context prevails, for they locate the cause and burden of responsibility within the individual. In addition, some authors argue that the child's confrontation of traumatic events, which is often encouraged in individual therapy, may negatively affect their coping mechanisms.

Third, players in the field of psychosocial intervention have come to accept that children's wellbeing largely depends on secure family relationships and a predictable environment. A number of studies have concluded that social support, social ties, and living in caring environments can be associated with positive mental health outcomes in children and adolescents (Stichick Betancourt, 2004).

It is also argued (Loughry & Eyber, 2003) that there is a need to end the debate between the two models and to accept a two-fold approach tailored to the specific needs and strengths of children in their own context. While developmental responses are regarded as the most appropriate as generic types of intervention, curative methods are said to be useful in a smaller number of specific cases, for example, those children that are extraordinarily affected, or those who have not benefited from generic intervention.

Intervention methods

Focused therapeutic interventions. Focused therapeutic methods address children from a curative perspective, based on individual trauma

and related psychosocial problems. Activities take place in individual or small group settings. These methods generally involve a longer term, open relationship between therapist and client, who engage in a joint trajectory with a therapeutic goal. Therapeutic sessions involve certain treatment, often including confrontation with experience and expression of emotions.

Some examples of focused therapeutic interventions are psychotherapy, self-help groups and counselling. Focused therapeutic interventions with children may be promoted by the longer term availability of (local) treatment services. Therefore, this area of intervention includes training of local mental health workers and strengthening of the public health system.

Child centred group interventions. A second category of interventions is formed by child centred group interventions by means of creative and recreational methods. A general distinction is made between structured interventions aiming at 'psychosocial development', and less structured, 'relaxation-based' interventions. As opposed to focused therapeutic interventions, child centred group interventions do not focus on stress related disorders but address children's wider psychosocial problems and needs. This type of intervention does not single out children in a secluded environment, but works with selected groups or in a community based setting. Sessions are led by animators rather than therapists, who may be outsiders, but are ideally community members. The animators develop a trusting relationship with groups of children, but do not engage in therapeutic relationships with individual children. Child centred group sessions focus rather on the exploration of the surrounding world, strengthening cognitive, emotional and social skills, through imitation, competition, cooperation, fantasy, etc.

Some of these interventions offer creative activities, based on the idea that creative activities offer a means to learn physical, emotional and social skills, helping children to express emotions, communicate and build relationships.

Other, often less structured interventions, offer opportunities for recreation. These activities do not particularly focus on specific developmental goals, even though they may contribute to the psychosocial development of the children. They offer the opportunity to play and have fun as a counterbalance to stressful experiences and the impoverished world surrounding a child in the aftermath of war. Recreation provides children with moments of relaxation and may therefore have a healing effect. The activities put children in a protected environment and allow them to express their emotions in a manner they direct themselves.

Various organizations and authors have diverse opinions on the classification of activities into creative and recreational categories; sports for example are regarded by some as a creative method, being part of a psychosocial rehabilitation process (Akhundov, 1999), while others solely recognize functions of fun and energy release. In practice, many child-centred group interventions contain elements of both methods. Examples of child-centred group interventions are: play, music and dance, art activities (drawing, painting and puppet making), drama and story telling, sports and games, and recreational activities.

Interventions aimed at normalising systems and structures. A third category of interventions is aimed at normalizing systems and structures. These methods pursue the restoration of an environment that resembles normalcy. Interventions aim at (re)building an environment that is conducive to the child's recovery and reintegration. Barenbaum,

et al., (2004) refers to this method as 're-establishing the psychosocial network'. Normalcy, among other things, means a stable community environment with structures such as schools, health services and community events. Some examples follow.

