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Alleviating the Effects of War and Displacement on Children[1]

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The mental health of children is severely compromised by war and consequent displacement. Nations have a duty under various UN agreements to alleviate the effects of war on children's mental health. This paper argues that fostering mental health in communities starts with re-establishing safety, basic health needs, education and re-creation. School and other community leaders need education in recognising stress reactions and in providing basic first aid. Large-scale programmes need to be developed and validated for delivery following wars and disasters. One such validated programme is described. Small group and individual work is also needed. As long as wars and disasters happen, so the international mental health community needs to prepare positively to meet the predictable, but usually unexpected, needs.

KEY WORDS: War, Displaced children, Refugee children, Traumatic events, Traumatization, UNICEF, Large scale intervention

The relative optimism for world peace that ushered in the new millennium was rudely shattered by the international terrorist attacks in New York and Washington on September 11, 2001. With over 3,000 people killed in the World Trade Centre alone, there were thousands more children who were left without one of their parents. Whatever financial compensation may be made to these families, the children will be brought up in reduced emotional circumstances.

The effects of traumatic events on children are even greater when that trauma is modern warfare. Since the end of World War II in 1945, it has been estimated that there have been more than 127 other wars with between 21.8 million and 40 million deaths. In addition to this slaughter, such conflicts have resulted in many refugees and displaced people worldwide. Since the ending of the “cold war” between the superpowers, the world is now realising that there are many local wars that give rise to real misery. The rise in nationalism and the civil wars associated with tribalism throughout the world are characterised by vicious targeting of the civilian population.

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UNICEF recently estimated that over 80% of the victims of today's warfare are women and children. Civilian populations are deliberately targeted; "ethnic cleansing" and massacres are almost commonplace; populations are held hostage and under siege; even international economic sanctions are used as weapons in the struggles.

It is not simply that children may be killed or wounded in the conflicts but there is also concern about safety of family members and often fear about abductions of young adults and children, displacement of populations both internally and across borders, social breakdown, lack of basic services such as health and education and lack of meeting basic needs. These in turn lead to the psycho-social consequences of the complex emergencies which include social and personal, individual effects such as anger, violence, depression, anxiety, early and unprotected sexual activity, teenage pregnancy, alcoholism, promiscuity, prostitution, drug abuse, family breakdown and so on.

Whether it be in Vietnam, Cambodia, Rwanda or Bosnia, modern wars result in many families with young children fleeing for safety. "Ethnic cleansing" in Yugoslavia deliberately caused hundreds of thousands of people to leave the places they grew up in and try to get refuge elsewhere. Simply to escape the fighting and risk of reprisal, people uproot and seek safety in other countries. The result is that it has been estimated that there are over 19 million people who are refugees (within the formal meaning of the term as defined by the 1951 UN Convention) with a further 27 million people living in refugee-like situations and 25 million being internally displaced but not having crossed any international border (Rutter, 1994; Machel, 1996). At least half of all refugees and displaced people are children.

Children may be exposed to many frightening and life threatening experiences when they are fleeing from their homes under threat, witnessing fighting and destruction, seeing violent acts directed at their loved ones, leaving their friends and possessions behind, marching or being transported in crowded vehicles, spending months in transit camps and eventually finding temporary respite in a country at peace while the authorities decide whether the family can be granted permission to remain legally and indefinitely. Children are sometimes separated from their parents and arrive "unaccompanied" in foreign lands. Even if they remain with their parents, parents may not be able to provide adequate care and psychological support due to their own trauma.

Children are sometimes willing or unwilling combatants. As such, they may be forced to or may participate in committing atrocities such as murder. In Uganda, abducted children were often forced to murder their colleagues who tried to escape or were too weak to travel. They did this by battering the victim until he/she died. Some were forced to participate in murdering close relatives or neighbours so that they would fear to return home. Thus they were effectively ostracised from the community and became bound to the rebels. Some of the girls were married off and/or raped and produced children with the rebels. These children are now referred to as the "fatherless ones".

