

THE MENTAL HEALTH OF CHILDREN FACING COLLECTIVE ADVERSITY

POVERTY, HOMELESSNESS, WAR AND DISPLACEMENT

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London
Street
Children
by Edward R.
King (1904)
UCL Art
Museum

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Suggested citation: Pacione L, Measham T, Kronick R, Meloni F, Ricard-Guay A, Rousseau C, Ruiz-Casares M. The mental health of children facing collective adversity: Poverty, homelessness, war and displacement. In Rey JM (ed), *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012.

Adversity can take multiple forms for children. It may stem from constitutional vulnerability, from parental and familial difficulties and dysfunction or from environmental stressors, all of which may jeopardize children's development and affect their mental health. Poverty, becoming orphaned, homelessness child labor and war all expose children to potentially harmful environmental stress. This chapter will describe the effects of these kinds of collective adversities on the mental health and well being of children. The experience of refugee children will be taken as an example to illustrate the approach to the mental health assessment and treatment of vulnerable children once they are in a situation of safety.

THE MENTAL HEALTH CONSEQUENCES OF POVERTY FOR CHILDREN

Defining poverty

Poverty is a difficult concept to define because it overlaps with many different cultural, social, and political dimensions. The "poverty line" is typically defined as the cut-off point that separates the poor from those earning what is considered to be an adequate level of income in a given country (Ravallion, 2010).

The World Bank defines the poverty line in two ways: A *relative poverty line* is one that depends on the income distribution within a given country and varies according to purchasing power. For example, the poverty line is often set at 50% of a given country's mean income. An *absolute poverty line* (also called *extreme poverty*) is defined using different methods, but is often determined in relation to the average cost of basic survival needs in the poorest 10 to 20 countries. In 2005, the World Bank defined the absolute poverty line at a household income of less than \$1.25 (US) per day (Chen & Ravallion, 2010). This new value is an increase from the previous value of \$1 (US) per day and is thought to better represent the cost of goods. Sometimes a household income of less than \$2 (US) per day is used as a cut-off to better describe the scope of poverty in a given country or region. Using a cut-off of less than \$1.25 (US) of household income per day, an estimated 1.29 billion people, or about a quarter of the population of the developing world, were living in absolute poverty in 2008 (World Bank, 2012). To put this in relative terms, the number of people living in absolute poverty is over 4 times the size of the US population as measured in the 2010 census.

A declaration and action plan developed at the UN World Summit on Social Development in Copenhagen in 1995 defined *absolute poverty* as "a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services." (Gordon, 2005). Poverty can therefore be interpreted as the state of having insufficient access to resources needed for survival. Given the concept of *relative poverty*, poverty can also be seen as a state of relative material and social disadvantage. These are obviously overlapping definitions but each has unique consequences for children's physical and mental health.

The multifaceted impact of poverty is captured by the United Nations (UN) official definition of poverty that was ratified by the heads of all UN agencies in 1998: "Fundamentally, poverty is a denial of choices and opportunities, a violation

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Conflict of interest: none reported

The section on child soldiers is partly based on: Denov M, Ricard-Guay A (in press). Girl soldiers: towards a gendered understanding of wartime recruitment, participation and demobilization. In *Gender and War: A Handbook*. Edward Elgar Publishers.

of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or clinic to go to, not having the land on which to grow one's food or a job to earn one's living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living on marginal or fragile environments, without access to clean water or sanitation" (Gordon, 2005). Indeed, Mahatma Gandhi has described poverty as "the worst form of violence".

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Children are particularly affected by poverty because they are usually dependent on their parents or other adults and in a powerless and vulnerable social position (Boyden & De Berry, 2004; Lansdown, 1994; Scheper-Hughes & Sargent, 1998). Poverty therefore has unique impacts on children.

Measuring child poverty

Given the vulnerable social position of children, The UN Children's Fund (UNICEF) has urged that the conceptualization of child poverty be expanded beyond the concept of income poverty. An operational definition of absolute poverty for children has been defined as the severe deprivation of two or more basic human needs for children, including severe deprivation in the following areas (Gordon & Nandy, 2008):

- Food deprivation leading to severe malnutrition
- Water deprivation with access limited to surface water or water sources far from home
- No access to sanitation facilities (toilet or latrine)
- Health deprivation, including lack of immunization or medical treatment
- Shelter deprivation (i.e., severe overcrowding with five or more people per room, or dwellings with no flooring material)
- No access to professional education of any kind
- Information deprivation (i.e., children aged between 3 and 18 with no access to newspapers, radio, television, computers or phones at home)
- Deprivation of access to basic services (i.e., children living 20 kilometers or more from any type of school or 50 kilometers or more from any medical facility with doctors).

Of these measures, severe deprivation of shelter, sanitation, information and water are the most common worldwide, but the indices vary depending on the affected region (Gordon & Nandy, 2008).

The scope of child poverty

Given the difficulties in measuring poverty using general data about income, access to resources and services can provide a clearer picture of poverty and social inequality for children. Among the estimated 2.2 billion children in the world, one billion are estimated to live on less than 1\$ a day (UNICEF, 2005a). Furthermore, for the 1.9 billion children who live south of the equator, there are:

- 640 million without adequate shelter (one in three)

In 2006, the UN General Assembly adopted the first internationally agreed upon definition of child poverty:

"Children living in poverty are deprived of nutrition, water and sanitation facilities, access to basic health care services, shelter, education, participation and protection, and that while a severe lack of goods and services hurts every human being, it is most threatening and harmful to children, leaving them unable to enjoy their rights, to reach their full potential and to participate as full members of the society" (Minujin & Nandy, 2012 p3).



Brot! (Bread!) lithograph by Käthe Kollwitz (1867-1945).

- 400 million with no access to safe water (one in five)
- 270 million with no access to health services (one in seven) (UNICEF, 2005a).

Although rates of absolute poverty are striking in developing countries, high levels of poverty in terms of relative economic and social deprivation are also found in Western countries. In wealthy countries, the risk of poverty is significantly affected by ethnicity, citizenship and immigration status. For example, in the US, Black and Latino children are disproportionately poor, lacking health insurance, and having limited access to social services and education (Fass & Caughen, 2008; Guendelman et al, 2005). Citizenship may also influence a family's risk of poverty. In Germany, the number of children in non-citizen families living in poverty almost tripled from about 5% at the beginning of the 1990s to 15% in 2001, while poverty levels for children of German citizens did not change (UNICEF, 2005b).

There is a strong relationship between poverty, health, social inequality and denial of basic human rights (UNICEF, 2000; 2006a). Women are estimated

to make up 70% of the world's poor and are thought to be disproportionately affected due to gender-based systematic discrimination that limits women's access to education, health care, economic opportunities and control of assets (United Nations Women, 2010). Consistently, female children are often disproportionately affected by poverty and under conditions of absolute poverty, they are more likely than their male siblings to suffer malnutrition, have stunted growth and be denied access to primary school education (Khuwaja et al, 2005; Baig-Ansari et al, 2006; United Nations, 2010). In some countries, gender biases in property and inheritance laws and restrictions on acquiring assets perpetuate the cycle of poverty for women and girls (UNICEF, 2006a).

Poverty and armed conflict

Poverty also interacts with political instability, armed conflict, violence and discrimination in ways that specifically affect children. For instance, in cases of armed conflicts and dire poverty, family survival strategies may single out children as expendable, through abandonment, trafficking, or militarization (Boyden & De Berry, 2004; Einarsdóttir, 2006; Scheper-Hughes, 1987). Minors who are displaced by armed conflict, and who are often not recognized or protected by national states are particularly affected by poverty (Boyden & Hart, 2007). In 2006, the UN High Commissioner for Refugees announced that 5.8 million people were stateless and 13.5 million internally displaced (Bhabha, 2009). For these children, the entitlement to social rights that is, in principle, assured by a nation state, is often denied or granted on compassionate grounds, if at all. Another example of the particularly vulnerable role of children is the case of citizen minors who lack access to education or health care because their parents do not have legal status within their host country (Bernhard et al, 2007; Ruiz-Casares et al, 2010).

Developmental, emotional and behavioural consequences of poverty for children

The consequences of poverty for children can include long-lasting impacts on psychological and physical development. In fact, the harm suffered due to malnutrition and inadequate health care in early childhood often has severe consequences on a child's development and well-being (Brooks-Gunn & Duncan, 1997; Nandy et al, 2005; Seccombe, 2000; Simich, 2006). The higher prevalence of neurodevelopmental disabilities and lower educational achievement among children growing up in severe poverty may be explained by a number of factors, including protein-energy malnutrition leading to structural brain abnormalities, dietary micronutrient deficiencies, environmental toxins, lack of early sensory stimulation, anemia secondary to parasitosis, and the sequelae of infectious disease (Bergen, 2008).