- Rehabilitation of schools: this restores opportunities for children, offers them a sense of predictability and security and may foster the development of social (support) networks.
- Rehabilitation and promotion of cultural rites and events: such events have a collaboration and peace building function and create a sense of belonging.
- Re-establishment of social networks: meaningful community engagement helps to restore a sense of belonging and personal dignity.
- Skills and vocational training: this offers children and youth hope for future success and income generation.
- Family interventions (reunification, awareness): a secure family environment has a positive effect on the child's overall psychosocial wellbeing.
- Integration activities: in order to support peace building and forgiveness among individuals and divided groups.
- Provision of material support (food, oil, grains and seeds, blankets, tools): access to basic commodities contributes to a secure and healthy environment.

The effect of curative interventions

As previously discussed, curative programmes generally address post traumatic stress reactions and related mental health problems. They mostly target children directly, but may also use intermediaries (e.g. parents or caregivers) to help children deal with traumatic experiences of war. The belief that children and adolescents can be

effectively treated with trauma focused cognitive behaviour therapy is based on research (randomized controlled trial or RCT) in industrialized countries, which was subsequently applied to other settings. Although there are reservations towards the projection of findings to non-western cultures, a number of authors have pointed at similarities, on the basis of research, such as a study into victims of violence in Los Angeles (Schauer, Neuner, Elbert, Ertl, Onyut, Odenwald & Schauer, 2004). Another example is Groenjian's RCT into early adolescent survivors of the Armenian earthquake (Schauer, et. al., 2004) from which it was concluded that standardized cognitive behaviour therapy (CBT), including exposure techniques, can be effective for children in vulnerable populations from different cultures.

Below, four programmes with a predominant curative approach are described. Three of them concern direct interventions with individual children, or specific target groups, while one programme addresses mothers as intermediaries to improve children's (psychosocial) health.

Narrative exposure therapy. Narrative exposure therapy (NET) is a standardized short-term approach for the treatment of survivors of wars and torture, in which the participant constructs a detailed chronological account of his own bibliography into a coherent narrative. KIDNET is the adapted child version of NET, with the assistance of play and visual aids to help children construct their story. A case study around the treatment of a child in Uganda (Schauer, et al., 2004) shows a high frequency of the child's post traumatic stress symptoms, using the post traumatic stress diagnostic scale (PTSDC). In a post test, the child's symptoms dropped to a degree below the diagnostic threshold for PTSD. With this outcome, KIDNET is claimed to be a successful approach for the

treatment of traumatized child survivors.¹ Its short and pragmatic method is said to be particularly appropriate in war and disaster areas. A note of caution is made however, not to inflict further harm by exposing patients to traumatic memories and not allowing them enough time, or treatment, to deal with these memories. It is also acknowledged that a better understanding is necessary of how parents, teachers and other significant adults can be involved in the recovery process of children, both individually and at community level.

Helping children by helping their mothers. Following the war in Bosnia and Herzegovina, a psychosocial intervention on young children's health and development was carried out. The programme consisted of regular semi-structured group meetings with mothers, focusing on coping with problems and promoting good mother-child interaction. The sessions included psychoeducation and therapeutic elements. During the intervention, participating families were also offered free basic medical health care. Dybdahl (2001) from the University of Tromsø (Norway) conducted a study into the success of this programme. Effects of the intervention were researched by means of an assessment of the intervention group and a control group, the latter receiving medical care only. The study included interviews with mothers, children and psychologist observers and made use of instruments such as the War Trauma Questionnaire (WTQ) and the Impact of Events Scale (IES). The intervention was concluded to have a positive effect on mothers' mental health, children's weight gain, and several measures of children's psychosocial functioning and mental health. Although on other measures, no difference was found between the intervention and control groups (e.g. depression scores showed less improvement for the

intervention group than for the control group). Positive effects, in spite of showing relatively high absolute value difference, were of limited statistical difference. This was possibly caused by the small sample size.