It is obvious that the best way to protect children from the dreadful effects of war is to avoid armed conflict altogether. In an ideal world, peaceful resolution of conflicts would be the norm. But the world is far from ideal. There are many deep-seated conflicts in well-known hot-spots around the world. Most of these are in countries torn and impoverished by war, crippled by debt repayments and where the resources available for basic health care and education may be woefully inadequate. It is against this background that one asks how best humanitarian aid can be delivered to have the maximum benefit for children and families.

This paper addresses these questions within the framework of what has been agreed internationally as the basic minimum rights of children, and drawing on the experience of many colleagues in delivering help to war affected children. Gradually, the many programmes initiated by United Nations Organizations and Non-Government Organizations (NGOs) are being more stringently evaluated and so there is some empirical evidence to draw upon.

The UN Convention on the Rights of the Child

As noted earlier, war results in many families being displaced. Only if they cross an international border do they get formal recognition as "refugees". It matters little to a child whether the place of relative safety is within their country or outside it, especially if they have lost contact with their families.

In addition to the protection that should be afforded by agreement made with the UN High Commission for Refugees and the UN Human Rights Commission, the needs of women and children are the responsibility of the United Nations Fund for Children (UNICEF).

The United Nations *Convention on the Rights of the Child* has been endorsed by all but two countries in the world – Somalia and the United States of America. In relation to children and war, some of the most relevant articles are:

- Article 9 - the right not to be separated from the parents
- Article 11 - measures to be taken to combat the illicit transfer and non return of children abroad
- Article 19 – right to the protection of the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment
- Article 24 - right of access to health care
- Article 28 - right to education
- Article 33 – right to protection from the illicit use of narcotic drugs and psychotropic substances
- Article 34 - protection from sexual exploitation and sexual abuse
- Article 35 – right to the prevention of abduction, sale and trafficking in children
- Article 38 - to respect rules of international humanitarian law applicable to states in armed conflicts which are relevant to the child. This article also refers to ensuring that persons who have not attained the age of fifteen years do not take direct part in hostilities. The same article also states that "States parties shall take all feasible measures to ensure protection and care of

children affected by armed conflict".

- Article 39 in full states that "States parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse: torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflict. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child".

In 1987, the Convention on the Rights of the Child established psycho-social care as a right of every child and a duty of providers of assistance to children in situations of abuse, exploitation and conflict. "The 1996 report of the UN Secretary General on the Impact of Armed Conflict on Children (The Machel Report) firmly concluded that psychological recovery and social reintegration must be a central feature of all humanitarian assistance programmes. The report, based in large part on the conclusions of regional consultations in Africa, Asia, Latin America and Europe, further states that programmes aimed at relieving psychological suffering must take into account the social and cultural context of the children and their families" (Report of Programme Workshop in the Area of Psychosocial Care and Protection, Nyeri, Kenya: 2-6 September 1998: UNICEF).

It is important to note that children's rights remain no matter how far they fail to be met as a result of war decimating the physical and social infrastructure of their communities. Even during conflict, efforts should be made to ensure basic health care and education. As soon as fighting ceases, it is as important to re-establish health care delivery and education as it is to embark on prestigious rebuilding of government buildings or palaces.

It should also be noted that the United Nations – the most international body of all – mandates member states to "take all feasible measures to ensure protection and care of children affected by armed conflict" (Article 38) as well as "to promote physical and psychological recovery and social reintegration of child victims…" (Article 39). The implication of this is that all agencies seeking to help children in the aftermath of war have to promote good mental health for all children by re-establishing a full range of activities and opportunities for development, recreation, education and, where necessary, specialist therapeutic interventions.

Hierarchy of Services

The ISTSS/UN text (2002 under preparation) on responding to trauma fully recognises that in responding to large-scale natural disasters or to populations affected by war, there is a need for rebuilding the full infrastructure of child support services at every level within a community. Meeting the needs of traumatised children is not synonymous with providing high quality individual therapy for them. Given the numbers involved, that is unrealistic a well as being undesirable. Not all children are so severely traumatised that they will require individual help. Rather, a range of co-ordinated interventions should be made available across a number of different agencies.