Much of the research on the impact of child poverty on mental health has been conducted with children in developed countries who are exposed to relative poverty and social deprivation. These data indicate that poverty increases the risk of behavioural and emotional symptoms in children and may also negatively affect mental health in adolescence and adulthood. In a study of 5000 low-income families in 20 large US cities, homelessness or precarious housing status was associated with more internalizing and externalizing problems among three-year-old children compared to their more stably housed counterparts (Park et al, 2011).

In a large longitudinal study done in Australia, exposure to poverty in utero and at six months, five years or 14 years were all associated with higher rates of anxiety and depression in adolescence and early adulthood, and repeated experiences of poverty were associated with poorer mental health (Najman et al, 2010). A study of poor rural US families who moved out of poverty because of an income intervention demonstrated that among families who moved out of poverty, their children exhibited fewer symptoms of conduct and oppositional defiant disorders, but no change in symptoms of anxiety and depression (Costello et al, 2003). This raises the possibility that the effects of poverty on internalizing and externalizing symptoms in children may be moderated by different mechanisms. In wealthy societies, on a population health level, child well-being is associated with greater income equality and a lower percentage of children in relative poverty rather than average household income alone (Pickett & Wilkinson, 2007). Therefore, relative child poverty has been shown to have a lasting impact on both child and adult mental health and may be related to both material and social deprivation and inequality. Reducing income inequality in wealthy countries may be an important goal in order to improve child well-being across society as a whole.

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How child poverty leads to poorer mental health outcomes is not clearly established, but some data suggest that the physical and psychological stresses of poverty have lasting consequences on the developing child. Poverty may mediate its effect on mental health through alterations in the function of the sympathetic nervous system, which increases release of adrenaline and noradrenaline, and the hypothalamic-pituitary axis, which stimulates the production of the stress hormone cortisol (Evans & Kim, 2007). Furthermore, excessive stress during childhood is



Nepalese Boy.
Photo: shashish
<http://www.flickr.com/photos/shashish/3527873250/>

associated with architectural changes in different regions of the developing brain, including the amygdala, hippocampus, and prefrontal cortex, which are involved in emotional experience, stress regulation, learning and ability to cope with adversity (Shonkoff et al, 2012).

Resilience

Despite the harmful effects of poverty on children, it is important to take into account the resilience and the coping strategies employed by these children. Boyden (2004) remarked that factors such as gender, class and ethnicity play a significant part in shaping children's experience and their capacity to deal with adversity. A longitudinal study on a multiracial cohort of children exposed to chronic poverty has also shown the importance of children's role within the community, along with the presence of social networks and personal resources (Werner, 1993). Children are thus agents of their own development and, even in situations of adversity and chronic poverty, they can consciously act upon and influence the environments in which they live.

Conclusion

In conclusion, we need to understand poverty as the result of the interaction of a multitude of factors, including labor markets, government policies, family efforts, political conflicts, social discrimination, and personal strategies. For clinical practice, it is important to look at the influence of poverty and social inequality not through a restricted focus on children's deprivation, but within a much more extensive framework which includes wider cultural, social, political, and individual dimensions (Sen, 2008).

GROWING UP TOO FAST

ORPHANS, CHILD HEADED HOUSEHOLDS, STREET CHILDREN AND CHILD LABOR

In most middle and low income countries, the issue of poverty is clearly related to other major risks to child health and well-being, including orphanhood, homelessness, displacement due to disasters and conflict, street children and child labor. The most vulnerable children are those who do not have any adult caregivers. These children often assume adult roles in order to survive under conditions of severe deprivation and adversity; however, they are typically denied the rights and privileges afforded to adults in society.

ORPHANS AND CHILD HEADED HOUSEHOLDS

The number of orphans globally is estimated at 153 million (UNAIDS, 2010). This includes all children (0–17 years old) who have lost one or both parents – *single orphans* and *double orphans* respectively – through death, separation or abandonment. Of these 153 million, almost 12% have lost both parents and 11% of these have lost one or both parents to AIDS (UNAIDS, 2010). These proportions, however, vary enormously by country; for example, 16% of all orphans in Namibia have lost both parents and 58% of these have lost one or both parents to AIDS (UNAIDS, 2010). Diversity of definitions of what constitutes an orphan renders the comparative analysis of evidence difficult (Sherr et al, 2008). In

Introduction to Working with Children and Psychosocial Support



Participant's Manual



Click on the picture to access "Introduction to Working with Children and Psychosocial Support Participant's Manual". The workshop is designed to raise awareness around the issues that children who are affected by HIV are facing and how to offer support and build resilience (Hope Worldwide Africa, 2006)

the last decade, based on existing research evidence on the situation of orphans and non-orphans in many countries, UNICEF and most international organizations have widened their focus to include a number of factors that make children and families vulnerable other than orphanhood (e.g., household poverty, parental education, child labor, homelessness etc). The expression “orphan and vulnerable children” is therefore more commonly used.

To this day most orphans and other vulnerable children are still living within their extended families, often with their grandparents (Monasch & Boerma, 2004; Nyangara, 2004). Multi-generational households and child fostering have a long tradition in many parts of the world as a means to strengthen relationships and redistribute resources within families (Madhavan, 2004). While purposeful fostering of children within the extended family can reduce the impact of orphanhood, there is evidence that children from families with little regular contact with relatives are at greater risk of being abandoned if their current caregiver dies (Foster et al, 1997). Sometimes, relatives neglect, exploit or cast orphan relatives out (Foster et al, 1997). Relocation and housing insecurity frequently surround parental death (Foster, 2000). As a result of war and displacement, millions of children grow up in the absence of one or both parents, often separated from siblings and other family members.

As a result of abuse, poverty, and family separation in contexts of armed conflict, natural disasters, and the AIDS pandemic, *child- and youth-headed households* have emerged (Luzze, 2002). In some cases, child- and youth-headed households are created in response to the last wishes of the deceased parent, or the preference of children themselves (Foster et al, 1997). CHHs generally emerge after the death of the mother. Since the first child- and youth-headed households were recognized in Uganda and Tanzania in the late 1980s, this phenomenon has been documented in many other countries in the region. There are also non-orphan, “functional” child- and youth-headed households which arise in order to allow children to complete their education (Ruiz-Casares, 2009).

The effects of parental separation due to a variety of causes have been studied in contexts of war, natural disasters and orphanhood. The loss of one or both parents is often compounded by separation from siblings and other family members, poverty, lack of access to basic services, stigma and exclusion (Cluver et al, 2008). Sibling dispersion among relatives is a common coping mechanism used in situations of orphan crisis, particularly when there are multiple infants and young children from the same family who require care (Foster, 2000). However, orphaned and separated children—particularly older ones – tend to try to stay together as much as possible (Germann, 2005). By remaining together in their parents’ home, children are able to help each other grieve; maintain sibling, family and community ties; secure assets; avoid abuse by relatives and obtain assistance and cultural guidance from elders in their communities (Germann, 2005).

Risks faced by orphaned children or child headed households

Orphaned children with no parents or adult guardians are especially vulnerable (Donald & Clacherty, 2005). Particularly disadvantaged are girls because they are usually the first in the household to drop out of school, care for younger siblings and take on many adult tasks (Francis-Chizororo, 2010). Some

Orphaned children try to stay together as much as possible to help each other grieve; maintain sibling, family and community ties; secure assets; avoid abuse by relatives and obtain assistance and cultural guidance from elders in their communities.

heads of child- and youth-headed households who are caring for multiple younger siblings are as young as nine years old (Roalkvam, 2005). Orphaned children are often forced into abusive situations and exploitative employment in an attempt to negotiate their survival (Cluver et al, 2008). Many children are forced into sex work, thereby exposing themselves to significant physical and psychological risks (Cluver et al, 2011). School dropout, serious health deterioration and a consequent loss of future are frequent consequences of orphanhood. Property grabbing by relatives or other community members is common and children are often not consulted about their preferred living arrangement after the death of their parent or other caregiver (Ruiz-Casares, 2009). In a study of more than one thousand children in Zimbabwe, orphans were found to suffer greater psychological distress compared to non-orphans. This distress was mediated by trauma, being out-of-school, being cared for by a non-parent, inadequate care, child labor, physical abuse, stigma and discrimination (Nyamukapa, 2010).