Trauma healing in secondary schools. In 2001, the African Centre for Rehabilitation of Torture Victims, a Rwandan association of trauma counsellors, launched the programme: Trauma Awareness, Healing and Group Counselling for secondary schools with severely trauma-affected adolescents. Before the intervention, many students indicated feeling lonely, isolated, experienced difficulties concentrating and suffered from PTSD, depression, fear and/or grief. These students were considered 'mad' and were referred to hospitals. However, once back at school, the problems continued: large numbers of pupils were involved in outbreaks of rage and other crises. To address these problems, the intervention programme included: (1) training of school staff in 'helpful active listening'; (2) sensitization in the form of psychoeducation for all students; (3) counselling, offered to staff, students, parents and guardians; and (4) youth clubs: anti-trauma clubs of students who sensitize others through various media (drama, poems, dancing, etc.). The programme was not scientifically researched but evaluated by means of interviews, observations, meetings and document study. The concluded achievements of the programme are multiple: students feel better 'listened to' by their teachers; they feel more accepted by others and have a better understanding of their own feelings. The general atmosphere, as well as the school performance of students, improved. The programme contributed to a reduction of trauma symptoms and no further crisis outbreaks occurred from the start of intervention. A problem generally felt, however, is that school staff lack time to offer sufficient services. Therefore,

professional trauma counsellors remain needed to provide counselling to the most-affected students (Olij, 2005).

The Theatre Action Group. The interventions of the Theatre Action Group (TAG, Sithamparanathan, 2003) involve the creation of therapeutic spaces where children can express their feelings and talk about problems. The members of TAG listen with care and respect and offer emotional support. TAG was formed by a group of artists from the Department of Fine Arts of the University of Jaffna (Sri Lanka), enlarged with secondary school students, teachers and others. TAG works in north and east Sri-Lanka, in refugee camps, schools and rural villages, with its workshops and performances primarily aimed at children. During its performance, TAG involves the children in discussions about their emotions and the violence in their lives. Themes are transferred into scenes and put on stage. When interest is shown, teachers are involved in workshops with the children. The programme was not scientifically researched, but reviewed on the basis of anecdotal information. Teachers have observed striking changes in some of the children's behaviour; shy children have become more assertive, aggressive children have become more manageable. Once contact has been established with children and teachers, TAG slowly starts spending time in the village. A drama may be performed, based on themes of children, whereupon spectators are involved in discussion. As a result, in some communities, members have acted and started to bring about changes.

The effect of community-based developmental interventions

Developmental interventions are based on the finding that the focus of children in many non-western cultures is more community centred than ego centred (Refugee Studies

Centre, 2001). Therefore, it may be found that stressful experiences of war and the aftermath are better dealt with at a collective level. People adhering to this approach find that most children are eventually able to deal with atrocities of war without developing psychopathological problems on a large scale. Children's resilience is considered to be supported by internal coping skills and external support. Developmental thinking has resulted in programmes that work with children's strengths, developing their cognitive, social and emotional capacities to actualize positive futures.

In this section seven programmes are described. Although some of the programmes focus on specific groups of children and youth, such as refugees and former child soldiers, the respective groups are approached from a developmental angle.

Developmental trajectory for refugees. Acting upon the need for intervention with children seeking refuge in the Federal Republic of Yugoslavia (FRY), a group of developmental psychologists of the University of Belgrade developed the Hi Neighbourhood programme, which was later funded by UNHCR and Rädde Barnen. This programme (Tolfree, 1996) takes as a starting point that its beneficiaries are 'affected' by war, but rather than regarding them as traumatized, or as having deficits, they are seen as capable and resourceful in dealing with problems themselves. The programme was built on the capacity of children for creative and imaginative play, through which issues can be explored and feelings expressed.

The central part of the programme consists of working groups in Collective Centres for refugees; groups for children, adolescents and adults operated concurrently. No attempt was made to advise the participants, but simply a platform was created for social interaction, and tools were given with which

they could build on their own resources. Individual and group expression was facilitated by a variety of media such as movement, human sculpting, performances, and creative and expressive games. Workshops were very open; anyone could attend and leave as they wished. An important aim of the workshop was for participants to introduce whatever issues had relevance to them. The workshops improved social interaction among refugees, but they still had difficulties engaging with the local community outside of the centres. Therefore, a range of activities was organised (meetings, outings, visits) to initiate interaction. Evaluation of impact was conducted by means of a variety of methodologies: perusal of project documents, observation, interviews and discussion. Drawing exercises, rating scales and questionnaires with participants resulted in positive outcomes. On a basic level the programme provided friendship and recreational activities, at a deeper level it promoted the development of coping skills. Young participants developed cognitive, social and emotional competence and improved their self-esteem, which in turn enhanced resilience. However, the open-ended nature of the programme and the need to deploy experienced professionals raised questions of sustainability.