Within the field of traumatology, it is understandable that professionals who have provided direct and indirect help to war affected children should write about their experiences from a traumatology perspective. As better ways of identifying severe stress reactions such as PTSD have become available, it was possible to demonstrate that a high proportion of exposed children did develop serious mental health problems that required help. In the enthusiasm to get across the two messages – (1) that many children needed specialist help and (2) ways were being found to deliver such help –- people seemed to overlook all the other community interventions that were undertaken – or should have been.

The ISTSS/UN text spells out the many faceted interventions at the different societal/community levels that should be considered. Let us briefly consider some of these for school aged children.

All children have the right to attend school. When a town or village has been laid waste, there may not be suitable buildings left to provide high quality schooling, but children can still be educated in small groups by such teachers as remain in the community and by older teenagers and other adults willing to act as teachers. UNICEF/UNESCO provides advice on education and has developed simplified teaching materials – "the school in a box" – that can be used whatever the physical surroundings.

From the children's point of view, stability in their lives can begin to be reintroduced by attending schooling regularly and thereby having some structure to their daily life. But schooling is not enough. Children also need leisure facilities. Again, one is not suggesting that expensive sports stadia should be built. Rather, some effort should be made by the community and relevant NGOs to ensure safe play areas – in other words one free of mines and other unexploded ordnance – together with rudimentary equipment for playing team games. The more children can be involved in healthy pursuits such as sport, playing music, involvement in other community groups, and so on, the more they will be able to cope with the aftermath of the war.

Of course, the adults who supervise these activities will need some basic help in responding to the new mental health needs of the children. For instance, in Bosnia teachers were unprepared for the acting out, rebellious behaviour of children who survived months of shelling. Previously, schools had been well disciplined places and the teachers had had little need to impose additional discipline from without. Nor had they experienced children reacting emotionally – crying in class when they remembered a dead parent, ducking under the desk when a plane flew low overhead. Whilst they recognised that some of this behaviour was related to the stresses the children had been under, they were unused to taking responsibility within the classroom for dealing with it. Previously, children with mental health problems would have been referred on to specialists located often many miles away. A whole new way of responding had to be developed.

However inadequate the buildings and however inexperienced the people appointed to act as teachers, schools are the main community institution where most if not all children can be reached. Hence, there is a need for appropriate training of the

teachers to recognise signs of distress in the children and to be able to provide first aid as well as to know when and to whom to refer children on for more experienced help.

Given that older children and teenagers may attend youth groups – run by religious organizations or NGOs – then there are natural opportunities for them to share worries and concerns with adults whom they come to trust. Again, the few specialist mental health personnel in a community should seek to support such youth leaders by giving them basic counselling skills and first aid to help the children with common problems. Once again, they need to be able to access advice and supervision and to know how and when to refer children on.

In the University of London/UNICEF /EU programme in Mostar in Bosnia from 1994, we tried to put these principles into effect. Following WHO policies on delivering mental health care through community resources rather than isolated clinics, we spent a long time with representatives of the schools and organizations on both the Croat and Bosniak sides of the old city discovering what help *they* wanted. From these discussions emerged a package of four seminars to be delivered to every school teacher in Mostar and the surrounding areas. A development of this package was subsequently delivered to over 2,000 teachers in central Bosnia.

This first level training consisted of four seminars whose content was worked out with local educationalists. The seminars covered "The role of the school in difficult circumstances", "Working with parents", "Burnout and prevention" and "Identifying and helping children". Local teachers were trained to deliver these seminars, each of which lasted 2-3 hours. It must be remembered that Yugoslavia had previously had a communist regime with the educational syllabus being tightly controlled centrally. Over half the people who were acting as teachers had had other professions prior to the war and all had lived through the horrors of the war, many being badly affected by their experiences. Hence the need to consider how best schools could respond to local needs, how they could collaborate on an equal footing with parents and how the teachers could look after themselves. This was not just another programme on PTSD being imposed insensitively from outside.

We provided some selected teachers with more advanced training. This covered such topics as: working with parents, CBT treatments, bereavement in children, anger management, classroom management, needs of pre-school children, special educational needs, and speech difficulties. We also trained staff of some NGOs in basic counselling skills so they could work with adolescents presenting at youth clubs. Finally, we set up a resource and counselling centre attached to a mother and child out-patient clinic to which children could be referred for small group and individual work.