In the case of parental loss due to HIV/AIDS, not only are children often alone in carrying the emotional burden of caring for and watching a loved one suffer and die, but they may also experience stigma, discrimination, and a reduction in social status and family economic power (Nyamukapa, 2010). Children orphaned by HIV/AIDS often experience extreme or increased poverty because of expenses related to caring for sick parents and the loss of parental financial support, and many live in fear that they have the disease themselves (Bhargava, 2005; Cluver et al, 2008; Germann, 2005; Luzze, 2002). Many do (Hillis et al, 2012). A systematic review of empirical studies on HIV/AIDS and orphans found that orphaned children often have negative psychological and physical outcomes (Foster, 1998). Researchers have found, for example, elevated levels of psychological distress in orphans, including anxiety, depressive symptoms, anger, loneliness, low self-esteem, social withdrawal, and sleep problems (Bhargava, 2005; Makame et al, 2002; Ruiz-Casares et al, 2009; Zhao et al, 2009).



Nermine, Street
Child in Cairo.
Photo: Linda
Forsell

Unaccompanied minors

Unaccompanied minors who are asylum-seekers, refugees or internally displaced in their home countries are a special population of homeless children who tend to face different challenges than non-migrant unaccompanied homeless children. They are often separated from their families in situations of armed conflict, natural disasters and political violence. Unaccompanied minors are defined by the UN Convention on the Rights of the Child as children less than 18 years of age “who have been separated from both parents and other relatives and who are not being cared for by an adult who, by law or custom is responsible for doing so” (Touzines, 2007). Unaccompanied minors can therefore be thought of as a high-risk subset of orphaned children. They report high rates of personal exposure to physical and sexual violence and have been shown to have high rates of mental health problems, including depressive symptoms and post-traumatic stress, which persist even after resettlement in a new country (Seglem et al, 2011). When compared to asylum-seeking children with families, unaccompanied minors seeking asylum have higher rates of psychiatric symptoms and disorders (Wiese & Burhorst, 2007).

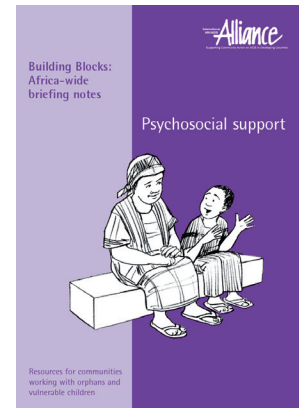
STREET CHILDREN

Children who are living on the streets, in poor urban slums or squatter settlements and those who are homeless because of armed conflict, natural disasters or political violence are amongst the most vulnerable and disadvantaged. These children suffer abuse, exploitation, sexual violence, and physical and mental illnesses. The problem of street children can be viewed from human rights, community mental health and economic development perspectives (McAlpine et al, 2010). Despite living under extremely harsh circumstances, street children display resilience and utilize effective coping strategies in their struggle for survival.

- The term *street children* is used to refer to children who work or sleep in the streets. There is no universally agreed upon definition of street children; UNICEF uses two definitions: *Homeless street children*, also called “street-based children” or “children *of* the street”, who live and sleep on the streets in urban areas, often on their own, living with other street children, homeless family members or other homeless adults, and
- *Non-homeless street-involved children*, also called “home-based children” or “children *on* the street”, who spend much of the day on the street but maintain contact with their families and typically return home at night (UNICEF, 2001).

In Western countries, the terms *homeless youth* and *street-involved youth* are used to refer to these two populations respectively. Street children therefore comprise a heterogeneous group of children who may sleep on the streets, sleep at home with their families or a mixture of the two; however, they tend to be unsupervised and unaccompanied for most of the day and are therefore at risk of abuse and exploitation. Based on these definitions, child laborers who work most of the day on the street as vendors, garbage collectors, porters, shoe and car cleaners, guards and street performers are also considered street children.

The number of street children cannot be accurately measured, but they are estimated to be in the tens of millions with some estimates as high as 100 million



Africa Network for Children Orphaned and at Risk

Click on the picture to access briefing notes about guidelines for programmes aimed at providing support to orphans and vulnerable children (International HIV/AIDS Alliance, 2003).

(UNICEF, 2006). With increasing global population and high migration to urban areas, the number of street children is believed to be growing (UNICEF, 2006b). Some studies use a capture-recapture method to estimate the number of street children in a specific area. Studies using this method have demonstrated that the majority of street children are male, maintain contact with their families, sleep at home at least once per week and are wage earners who help support their families of origin (Bezerra et al, 2011; McAlpine et al, 2010). An estimated 80% of street children are boys, which may be the result of girls' perceived value as domestic workers (Abdelgalil et al, 2004; Le Roux, 1996).

The primary reasons that street children report for becoming homeless include family poverty, abuse and family violence, being orphaned or becoming separated from their parents during migration (Abdelgalil et al, 2004; McAlpine et al., 2010). Homeless children are much more likely to report having fled abuse in their families of origin compared to non-homeless street children (McAlpine et al, 2010). Unfortunately, once on the street, children are often exposed to more abuse. Children who are homeless and sleeping on the streets without contact with family members or caregivers are estimated to comprise around 15% of all street children (Bezerra et al, 2011). Street-involved children who sleep at home tend to report different reasons for street-involvement, including family poverty, being pressured by their parents to work or beg on the street and the desire to play or spend time with friends (Lalor, 1999).

The health of street children

Most studies on the health of street children are small and many focus on drug use, infectious disease, especially HIV/AIDS, and abuse. However, being in the streets exposes children to a multitude of health risks. Street children report high levels of abuse and harassment by police and other street children, inability to attend school, involvement in crime, and medical problems, including injuries and skin and respiratory infections (Ali & Muynck, 2005; Huang et al, 2004). In Brazil, thousands of street children have been murdered and the majority were believed to have been killed by death squads, the police or other types of criminal gangs (Inciardi & Surratt, 1998).

Both girls and boys living on the street report high rates of sexual assault by strangers and engagement in “survival sex”, whereby children exchange sex for food, shelter or money, is common (Pagare et al, 2005; Sherman et al, 2005). In a study of street children in Rwanda, more than three-quarters of girls, including 35% under the age of 10 reported being sexually active and 93% reported having been raped while over 60% of boys reported having perpetrated rape (Save the Children, 2005). A high proportion of street youth are sexually active with multiple partners and do not use any protection against pregnancy or sexually transmitted diseases (Nada & Sulima, 2010). Homeless street children who are also orphaned may have even greater health risks than non-orphaned homeless children, including a greater risk of HIV/AIDS (Hillis et al, 2012). Trauma, stigmatization and marginalization limit street children's access to services for children affected by HIV/AIDS (Jones, 2009).

Rates of substance use are very high among street children and according to the WHO, between 25% and 90% use psychoactive substances, including alcohol, nicotine, stimulants, inhalants, cannabis and opioids (WHO, 2010). Among street



Click on the picture to access “Guidelines for Working with Street Children” by Judith Ennew



Click on the picture to access WHO's “Working with Street Children: A Training Package on Substance Use, Sexual and Reproductive Health Including HIV/AIDS” (WHO, 2002).

children inhaling volatile substances including glues, nail polish remover, lighter fluid, spray paint and other household products, perceived benefits included increased physical strength, decreased shyness, promoting sleep, promoting a sense of well-being and numbing physical and psychological pain (Sharma & Lal, 2011). Rates of mental illness among street youth, including substance use disorders, mood disorders, hyperkinetic disorders and anxiety disorders may be as high as 98% (Scivoletto et al, 2011).

WORKING CHILDREN AND CHILD LABOR

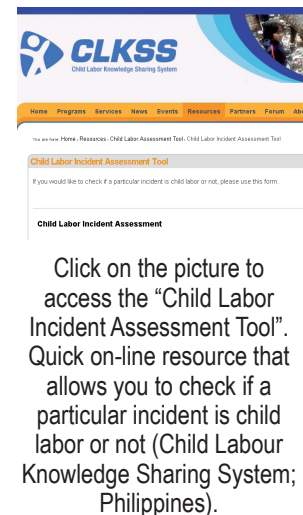
Children, whether living with their parents, in child- and youth-headed households or on the street, often contribute meaningfully to their households by doing chores or other kinds of work. However, in the poorest regions of the world, children are often engaged in work that is hazardous or exploitative in order to ensure their own survival and that of their families. Child labor is a complex issue, and in addition to abuse and exploitation, the realities of child workers include socialization, participation, learning and skills development, independence, recognition, power, security and pride in their ability to contribute meaningfully to their households (Liebel, 2004). However, the majority of children and young adolescents in developing countries work out of financial necessity to support their families and many do not enjoy the work they do and would prefer to be in school (Mathews et al, 2003; Tabassum & Baig, 2002).