Psychosocial adjustment of demobilized child soldiers. The International Rescue Committee (IRC), in conjunction with Columbia University, conducted a study to construct a research instrument for measuring psychosocial adjustment of demobilized child soldiers and used it to measure effects (MacMullin & Loughry, 2004). Starting in Sierra Leone, researchers, with the help of local children, created a measurement tool based on a combination of existing instruments (Child Behaviour Inventory and Cross-National Adolescent Project

questionnaire). The final questionnaire (Northern Uganda Child Psychosocial Adjustment Scale) was completed and implemented in Northern Uganda. The questionnaire was administered to a stratified sample in four groups of children: (1) former child soldiers (abductees) who had participated in a 3-10 days accommodation and reunification project; (2) abductees who attended a project including 3 months housing, counselling and vocational skills training; (3) abductees who were reunited with their families immediately after release; (4) children who had never been abducted. The result of this study can be summarized as follows. All former abductees living with parents were found to be less anxious and depressed than those living with guardians. Children who had had short-time accommodation were less anxious and hostile than children who went straight home. Children who had received counselling, housing and vocational skills training were found to be more confident than other children.

Despite research limitations (very little was revealed about the nature and duration of adjustment) this study shows that the abductees benefited from participation in one of the projects; and hence that methods used in projects are likely to have a positive impact on children. Unfortunately it remains unclear, which project activities made a difference for these children.

Youth clubs for refugees. During the war in 1992, youth clubs were organized in boarding schools and youth hostels in Serbia. The clubs were open to youngsters attending the schools and hostels (refugees) as well as other local young people. The adolescents had complete say in the content of creative and recreational activities offered, generally consisting of music, poetry, communal games, painting, drama, sporting activities, talk shops and discussions. An evaluation

study was done in the form of empirical research rather than a very strict scientific study (as strict scientific methodology was hard to apply in a war situation). The evaluation did however make use of scientific instruments, such as the War Trauma Questionnaire (WTQ) and the Impact of Events Scale (IES) and included a control group of youngsters who had not taken part in the youth clubs.

The study showed positive effects such as an increase of self-respect in all adolescents and a decrease in psychosocial problems of young people, particularly refugees. The majority of adolescents indicated an increased understanding of themselves and others and said it was much easier for them to make contact with peers. However, outcomes also included a slight increase in trauma related symptoms among refugees (measured by the IES of intrusion and avoidance), which is thought to be caused by the possibility that the intervention allowed the youngsters to face previously suppressed painful memories.

Non-formal education. In 2000, the International Rescue Committee (IRC) launched an emergency education programme, consisting of non-formal education and recreational activities for Chechen internally displaced (IDP) children and their families in Ingushetia, Russia. Among other things, the programme aimed at normalizing structured activities for children and adolescents to address psychosocial and cognitive needs, and to increase the capacity of the displaced community to respond to the protection and psychosocial needs of their children by encouraging parental and community involvement. The programme prioritized involvement of youth beneficiaries, their families and the larger community in developing the intervention.

As IRC consultant and Harvard associate, Stichick Betancourt (2000) conducted a

comprehensive evaluation study of the non-formal emergency education programme. One of the aims of studying this intervention was to explore whether the programme resulted in psychosocial benefits for young people. Data were collected through semi-structured interviews with respondents selected by purposive sampling.

Outcomes of the study indicate a number of ways in which the programme resulted in benefits for young people, such as enriched sources of support, access to meaningful activities, opportunities to learn, and a place and space to spend time and connect to others. In particular, youths describe how the programme improved their confidence in working with others and influenced their career goals.