In collaboration with other agencies, we supported the UNICEF/WHO "baby friendly hospital" initiative. Even though the maternity ward was one of a number of ship containers placed within a former fruit and vegetable warehouse, staff encouraged new mothers to breast feed their babies. We provided advice to primary care personnel and brought in a trainer who worked with mothers of young infants to improve their emotional development. In Tusla, Dybdahl (2001) independently employed the same WHO programme and showed that the infants of mothers who

participated put on more weight than did the children of mothers in a waiting list control group. We also worked closely with the staff responsible for providing nursery education within the divided city.

Reading this now, it sounds very organised and well thought out. By following some basic principles, I suppose it was. The point I would like to emphasise is that all this takes time. The brief we were given by UNICEF was to help re-establish child mental health services in a city that had been the site of fierce fighting for a number of years. In "development speak" we were to build local capacity in such a way that developments would be sustainable. In other words, the role of the international consultant was not to set up short-term services provided solely by themselves – such services wither as soon as the consultant returns home – but rather to find out the needs of local people and to provide appropriate skills training for them so that the new skills can be built on long after the consultant has gone home. This cannot be achieved in 2 or 3 months. Rather, such programmes need to be developed at the rate local people can assimilate them. In other words, building or rebuilding people-led services requires a different time-scale from rebuilding a youth centre and sufficient funding over sufficient time needs to be made available to achieve the aims of the programme effectively and efficiently.

The need for evaluation

Increasingly, international donors rightly ask for harder evidence that the money they give has been put to good use – that the programmes of intervention are both effective and efficient. It is no longer enough to state that by "training" 30 teachers in a one-day symposium one would affect the lives of hundreds of children. Harder evidence was and is needed to demonstrate that the children really did benefit more than if nothing had been done. In turn, this means that better tools to measure the effects of trauma on children are required.

It was part of UNICEF and our remit to develop a battery of instruments that would indicate both the levels of exposure to war trauma and the subjective reactions the children experienced. The aim was that such a battery could be used both to estimate the level of need within a population and also monitor the effects of planned interventions. There was little to guide us when we started in 1993 and there was no time to wait while ideal instruments were developed. This was action research in the raw!

Following a number of seminars organised by UNICEF in Bosnia and Norway in 1993 and 1994, a strategy was developed and implemented whereby in collaboration with the Center for Crisis Psychology in Bergen, our group would take the lead in developing a suitable battery. We aimed to develop a brief battery that could be used in mass screening, would be sufficiently comprehensive to cover most of the major reactions expected, and yet would be easily understood and acceptable to children, parents, teachers and government officials. UNICEF encouraged all NGOs it sponsored to use the core battery and we hoped that different groups would add other measures as they chose so as to add to knowledge while still permitting comparison across different interventions.

The core group of measures consisted of a version of the War Trauma Questionnaire adapted for the Bosnian experience; a revised version of the Impact of Event Scale for children, including items on arousal; the Birleson Depression Scale; the Children's Manifest Anxiety Scale; and a brief Grief Inventory. Our studies in Bosnia indicated that these aims were mainly achieved. The battery has been used in subsequent studies by different investigators and in different languages (e.g. Papageorgiou et al, 1999 with Serbian refugees in Greek Macedonia; Giannopolou et al in press, with Greek children following the Athens earthquake; by many colleagues in Turkey following the recent earthquake there; Yule et al, 2001, with Albanaian refugees from Kosovo). Whilst improvements are constantly being made, this battery seems to be serving many useful purposes and illustrates the need to have good measures to guide better practice. To date, the data gathered indicate that the battery has good validity across many cultures.