There is significant controversy around whether children should do economic work at all, which kind of work may be beneficial or harmful, and the nature of work that may be considered appropriate for children and adolescents (Abebe & Bessell, 2011). Opinions on child labor are also informed by the meaning of *childhood*, which varies across cultures, and an understanding of children along a continuum from vulnerable, passive entities in need of protection to competent actors who can contribute meaningfully to society and act as agents of their own destinies (Abebe & Bessell, 2011).

Ennew, Myers and Plateau (2005) identified four key viewpoints on child labor:

- The *labor market* perspective, which views child labor as a sign of poverty and underdevelopment that will be overcome as nations develop
- The *human capital* perspective, which sees childhood as a protected time in which scholastic education is paramount and in opposition to participation in labor
- The *social responsibility* perspective that defines child labor as a cause and consequence of social exclusion, where children's work is seen as exploitative, alienating and oppressive and
- The perspective that emphasizes the right of children to be protected from exploitative labor.

Thus, while Western interests have often called for a complete ban on child labor, working children's organizations in developing countries have called for equal rights and participation, including the right to be included as members on the very labor advisory boards that aim to represent and protect them (Liebel, 2004 pp25-32).



Current status and definitions

According to the International Labor Organization (ILO), founded by the UN in 1919, there were an estimated 215 million children aged 5 to 14 years involved in economic work in 2008, mainly in Asia, Africa and Latin America (ILO, 2010). This represents a decrease from the estimated 222 million children who were employed in 2004, however, these estimates do not include children in modern forms of slavery including forced or bonded labor and or other forms of illicit work, including child soldering, sex work and drug trafficking. Furthermore, estimates do not include children, often girls, who do domestic work or raise younger siblings in their own households.

Based on definitions created by the ILO, children who do at least one hour of economic work per week are defined as being involved in the labor economy (Hagemann et al, 2006). These children are then divided into different groups based on their age and the type of work they do:

- *Economically active or working children* refer to children aged 5 to 17 years
- *Child labor* refers to working children aged 5 to 14 years
- *Children in hazardous work* refers to children aged 5 to 17 who work in dangerous occupations such as mining and construction, use heavy machinery, are exposed to toxins such as pesticides, or work more than 43 hours per week.

UNICEF uses a different definition that includes children who do excessive hours of domestic chores in their own households (at least 28 hours per week for children aged 5 to 14 years or at least 42 hours of combined domestic chores and economic work for children aged 12 to 14). However, this definition of child labor excludes children aged 12 to 14 who do less than 14 hours per week of economic work and less than 42 hours of combined economic work and household chores per week (Gibbons et al, 2005). When household chores are included, girls represent 38% of children involved in child labor worldwide (Gibbons et al, 2005).

In 1921 the ILO passed the first convention on child labor setting the minimum age for employment in industry at 14 years. More recently, increased attention has focused on eradicating the worst forms of child labor that are likely to harm "the child's health or physical, mental, spiritual, moral or social development" including child soldering, participation in the sex trade and other work that exposes children to the risk of physical or psychological harm. In 1992 the ILO ratified Convention 182 on the Worst Forms of Child Labor. However, many countries have not ratified these conventions, and as of 2008, 115 million children worldwide were engaged in hazardous work (ILO, 2010). By far, the majority of child laborers are unpaid family workers and 60% work in agriculture (ILO, 2010). Only 20% of working children are wage earners, however, in some households, children earn a large proportion of the household income (ILO, 2010). Even as unpaid family workers, children may work alongside their parents in small industries, including artisan production, trades and services such as mechanic and rug weaving. While often viewed as less hazardous, the children working in these

industries are frequently exposed to physical strain, long hours of work, low wages, and high exposure to noise, dust and chemicals without protective equipment (Nuwayhid et al, 2001).

Child labor as a risk to child health

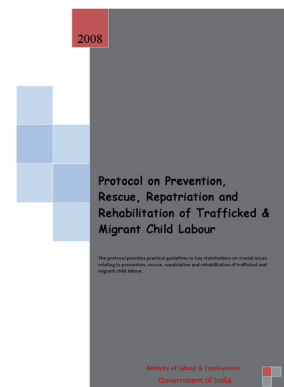
Child labor has been described as "the largest single cause of child abuse across the globe" (Scanlon et al, 2002). The harms associated with child labor include risk of physical injury and illness, acute or chronic poisoning, risk of abuse, ill treatment, exploitation and exposure to harsh working conditions. Working children may also be unable to attend school. Both female and male children involved in prostitution and work with armed groups risk exposure to physical, emotional and sexual violence, infectious diseases including HIV/AIDS, low self-esteem and emotional and psychological harm.

Most studies that report the health risks of working children are small and populations of child workers are often hard to access, particularly those who are working in very hazardous or illicit industries, including forced labor and prostitution. Determining the impact of child labor on health is also made difficult by the long latency period before disease onset, under-recognition of health problems, difficulties in measuring developmental changes and psychosocial effects, and the "healthy worker effect" whereby the healthiest children are selected for work and children who become ill or injured are excluded (Parker et al, 2010). Consistently, studies that look at child workers in general often do not demonstrate an overall negative impact of working on child health, however, studies that look at specific populations of children doing hazardous work have demonstrated harm (Understanding Children's Work 2003a; 2003b).

The majority of the world's working children are employed in agriculture and risk acute and chronic pesticide poisoning as a result of occupational exposure (Corriols & Aragón, 2010). Certain agricultural industries, such as cocoa harvesting and tobacco production, have been shown to employ children who work without protective clothing and are exposed to multiple health risks, including risk of injury and exposure to toxins (McKnight & Spiller, 2005; Mull & Kirkhorn, 2005; Otañez et al, 2006). Working children who are exposed to solvents, such as those working in machine and artisan shops, perform worse on most neurophysiological and neurobehavioral tests compared to both non-working schoolchildren and to working children who are not exposed to solvents (Saddik, 2003; 2005). Unacceptably high blood levels of lead, a known neurotoxin that has been shown to lower IQ and cause behavioral problems, have been demonstrated in children working in ceramic-making, garbage scavenging and street vending (Ide & Parker, 2005). Children and adolescents exposed to dusty conditions in mining, stone polishing, pottery and brick making industries without protective equipment are at increased risk of developing silicosis, a chronic debilitating lung disease (Chiavegatto et al, 2010; Saiyed, 1995). Children and adolescents employed in industry, especially those who work with powered wood cutters, risk hand injury and amputation (Durusoy et al, 2011). The impacts of harmful work on children therefore include acute and chronic health risks and developmental insults that may limit children's cognitive potential.

One of the most frequent harmful consequences of child labor may be the inability or decreased ability to attend school. Clearly, child labor is intertwined

Child labor has been described as the largest single cause of child abuse across the globe



Click on the picture to access briefing notes about guidelines for programmes aimed at providing support to orphans and vulnerable children (International HIV/AIDS Alliance, 2003)

with the issue of poverty because poverty itself may both preclude a child's ability to attend school and force a child to work in order to help ensure family survival. While many children successfully balance work and school, high rates of child labor tend to be associated with poorer school attendance. For example, among African countries in 2004, Swaziland had a child labor rate of 10% and a school attendance rate of 78%, while Niger, at the other end of the spectrum, had a child labor rate of 72% and a school attendance rate of 30% (Gibbons et al, 2005). Child labor, and girls' involvement in particular, can be understood as contributing to a cycle of limited educational attainment, inter-generational poverty and poor health (Leinberger-Jabari et al, 2005). However, it should also be noted that for some children whose families cannot afford to send them to school, children's participation in the work force allows them to afford school fees, books and school supplies (Woodhead, 2001). Despite the efforts of children to improve their own situations, poverty and the need to work can interfere with their ability to attend school, achieve academically and transcend the cycle of poverty.

Child labor as a risk to child mental health and well-being

There are relatively few studies that look at mental health outcomes of child laborers. One study in Ethiopia that compared 528 child laborers 5-14 years of age to their non-working counterparts found that working children had significantly increased rates of behavioral and emotional disorders, including depression (Fekadu et al, 2006). Among child laborers, starting work at a younger age and working long hours are associated with poorer mental health (Caglayan et al, 2010). While there is a paucity of data on mental health outcomes of child laborers, there is a well-established link between poor child and adult mental health and physical, emotional, and sexual abuse and neglect in childhood (Gilbert et al, 2009). A high proportion of working children reports being emotionally, physically and sexually abused by their employers (Gharaibeh & Hoeman, 2003; Mathews et al, 2003). Furthermore, girls engaged in economic work may be at increased risk of sexual violence. Among girls in Nigeria selling goods on the street, working in shops or as domestic workers, 78% reported having been raped, the majority by customers, and the risk was increased among girls who were younger than 12, worked for more than eight hours per day or had two or more jobs (Audu et al, 2009). Unsurprisingly, girls who are employed as domestic servants are highly vulnerable to physical, psychological and sexual abuse (Banerjee et al, 2008).