At the same time however, it became clear that the desire of youth to lead normal lives could not be met by the delivering capacity of this emergency programme. The programme offered creative and adaptive strategies that were by no means a replacement for mainstream education.

Restoring community coping mechanisms. In a project in Eritrea that took place during the border war with Ethiopia, the activities were aimed at restoring community coping mechanisms. After consultations with the community in a refugee camp, emergency schools were started, a youth association was put together that organized all kinds of activities for children and youth, support was organized by mothers at home during coffee ceremonies and memorial meetings were organized in order to support the mourning of the widows in the camp. The project was evaluated with the Community Participatory Evaluation Tool. As a result of the programme, the quality of the daily life of the children in the camp had improved and community coping mechanisms had been re-instated or strengthened (Bragin, 2005).

Creative techniques in classrooms. During a long-term psychosocial intervention with children in Kosovo, workshops including creative techniques and sports were offered in cooperation with local schools. The leaders of the workshops claimed that the behaviour of children changed: for example a timid withdrawn child started to play with the other children, the children start to work together, and that the attitude and approach of the teachers toward the children also changed.

Training teachers in Bosnia and Kosovo. During programmes based on the assumption that schools and teachers have an important protective influence on the psychosocial development in children, teachers were trained on subjects such as cooperating with parents, dysfunctional families, the impact of poverty, stress in children, the traumatized child, loss and grieving in children, etc. As a result of the training and its follow-up programme the teachers felt empowered and stimulated in the sense that they had more energy for coping with their job, as well as with their own difficulties, the effect on the children and their parents was not measured (Mikus Kos, 2005).

Discussion

The projects described above all claim positive results. It should be noted however that the field of research is still immature; the number of studies is limited, it remains difficult to draw conclusions across studies, and outcomes of programmes cannot automatically be generalized to the wider area of intervention than the area they belong to. Reservations should also be made about the validity of some of the outcomes, as sample sizes are relatively small and long-term effects have not been researched. To obtain a stronger base of evidence, additional research with larger numbers of children

would be needed. Also, more attention should be paid to the way children cope in the long run.

Generally, research into curative programmes has a stronger scientific basis than studies of developmental programmes. This may be due to the fact that curative programmes are more suitable for structured measurement as they can make use of instruments developed in the mental health field, such as treatment-protocols and validated questionnaires. Concepts of individualized distress are more easily put into operation than some of the issues of general psychosocial development. This also explains why scientific studies into developmental interventions tend to express programme results in terms of a reduction of trauma-related symptoms, rather than a change in factors of positive psychosocial development.

From the current base of evidence, it cannot be concluded that the one type of intervention is generally more successful than the other. Selection of a certain type of intervention should be based on what best fits the need of children, which may include a combination of methods. Children have diverse responses to crises, regardless of the severity of events they have witnessed or survived. Because childhood is, to a large extent, socially constructed, children in different social settings experience different kinds of childhood, leading to discrepancies in their safety and resilience during times of external stress. In some societies for example, resilience learning is part of the formal rites of passage (Boyden, 2001). Differences do not only occur between children from various cultural backgrounds, but also appear in other aspects of diversity, such as gender. It has therefore become of growing importance to understand children's reactions to war experiences in order to be able to help them (Macksoud, 2000).

Curative programmes may be useful in specific situations where children need special attention, or are severely traumatized. However, such programmes typically can help only a small number of children. In catastrophic situations where thousands of children are affected, their usefulness is very limited. It should also be realized that programmes addressing individual deficits generally need long-term attention, which was illustrated by the study into trauma healing at Rwandan secondary schools, where professional trauma counselling appeared a continuing need. Curative programmes also include the risk of bringing out negative experiences that are not appropriately dealt with, as was concluded from research into KIDNET. Based on the same study it was argued that, within the context of curative programmes, there is a need to involve significant adults in the recovery of children.

Although the success of developmental programmes seems even more difficult to demonstrate scientifically than the effects of curative programmes, it is now widely regarded as the most appropriate generic approach to psychosocial intervention with war-affected children.