"Being poor is in itself a health hazard; worse, however, is being urban and poor. Much worse is being poor, urban, and a child. But worst of all is being a street child in an urban environment."

Ximena de la Barra, UNICEF (de la Barra, 1998)

Orphaned and vulnerable children, poverty, homelessness and child labor

There is a clear relationship between poverty and reliance on child labor as a family survival strategy. A national survey in Guatemala revealed that poor households were more likely to use child labor and schooling reduction as strategies to cope with socioeconomic hardship (Vásquez & Bohara, 2010). Among a sample of poor families in Nigeria, thirty-nine per cent of parents indicated that they thought their school-aged children should be working in order to supplement family income, help with the family business and to allow children to gain work experience (Omokhodion & Uchendu, 2010). Children who are poor, orphaned and engaged in child labor have to cope with multiple interrelated challenges. For orphaned children in Zimbabwe, being engaged in child labor and not being in school are risk factors associated with greater psychological distress (Nyamukapa et al, 2010).

When the number of children orphaned by HIV/AIDS overwhelms the ability of families and communities to care for these children, orphaned children are at high risk of becoming homeless. In Brazzaville, Congo, an estimated 50% of street children are orphans (Nkouika-Dinghani-Nkita, 2000). Likewise, in Lusaka, Zambia, 58% of street children were orphans: 22% had lost both parents, 26% had lost their father, and 10% had lost their mother (Concern/UNICEF, 2002).

Impoverished families who take in orphaned relatives often have insufficient resources to support these children, resulting in financial hardship and the need for orphans to do economic work to help support the family (Balew et al, 2010). However, while orphans are often viewed as a burden to families, they also contribute meaningfully to family preservation through their work, for example, by caring for sick relatives (Robson, 2004). For orphans in Uganda, identified barriers to school attendance and academic success include hunger and being at school all day without eating, heavy domestic workload including early morning agricultural responsibilities causing late arrival at school, lack of school uniforms and books, and limited options for education beyond the primary level due to financial constraints (Oleke et al, 2007). Furthermore, some orphaned adolescent girls resort to engaging in sexual relationships with wealthy older males, commonly referred to as “sugar-daddies”, as a way of securing funds to pay for school tuition and supplies (Oleke et al, 2007). Thus, under conditions of severe poverty and deprivation, orphans engage in complex negotiations regarding their health, emotional well-being and the possibility for a better future for themselves and their families.

Vulnerable children, including poor, orphaned and homeless children are at great risk of abuse and involvement in the most exploitative forms of child labor, including debt bondage and other forms of slavery, association with armed groups, begging, child prostitution and other forms of sexual exploitation.

Resilience

Despite the obvious dangers, severe adversity can lead children and adolescents to develop effective survival strategies that allow them to promote their own growth and development (Ruiz-Casares, 2009). Children under difficult circumstances can develop, among other things, practical survival and management skills, independence, the ability to cope with stress, make important decisions and develop a greater sense of self efficacy (Liebel, 2004). In her study of child- and youth-headed households in Namibia, Ruiz-Casares (2010) documented how children of all ages demonstrated an ability to obtain goods and services that they needed, and to maintain supportive community ties. Children in child- and youth-headed households display resilience in the way that they are able to mobilize their social networks, including siblings, friends and neighbors to provide emotional and academic support and material goods (Donald & Clacherty, 2005). Nonetheless, few studies have explored strengths or positive outcomes. A study looking at homeless street children in Kenya found that compared to non-street children, they displayed a high degree of adaptability and flexibility in the face of adversity which allowed them to remain remarkably well adjusted (Ayuku et al, 2004; Luna 1991). Orphaned, poor, homeless and working children can also thus be seen as agents of their own development who are trying to cope the best they can with the difficult



Child Soldier in Darfur. Outpost Magazine. Photo: Marie Frechon

circumstances in which they find themselves. Children should therefore not be seen solely as passive victims, but also as active participants in their families and communities who have a voice and are deserving of respect.

CHILD SOLDIERS

Issues of poverty, street children and child labor are intertwined with the problem of minors being associated with armed forces or armed groups. Not only do poverty, homelessness, forced child labor and, of course, the presence of war and conflict constitute risk factors for recruitment of child soldiers, these issues also represent challenges in the rehabilitation and reintegration of former child soldiers back into civilian life.

Child soldiering is considered convenient and cheap (Wessels, 2006). Children – boys and girls alike – are perceived as highly obedient and easily manipulated (Denov, 2010; Wessels, 2006). According to the Coalition to Stop the Use of Child Soldiers (CSUCS), this may partially explain why the use of child soldiers is widespread in countries and regions affected by war (CSUCS, 2008). Acknowledging the difficulty in getting accurate figures, the CSUCS (now called Child Soldiers International) estimated in its 2004 report that 250,000 children were part of fighting forces in both state and non-state armed groups (CSUCS, 2004). Since then, between 2004 and 2007, while the Coalition reported a decrease in the number of child soldiers following peace agreements and demobilization programs in different countries, armed groups in 24 countries are known to have recruited children under 18 years old (CSUCS, 2008).

Terminology and definitions

The commonly used term of *child soldier* is contested in scholarship and considered problematic in many aspects (Denov, 2010; Wessells, 2006; McKay et al, 2010). Like any other label, *child soldier* is applied to a wide range of children and youth with highly diverse experiences. As highlighted by some authors (Denov, 2010; Wessells, 2006), the notion of “soldier” carries some archetypal image of well-trained combatants embodied mostly by a male figure in uniform. Yet this imagery obscures the multiplicity of the roles and tasks they undertake. Child soldiers are not only active combatants carrying guns, they also spy, cook, guard, porter, messenger or are forced into sexual slavery.

In an attempt to acknowledge the varied tasks of child soldiers, the term *children associated with armed forces or armed groups* has been introduced, and has been defined in the UN Paris Principle (2007) as: “Any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities.” (United Nations, 2007, p7)

However, this definition is still problematic. The notion of “childhood” itself is a highly contested concept. As a social construct mainly based on Western views and on biological age, the concept of children as being under the age of 18 years may disregard the varying meanings of childhood across cultures. Finally, while the majority of child soldiers are adolescents, a large number of children younger than ten years are associated with armed groups (Machel, 2001).

Experiences of child soldiers

Child soldiers may become involved with armed groups through forced or unforced recruitment (Denov, 2010; Wessells, 2006). Means of *recruitment* are diverse, and while violent abduction and forced recruitment are pervasive in many conflicts, the line between forced and unforced involvement is often unclear and the notion of *voluntary* child recruits should be considered carefully (Wessells, 2006). Based on testimonies, studies have shown that when not forcibly abducted, boys’ and girls’ decision to join armed groups are often made in contexts of deprivation, hardship and maltreatment. Many reasons may drive girls and boys to join armed groups (Wessells, 2006; Denov, 2010; Brett & Specht, 2004):

- Poverty and the opportunity to obtain food and shelter
- Lack of socio-economic opportunities
- To seek protection
- To flee abuses from their family of origin
- For religious or political beliefs
- To gain a sense of family or peer group
- To avenge the deaths of parents, other family members or friends
- Soldiering may also be attractive for the uniform or prestige.

Therefore, over-simplifying the dichotomy between forced and non-forced recruitment methods can be problematic as it is often difficult to distinguish between unwilling victim and willing perpetrators of violence.



Click on the picture to access “Psychosocial Adjustment and Social Reintegration of Children Associated with Armed Groups: The State of The Field and Future Directions” (Betancourt et al, 2008).

Recent studies have gone beyond narratives of victimization to explore how, despite extreme violence and controlling environments, children do deploy some forms of agency and resistance strategies (Denov, 2010; Denov & Maclure, 2007; Wessells, 2006). Testimonies from former child soldiers, boys and girls alike, illustrate how experiences in armed groups are marked by an oscillation between victimhood and resistance, or active participation in violence (Denov, 2010): "... children's experiences reveal that they *continually drifted between committing acts of violence and simultaneously being victims of violence by others.*" (Denov, 2010, p129). The process of militarization of boys and girls includes powerful indoctrination, harsh training, and the use of threats and violence to promote terror and compliance (Denov & Maclure, 2007). Adjustments to a militarized and highly violent environment entail shifts in behaviour, relationships, self-perception and sense of identity (Veale & Stavrou, 2007; Denov & Maclure, 2007; Wessel, 2007). Sometimes, obedience may become an imperative to survival (Denov, 2010). These factors will have important consequences in the process of reintegration into civilian life.

According to the Child Soldiers Initiative, an estimated 40% of child soldiers are girls and they take on roles as varied as boys (Child Soldiers Initiative, 2010). However, evidence shows that girls, because of their gender, will experience armed conflict differently than boys (McKay & Mazurana, 2004). One dimension of their gendered experiences is the pervasive sexual violence perpetrated against girls. Testimonies from former girl soldiers in Northern Uganda, Sierra Leone and Mozambique reported extensive sexual violence, including rape and gang rape (McKay & Mazurana, 2004; Coulter, 2009). Girls also reported being forced into sexual slavery by being ordered to *marry* males within the armed group and become their sexual property, also known as being *bush wives* (Coulter, 2009; Denov, 2010). This would allow protection from random sexual assaults from other male combatants, while being obligated to be constantly sexually available for their "husbands" (Coulter, 2009). Forced marriage to powerful commandants can be a survival strategy, and as such, both a source of protection and violence. In addition to the psychological and social consequences, sexual violence also exposes girls to sexually transmitted infections, most notably HIV/AIDS, unwanted pregnancy, and severe injuries resulting from violent sexual assault (ACQUIRE Project, 2005). Girls' brutal experiences of violence are thus important to acknowledge. In contrast, in some conflict settings there are strong prohibitions against the sexual victimization of girl soldiers and girls report feeling protected (Kearns, 2002). Girls' victimization is only one facet of their lived realities and much of the recent literature has sought to challenge the unidimensional portrayals of girl soldiers as victims (Coulter, 2009; McKay et al, 2010; Denov, 2010; Veale & Stavrou, 2007). While often carrying out female roles and domestic work, such as cooking and sexual service, girls' roles also include military duties and participation in combat activities (Denov, 2010).

The aftermath: psychosocial consequences

In the aftermath of participation in armed violence, whether the conflict has ended or not, former child soldiers face critical transitions as they attempt to reintegrate into civilian life (Denov, 2010). The term *reintegration* is contested, as it tends to assume that former child soldiers return to their family or community



Click on the picture to access the Child Soldier Treatment Centre database: organizations and centres that specialize in the treatment, rehabilitation, education and rehabilitation of former child soldiers, abductees or child victims of war, sorted by country.

of origin and to their normal and previous lives'; however, this is rarely the case. Moreover, former child soldiers may have been affected by war in very different ways and thus may not require similar support. Some may be disabled, orphaned or injured; some girls may be mothers or widows, or none of the above. They may have been forced to commit atrocities – killing and raping – or may have carried out domestic work. Some have been violently abducted, sometimes to the extent of being forced to kill family members. This diversity needs to be acknowledged in the understanding of their post-war lives (Wessells, 2006).

Given the profound psychosocial implications of exposure to violence, the mental health and well-being of former child soldiers is key in the process of reintegration to civilian life (Wessel, 2006). Acute war experiences and exposure to extreme violence will affect former girl and boy soldiers in many ways, both physically, such as through injuries, disabilities and infectious diseases, and psychologically. A handful of studies examining mental health outcomes have reported symptoms of post-traumatic stress disorder (PTSD), anxiety and depression among former child soldiers (Derluyn et al, 2004; Betancourt et al, 2008). Among former child soldiers studied in northern Uganda, 97% reported symptoms of PTSD (Derluyn et al, 2004). Importantly, it is not only girl soldiers who report sexual violence. Male soldiers also report sexual violence and being forced into sexual servitude, which is associated with higher rates of symptoms of depression and PTSD, social dysfunction and suicidal ideation compared to their combatant peers who did not experience sexual violence (Johnson et al, 2008).

However, as pointed out by some scholars, the scarce literature on mental health outcomes of former child soldiers almost exclusively focuses on the signs and symptoms of PTSD. This trauma-focused Western medical approach has been criticized for its emphasis on pathology and deficits (Wessells, 2006; Betancourt et al, 2008; 2010; Klasen et al, 2010). Furthermore, PTSD may represent only a fraction of the wide range of psychosocial implications of wartime violence (Betancourt et al, 2010; Wessells, 2006). Using a resilience frame, a few studies have explored the positive adaptation, psychosocial adjustment and adaptive capacities of former child soldiers (Klasen et al, 2010; Wessells, 2006). Girls – as much as boys – are not only victims of war trauma, they adjust to their new life and employ creative coping strategies in the face of their many struggles (Betancourt et al, 2010; Klasen et al, 2010; Denov, 2010).

Disarmament, demobilization, reintegration and rehabilitation

Post-demobilization experiences are inevitably shaped and constrained by many other factors apart from war-time experiences, including gender, ethnicity, socio-economic status, ability, position within the community and access to social support. Poverty, displacement and loss of home following demobilization have profound psychosocial implications (Wessells, 2006). What stands out in recent studies regarding reintegration and rehabilitation of former child soldiers is that exposure to violence only represents part of the picture (Wessells, 2006), and does not exclusively account for mental health problems or well-being (Betancourt et al, 2008; 2010; Kohrt et al, 2008; Klasen, 2010). Post-conflict factors may have positive or adverse effects on the mental well-being of former child soldiers who



Mental health and psychosocial support in humanitarian emergencies

The target group for WHO work on mental health and psychosocial support in emergencies is any population exposed to extreme stressors, such as refugees, internally displaced persons, disaster survivors and terrorism, war- or genocide-exposed populations. Click here to access key documents related to this field.

face diverse challenges, including social stigma and limited access to education, health care, sustainable livelihoods and economic opportunities (Worthen et al, 2010; McKay et al, 2010; Wessells, 2006; Denov, 2010).

Social stigmatization and the discrimination experienced by former child soldiers have been identified as key post-conflict factors contributing to adverse mental health outcomes (Betancourt et al, 2008; 2010; Klasen et al, 2010). In this regard, girls face particular and unique challenges affecting their post-conflict lives. In addition to the physical and emotional scars resulting from sexual violence, many former girl soldiers face greater risk of stigma following reintegration because they are viewed as sexually impure or even unfit for marriage, which can have important psychosocial consequences (Betancourt et al, 2008; McKay et al, 2010; McKay & Mazurana, 2004). On the other hand, community and family acceptance and support have been identified as critical factors for successful reintegration and enhanced psychosocial adjustment (Betancourt et al, 2010). Access to education and socioeconomic opportunities are also important positive post-conflict factors.

The transition to civilian life – meaning abrupt shifts in relationships, behavioural patterns, and expectations – entails a reshaping of identities, from *militarized* identities to civilian life (Veale & Stravou, 2007; Denov, 2010). In fact, identity transformation and negotiation constitute a core challenge in the reintegration process (Veale & Stravou, 2007, p286). The process of *making* child soldiers – through abduction, harsh training and indoctrination – means that complex identity negotiations are required to *unmake* child soldiers upon demobilization (Denov, 2010; Denov & Maclure, 2007).

Disarmament, demobilization, reintegration and rehabilitation (DDRR) is used to describe the process by which child soldiers are returned to civilian life. This process is also used for adult combatants, but child-specific programs are common and take different forms in different regions. As previously discussed, disarmament is not always necessary because children fulfill many non-combatant roles within armed groups. Despite being in widespread use, there is little data on the success of DDRR programs. One study in Sierra Leone (Williamson, 2006) identified nine areas of intervention contributing to successful family and community reintegration:

- Community sensitization to the returning children
- Formal disarmament and demobilization
- A period of transition in an “interim care center”
- Family tracing and mediation
- Family reunification
- Traditional cleansing and healing ceremonies and religious support
- School or skills training
- Access to health care for those in school or training, and
- Individual supportive counseling.

One study in Mozambique that followed former child soldiers for 16 years showed that long term reintegration and self-sufficiency was facilitated by community acceptance and forgiveness, traditional cleansing and healing rituals, livelihoods and apprenticeships (Boothby et al, 2006).



Click on the picture to access “Humantrafficking.org” a web resource for combating human trafficking (multiple countries). Contains resources useful for children who are trafficked for labor or sexual purposes

Interim or transitory care centers are typically the first places where demobilized children stay after returning from the armed groups with which they were affiliated. In one such center, the Goma Transitory Care Centre in eastern Democratic Republic of the Congo, 250 children are grouped into *families* of around 30 children, each with its own dormitory and staff counselors (Humphreys, 2009). The children in each family group come from mixed ethnic backgrounds and armed groups. In addition to limited individual counseling for children with specific issues, the family groups are designed so that the children can listen to and support each other. The children spend three months at the center before being reintegrated into the community.