References

- Akhundov, N. (1999). Psychosocial rehabilitation of IDP children: using theatre, art, music and sport. *Forced Migration Review*, 6, 20-21.
- Allwood, M. A., Bell-Dolan, D. & Husain, S. A. (2002). Children's Trauma and Adjustment Reactions to Violent and Nonviolent War Experiences. *Journal of the American Academy of Child and Adolescent Psychiatry*, (41)4, 450-457.
- Arafat, C. & Boothby, N. (2003). *A Psychosocial Assessment of Palestinian Children*. National Plan of Action for Palestinian Children (NPA), Save

- the Children (SC) and the United States Agency for International Development (USAID).
- Barenbaum, J., Ruchkin, V. & Schwab Stone, M. (2004). The psychosocial aspects of children exposed to war: practice and policy initiatives. *Journal of Child Psychology and Psychiatry* vol. 45, 1, 41-62.
- Boyden, J. (2001). *Social healing in war-affected and displaced children*. University of Oxford: Refugee Studies Centre.
- Bracken, P. J., Giller, J. E. & Summerfield, D. (1995). *Psychosocial Responses to War and Atrocity: The Limitations of Current Concepts*. Elsevier Science Ltd.
- Bracken, P. J., Giller, J. E. & Summerfield, D. (1997). *Rethinking Mental Health Work with Survivors of Wartime Violence and Refugees*. Oxford University Press.
- Bragin, M. (2005). The community participatory evaluation tool for psychosocial programs: a guide to implementation. *Intervention*, 3, 3-24.
- de Berry, J. (2004). Community psychosocial support in Afghanistan. *Intervention*, 2, 143-151.
- Dybdahl, R. (2001). Children and Mothers in War: An Outcome of a Psychosocial Intervention Program. *Child Development*, 4, 1214-1230.
- EPPI (2004). *Protocol: How effective are measures taken to mitigate the impact of direct experience of armed conflict on the psychosocial and cognitive development of children aged 0-8?* University of London: Social Science Research Unit.
- Fazel, M. & Stein, A (2002). The mental health of refugee children. *Archives of Disease in Childhood, Royal Coll Paediatrics*, (87) 366-370.
- International Rescue Committee (IRC) (2003). *Guiding Principles For Aiding and Protecting War-Affected Children and Youth*.
- Loughry, M. & Eyber, C. (2003). *Psychosocial Concepts in Humanitarian Work with Children; a Review of the Concepts and Related Literature*. Washington: National Academies Press.
- Lustig, S., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., Keane, T. & Saxe, G. (2003). Review of Child and Adolescent Refugee Mental Health. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), 24-36.
- Machel, G. (1996). *Promotion and Protection of the rights of children: Impact of the armed conflict on children*. United Nations.
- Macksoud, M. (2000). *Helping Children Cope with the Stresses of War; a manual for parents and teachers*. New York: UNICEF.
- MacMullin, C. & Loughry, M. (2004). Investigating Psychosocial Adjustment of Former Child Soldiers in Sierra Leone. *Journal of Refugee Studies*, vol. 17, 4.
- Miskus-Kos, A. (2005). Training teachers in areas of armed conflict. *Intervention* (3) Supplement.
- Olij, J. (2005). Trauma awareness, healing, and group counselling in secondary schools. *Intervention*, 3(1), 51-56.
- Paardekooper, B. (2002). *Children of the Forgotten War: A comparison of two intervention programmes for the promotion of well-being of Sudanese refugee children*. Amsterdam.
- Psychosocial Working Group, PWG (2002). *Research Agenda*.