Conclusion

In summary, within the context of reintegration, former child soldiers face many other challenges in addition to coping with the scars of war experiences. Indeed, access to education and employment, financial security, community acceptance and many other factors related with their post-conflict life conditions have psychosocial implications. An understanding of the impact of multiple war-related and post-conflict factors is important for identifying appropriate intervention targets. (Betancourt et al, 2010).

THE MENTAL HEALTH OF WAR-AFFECTED CHILDREN

This section will limit itself to the effects of war on children who have needed to leave their home countries because of war and have migrated to a new host country. Practical approaches to assessment and treatment planning will be outlined to address these children's mental health needs.

Research suggests that war trauma can affect children's mental health. The effects of this trauma are complex, given that experiences of war entail exposure to multiple stressors including violence, displacement, family separation, loss and bereavement, disruption of education and the breaking of social ties.

Exposure to violence has been linked with psychological difficulties in children ranging from sleep difficulties and anxiety to post traumatic stress disorder (PTSD) (Fazel et al, 2011; Hjern et al, 1991, Rothe et al, 2002). It appears that the severity and quantity of violence exposure is important: children with multiple exposures to violence over longer periods of time continue to exhibit mental health difficulties up to nine years after seeking asylum. In contrast, children who have experienced fewer adverse events tend to become asymptomatic more rapidly (Montgomery, 2010). The exposure of parents to violence also affects children's well-being. Studies have demonstrated that children's mental health is negatively impacted if their parents have been tortured (Almqvist & Brandell-Forsberg, 1997; Cohn et al, 1985; Daud et al, 2008; Fazel et al, 2011). One study has also noted that a child's knowledge of a parent being detained is associated with the development of PTSD (Montgomery and Foldspang, 2006).

Children of war are sometimes separated from their families and forced to flee alone. Separation from family, itself, was associated with PTSD in one study (Geltman et al, 2005). Being unaccompanied when seeking asylum puts young people at greater risk of mental health problems (Hjern et al, 1998). Children whose



Hunger

Käthe Kollwitz (1867-1945)

(permanent loan by Gudrun & Martin Fritsch to the Käthe Kollwitz Museum, Berlin)

families are continuing to undergo adversity (for example, if a parent is detained or still in a war-torn country) tend to have worse psychological functioning. On the other hand, children's mental health appears to be protected when their families remain cohesive and supportive (Fazel et al, 2011; Rousseau et al, 2004). Positive school and peer experiences are also correlated with wellbeing in refugee children (Fazel et al, 2011; Geltman et al, 2005, Sujoldzic et al, 2006).

Experiences of migration

Families who have experienced organized violence prior to migration can sometimes face difficulties in their welcoming countries including violence (Jaycox et al, 2002), racism (Gunew, 2003), poverty (Beiser, 2002), and uncertain immigration status. Ongoing experiences of discrimination (Hassan & Rousseau, 2008; Rousseau et al, 2009), and barriers to securing care will influence children's psychological well-being as well as the trust and collaboration that can be fostered within the care-provider relationship. One study of Somali adolescents who had

fled to the US demonstrated that depression and PTSD were associated with the youth's experiences of discrimination in the host country (Ellis et al, 2008).

It is important for clinicians to keep in mind that families fleeing war are also often met with many barriers when trying to seek asylum. This too has an impact on children's psychological well-being. In fact, some longitudinal studies suggest that post-migratory stressors are a stronger predictor of depression in refugee children than are past conflict-related events (Sack et al, 1993). One such stressor is immigration detention. Many industrialized countries have policies of detaining children and families who are seeking asylum. For children fleeing war, detention is potentially re-traumatizing and correlates with high rates of psychiatric difficulties.

Migrating families are in a period of adaptation that is sometimes very stressful. The process of understanding difficulties and proposing solutions are tasks that need to be worked together with families, taking into account a family's strengths, their readiness and ability to cope with difficulties, their understandings of the causes of their difficulties and their feelings about solutions proposed to address them.

Resilience

On the path to rebuilding a life there is a new balance to be made between maintaining some continuity with the past and adopting new coping strategies to deal with the unknown. In general, research suggests that the process of acculturation in asylum seeking children is complex, and that no one path is more protective or harmful for all children (Fazel et al, 2011). Spirituality plays a central role for many families (Boehnlein, 2007), either in the form of personal prayer or the support derived from attending religious rituals and celebrations. These ethno-religious social networks may also give children a sense of belonging. However, they may also act as a traumatic reminder when religion was associated with trauma. Artistic activities, sports, work, and study, if they establish continuity with meaningful aspects of the life of a child before the experience of migration and traumatic disruption, are important strengths. The same activities may also be new to a child and, when given the appropriate support to learn these new roles, they can represent positive dimensions of their adaptation.

It is important to acknowledge that all outcomes of war do not solely lead to loss and disability. Traumatic events can promote creative coping skills, and be transformed into a source of strength and resilience (Rousseau et al, 1999).

Dealing with the consequences of war: the assessment and treatment of war-affected children

Intervention for children affected by war as well as other humanitarian disasters has been considered along an intervention pyramid, where the base of the pyramid represents advocating for basic services to ensure safety. The next layer of the pyramid involves strengthening community and family supports, followed by more focused non-specialized person to person supports. Specialized mental health services form the top of the pyramid. It has been advocated that all of these interventions are ideally implemented concurrently. A practical guide to addressing the provision of psychosocial and humanitarian support in humanitarian crises is

available in a number of languages from the Interagency Standing Committee (IASC, 2010)

Assessment

Accessing care: primary care, prevention and interpretation

A number of practical points can help support the assessment and treatment of children who are experiencing mental health difficulties as a result of war, as well as their families. Efforts to support schools, primary care workers and community workers to help address the needs of these children and their families are important, as these children's difficulties frequently present first to these persons. Children and families have been offered help in community settings such as schools (Kataoka et al, 2003; Ngo et al, 2008; Hodes 2008; Duncan & Kang, 1985) and primary care clinics, where front-line professionals are supported by mental health teams. This support at the front line level can also facilitate access to more specialized care when needed.

School and community-based prevention programs can also play a key role in promoting the mental health of children from migrant and ethno-cultural communities. Classroom-based activities can support children in assimilating past and present experiences by presenting these as learning opportunities, facilitating emotional expression with respect to their experiences and promoting the development of positive relationships within the classroom and society (Green et al 2005). Some prevention programs use specific treatment modalities such as artistic expression to support the transformation of past and present adversity through creativity and metaphorical representations and by fostering the development of solidarity among children (Rousseau & Guzder, 2008). Successful support of families and children at the community level also marks the beginning of a process of alliance building and service provision that supports the biopsychosocial needs of children who have experienced war and their families.

Finally, families who speak a language other than the dominant language of the health care system should be offered interpreters to help support the assessment and treatment process. Interpreters facilitate the clinical encounter by providing translation and, in some cases, may support assessment and treatment by acting as cultural brokers and co-diagnosticians to help understand, reframe or transmit cultural knowledge (Hsieh, 2007; Rousseau et al, 2011)

Self-reflexivity in the clinician

Exploring cultural references in clinical encounters requires a clinical openness to acknowledging the clinician's own identity, a capacity to reflect on how others see oneself, and an openness to perceiving oneself as a tool in the therapeutic work (Kirmayer et al, 2003). This will facilitate the assessment and will help the clinician to explore such areas as explanatory models of illness and approaches to healing. Familiarity with ways of addressing cultural elements in mental health practice, such as the cultural formulation of the DSM-IV and work providing guidance about how to adapt the cultural formulation to child mental health care practice (see for example Ecklund & Johnson, 2007; Measham et al, 2010) can help support an assessment that is attuned to cultural issues.



Child mental health rating scales in war-affected and traumatized children

Click on the picture to access several rating scales (the Children's Revised Impact of Event Scale, CRIES; Depression Self-Rating Scale for Children, DRSRS; Post-traumatic Cognitions Inventory, cPTCI, the Self-Report for Childhood Anxiety Related Disorders, SCARED and others) (Children & War Foundation)

The assessment process

The assessment of children and families who have experienced war includes an exploration of several important themes:

- The family's experiences in their home and host country
- The child's symptoms
- Symptoms experienced by other family members
- Familial and individual strengths
- Resources and previous help-seeking trajectories; and
- A negotiation of the complex reconstruction of the family and its social network.