- Psychosocial Working Group, PWG (2003). *A Framework for Practice*. *cents Displaced by War in Chechnya*. Working paper 22.
- Refugee Studies Centre (2001). *Children and Adolescents in Palestinian Households: Living with the Effects of Prolonged Conflict and Forced Migration*. University of Oxford.
- Richman, N. (1996). *Communicating with children: helping children in distress*. London: Save the Children.
- Save the Children (1996). Promoting psychosocial well-being among children affected by armed conflict and displacement. Working Paper No. 1.
- Save the Children (2004). *Children in Crisis: Good practices in evaluating psychosocial programming*.
- Schauer, E., Neuner, F., Elbert, T., Ertl, V., Onyut, L. P., Odenwald, M. & Schauer, M. (2004). Narrative Exposure Therapy in Children: a Case Study. *Intervention*, 2(1), 18-32.
- Sithampanathan, K. (2003). Interventions and Methods of the Theatre Action Group. *The International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 1(1), 44-47.
- Stichick Betancourt, T. (2000). *Stressors, Supports and the Social Ecology of Displacement*. Working Paper 21.
- Stichick Betancourt, T. (2001). The Psychosocial Impact of Armed Conflict on Children. Rethinking Traditional Paradigms in Research Intervention. Child and Adolescent Clinics of North America.
- Stichick Betancourt, T. (2004a). *Connectedness, Social Support and Mental Health in Adoles-*
- Stichick Betancourt, T. (2004b). Mental Health in Postwar Afghanistan. *The Journal of the American Medical Association*, 292(5), 626-628.
- Summerfield, D. (1999). A critique of seven assumptions behind psychosocial trauma programmes in war-affected areas. *Social Science & Medicine*, 48, 1449-1462.
- Summerfield, D. (2000). War and mental health: a brief overview. *British Medical Journal*, 321.
- Summerfield, D. (2002). Effects of war: moral knowledge, revenge, reconciliation and medicalised concepts of 'recovery'. *British Medical Journal*, 325, 1105-1107.
- Tolfree, D. (1996). *Restoring playfulness: different approaches to assisting children who are psychologically affected by war or displacement*. Save the Children Sweden.
- Tolfree, D. (2003). *Community Based Care for Separated Children*. Save the Children Sweden.
- UNHCR (2004). *Refugee Children: Guidelines on Protection and Care*. Geneva: UNHCR.
- UNICEF (2003). *Psychosocial Interventions: Evaluation of UNICEF supported projects (1999-2001)*.
- USAID (2002). *Helping Children Outgrow War*. Technical Paper No. 116.
- Wertheim Cahen, T. (1999). *Huizen van Karton: creatieve therapie met asielzoekers, mogelijkheden en onmogelijkheden*. Stichting Pharos. Raalte: Veldhuis.

WHO (2003). *Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors*. Geneva.

Women's Commission for Refugee Women and Children (2001). *Against all odds: Surviving the war on adolescents*.

¹ In academic circles the use of a randomized controlled trial (RCT), a prospective experimental study, is regarded as the most statistically significant, and therefore the only form of research that is measuring true effect. An RCT is a study with two groups, one treatment group and one control group. Individuals who are similar at the beginning are randomly allocated to one of these groups. The treatment group receives the treatment under investigation, and the control group receives either no treatment or some standard default treatment. The treatment in the experimental group is based on strict protocols. The outcomes of the groups are compared after sufficient follow-up time. None of the studies into the effects of psychosocial programmes for war-affected children described in this article have been researched according to RCT standards. Some organizations strive towards RCT studies but do not manage to

meet the full requirements. Others, such as the Psychosocial Working Group (PWG), argue that experimental designs such as RCT are often unfeasible to measure programmes that aim at urgent response, and may be unethical as well. Instead, given the complexity and heterogeneity of the humanitarian field, PWG (2002) sees a clear role for coherent case study replication and evaluation-oriented impact assessment.

Brechtje Kalksma-Van Lith has a degree in Advanced Development Studies and has been working with War Child since early 2004. After a mission in Eritrea and assignments in the Caucasus and Sierra Leone, she is now working in Colombia as War Child's Country Representative. Email: brechtje@cable.net.co

The writing of this article was made possible by War Child (www.warchild.nl), an independent international NGO. War Child invests in a peaceful future for children affected by armed conflict. Its programmes strengthen psychosocial development, contribute to peace building processes and advocate for the rights of children and youth, applying the power of creative arts and sports.