Attention to the therapeutic alliance is of great importance when addressing the consequences of war on children. Families and children are often meeting with unfamiliar persons and are guarded about who to trust and how much to trust. In addition, some family members may remain in situations of peril, so that confidentiality of the therapeutic space is of paramount importance.

While it is important to explore children's and families' experiences of war trauma, the timing of these inquiries, the ways in which this information is solicited and cultural values around disclosure need to be understood. Soliciting disclosure in a Western way with respect to events that are culturally taboo can be harmful, and addressing disclosure with children needs to take into account their development and the effect of disclosure on parent-child relationships and trauma transmission. Cultural brokers can help to understand what is at stake around understanding traumatic experiences. In the case of children, approaching disclosure in a modulated way, including an acknowledgment of the role of parents as gatekeepers who can help their children understand their experiences is helpful. Indirect methods to assess trauma through art, play, and metaphor may also reveal important information for assessment, while not being experienced as overly intrusive by family members (Measham & Rousseau, 2010).

When family survival is at stake, attention needs to be paid to the family's pressing needs such as asylum, housing, security and education. Similarly, in a refugee child mental health assessment, a systemic appraisal of the family's pathway to survival is needed. Therapeutic efforts directed at interrupting further traumatic losses and the negative chain of consequences that can ensue from these are important (Miller & Rasmussen, 2010). Symptoms and the meaning of diagnoses also need to be addressed. It is important to note that diagnoses can have important ramifications outside the therapeutic space. In particular, a diagnosis that does not recognize the post-traumatic aspects of symptoms can inadvertently be unsupportive to people whose refugee status is in question as the PTSD diagnosis is well accepted in legal circles, where it is often seen to lend credibility to a traumatic story, and its absence is – falsely – considered proof that the person alleging trauma is lying (Stein et al, 2007)). On the other hand, the victim identity associated with the PTSD label, while encouraging empathic responses, may also unduly medicalize problems and disempower the family and social network. Seeing psychiatrists and receiving diagnoses may also be stigmatizing, and the effects of receiving a diagnosis on children needs to be addressed.



Click on the picture to access "Working with Distressed Children Toolkit". Includes information on identifying and communicating with distressed children and psycho-social intervention and cultural considerations (Action for the Rights of Children, Working with Children, Revision version 01/01)



Refugee camp in Kenya, home to Somalis fleeing famine and conflict

Finally, the importance of identifying individual and family strengths and of reinterpreting family roles in the context of post traumatic adaptation will help in the building of treatment plans. For example, children's *parentification* toward the nuclear or extended family is often negatively perceived as a burden, while this role may also be reassuring during the period of post-traumatic reconstruction. Although parentified children may be suffering, their sense of having a purpose and a mission is often simultaneously protective.

Treatment

Symptom reduction and reconstruction of the social world

Treatment involves a reconstruction of the personal, family and sociocultural worlds with the aim of restoring a sense of normality for a child by allowing life to go on (social integration) and overcoming the paralysis that terror and grief can cause (symptom reduction). Gain in terms of reduction of impairment and improvement in functioning need to be considered, and it is important to note that their relation to symptom relief is not linear (Pynoos et al, 2009). The main implication of this for treatment is that it is just as important to restore the continuity of life by facilitating a child and family's social integration into the host country as it is to reduce symptoms.

From precarious status to stability

Clinicians may feel uneasy when asked to help asylum claimants with their immigration papers. The support provided by a clinician to asylum-claiming families through a letter supporting their immigration application is an explicit testimony that the clinician acknowledges the authenticity of the family's refugee experience (Rousseau & Foxen, 2005). When such testimony enables asylum seeking families to obtain secure immigration status, this relieves considerable psychic suffering and symptomatology given that a precarious immigration status

is associated with poor mental health (Bean et al, 2007; Bodegard. 2005; Nielsen et al, 2008). Moreover, this support, even if families do not gain secure immigration status with the clinicians efforts, can partially counteract the destructive impact of a rejection of the asylum claim, which can be profoundly re-traumatizing.

Meeting basic needs

Solving everyday problems plays a key role in achieving a certain normality that allows the establishment of routine. Most refugee families will request some type of practical help from community organizations, primary social and health care services, or even from schools, in resolving settlement problems. Sometimes, reestablishing contact with families from the same homeland through community organizations may facilitate the development of a social network. However, many communities torn by organized violence are fragmented and remain in conflict even when the community is in exile. Thus, the clinician needs to understand which social contacts can provide a social shield, and which can result in further stressors.

Psychotherapeutic modalities: therapy, medication and traditional healing

Trauma-related anxiety disorders (mainly studied with respect to PTSD), and depression, stemming from multiple losses in an exile setting, can be treated through various forms of psychotherapy. Short-term therapy, either cognitive behavioral therapy (CBT) or narrative exposure therapy, have been promoted for refugee children and adolescents not because they provide a complete resolution of trauma-related suffering, but because they are helpful in alleviating symptoms and can realistically be implemented in settings including schools (Ehnholt & Yule 2006; Kataoka et al, 2003; Ngo et al, 2008).

While psychopharmacology is an option for these children, we recommend caution given that there is little to no evidence of efficacy for refugee children and adolescents, so that evidence for efficacy is extrapolated from studies with non-refugee children with similar diagnoses. Therapies that integrate traditional elements show promise in the medical literature. Creative arts based therapies, such as art therapy, are sometimes preferred by refugee families, in part because these therapies often emphasize nonverbal therapeutic methods, thus helping persons who are reluctant to engage in verbal therapy. This may reflect either cultural attitudes or the fact that verbal approaches may be seen as being disrespectful of certain avoidance strategies. While Western treatment methods may favor a more direct working-through of trauma by focusing therapeutic work *on* trauma, other cultural traditions may prefer to work *around* trauma (Rousseau et al, 2005). Finally, the unilateral imposition of either Western expertise or culturally sensitive modalities may be experienced as coercive if the family's or child's choice of opting in or out of their own culture at a particular time is not taken into account.

Drawing up an inventory of available resources in a particular community is essential for a realistic treatment plan. In many settings, specialized psychotherapy may not be widely available, but committed community workers and primary care professionals may provide excellent therapeutic support and a forum for empathic listening that may begin to give relief to children and their families.

Conclusion

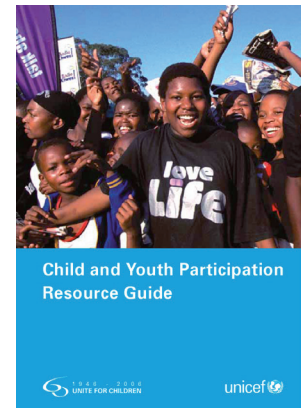
Addressing the consequences of war on refugee children whose families

have experienced pre-migratory trauma requires a combination of cultural knowledge and trauma therapy methods that encompass not only individually focused psychotherapies and traditional therapeutic approaches, but also systemic interventions addressing the consequences of organized violence on the family's social relationships. Primary care institutions, including clinics, schools and community organizations, because they are very close to the family's living environment, may be particularly helpful in establishing a support network around a refugee child and his or her family. They may however experience more difficulties in providing specialized therapy. Efforts to strengthen preventive and community-based supportive approaches to address the consequences of war on children, while ensuring access to specialized mental health services as needed, will help to address the multiple needs and strengths of refugee children and to provide the right kind of support at the right place and the right time.

CONCLUSIONS

Child mental health services need to address the adversity stemming from social and environmental stressors. Although different forms of treatment may help to alleviate symptoms and support the resiliency of a child and family, an acknowledgment of the collective nature of social suffering and a validation of a child and family's experience may be key. Mental health professionals in all countries can play an important role through intersectorial forms of intervention that help buffer this stress and even in some cases prevent it. Respecting the Convention on the Rights of the Child (see Chapter J.7) is a long term goal. In high income countries this could entail recognizing equal rights to health and education for non-citizen children and other vulnerable children. In low and middle income ones it could be linked to the implementation of protective measures to decrease children's exposure to multiple adversities and improve their health and well-being.

Although these social changes are beyond the mental health professional's mandate, health professionals can have a critical role in advocating for the social changes that can improve the mental health and well-being of children.



Click on the picture to access the UNICEF's "Child and Youth Participation Resource Guide". This guide has resources on child and youth participation from Asia, Europe, North America, Latin America, Africa, Australia and the Pacific. Most of the materials are available in electronic form. The main audiences for this resource guide are practitioners and managers involved in promoting child and youth participation in government, community-based organizations, child-led organizations, NGOs, UN and donor agencies (UNICEF, 2006c).

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