Particular needs of refugee children

For the purposes of this paper, I am assuming that readers of *Traumatology* are familiar with the nature of stress reactions in children. It is now well established that significant proportions of children develop debilitating emotional reactions and disorders following various acute traumatic events. Experiences during war time and its aftermath amount to multiple and chronic stressors, and again it is now well established that significant proportions of children may develop stress reactions, depression, phobias, anxiety disorders and complex grief reactions. Children who are displaced and become asylum seekers and refugees will probably have experienced an unusual number or degree of stressful experiences. Some people may well protest that it is "pathologising" or "medicalising" these experiences to be talking about stress reactions at all, let alone talking about PTSD. It has already been noted that there are wide individual differences in response to stress and by no means all children exposed to a life threatening experience go on to develop PTSD. But many do show other stress reactions and, of course, children who have been uprooted from their homes and who may have lost a parent or other loved one during the turmoil may also have unresolved grief reactions. While recognising that most of these reactions are "normal" in the sense of being understandable, they still require that action be taken by those in authority to alleviate the children's distress. Diagnosis and labelling are but means to mobilising the needed resources.

It is also true that children can be resilient. For example, half the adolescents who survived the sinking of the cruise ship, "Jupiter", went on to develop a full-blown PTSD. Among the others, many showed a number of stress symptoms that interfered with daily life but fell short of a diagnosable condition. While it is true that from the point of view of understanding development it is good to focus more on invulnerable and resilient children, it remains the case that vulnerable ones require help.

These stress reactions are not merely transient phenomena that settle down quickly once a child feels safe and secure. That may happen, but in the case of children exposed to war, the long term effects can continue for many years (Elbedour, Bensel and Bastien, 1993). Even in the case of civilian disasters, the effects can be long lasting, so that the seven year follow-up of survivors of the "Jupiter" sinking is currently reporting that half those who had PTSD within the first year still have it

seven years later. Many others experienced other anxiety states and depression in the interim.

So what can and should we do? The first thing is to note that refugee children are at high risk of having mental health problems. It follows, therefore, that the school and other public health services should ensure that proper monitoring procedures are in force to ensure that help is given when required. This may mean having consultations and discussions with local child guidance, school psychological services and other mental health services, as well as contact with appropriate refugee advocacy groups.

The best thing the school can then do is to provide a secure and predictable environment in which the child can settle and learn. [See examples of good practice in Rutter & Jones, 1998] Education is even more highly prized among many refugees as that leads on to skills that can be taken with the child whatever the outcome of applications for citizenship. Within the pastoral care system, those teachers who will be caring for the refugee need to be alerted to some of the issues discussed above. They need to develop good, trusting relationships with the child in the hope that worries and concerns may be shared.

But this is where a particular problem in working with refugees comes to the fore. As van der Veer (1992) points out, many refugees will have gone to great lengths to escape the country where they felt threatened and may have been involved in illegal activities to get to their country of refuge. They may be suspicious of all people in authority and adults may have told children never to tell outsiders anything. They may have to conceal things they did while fleeing. Until decisions are taken about their future legal status, they will be reticent to share all the truth. Thus, teachers and other adults should not expect children to be totally frank about what happened to them, and this may hinder the process of helping children come to terms with their experiences.

A further complication arises when the fate of those left behind is unclear. Adults try to protect children from the worst, and this may be counterproductive. Discussing the needs of refugee children in Slovenia, a number of teachers told me that the worst thing they had to deal with was when they knew that a child's father had been killed in the war in Bosnia, but the mother had forbidden them to tell the child. A brief discussion confirmed that the teachers agreed that it was by far the best policy to be honest and truthful with the children as otherwise when they did discover that the father was dead, they would be angry with mother and teacher and find it harder to trust adults in the future. In any case, the child surely had a right to grieve. In that instance, what started out as a series of crises could be resolved by developing a school policy of openness. Parents would be told that the school would help them to tell children any bad news and would be on hand to support them through the difficult time. Again, teachers helping refugee children need to be aware of any family left behind who are seen as being at risk from the authorities and need to allow children to share their worries as far as is possible.

In the early days when a child joins a school, the help of an interpreter may be necessary. Here, a further possible complication may have to be considered. Many

modern conflagrations are civil wars, often of complex natures and divided along religious or ethnic lines. It is vital to check that any interpreter that one involves is acceptable to the child and family. Families are understandably nervous that emigrés of different groupings may be spies or may feed information back to their original country. Considerable sensitivity is required. To say to a child, "Oh, you are from Iran [or Iraq, or Rwanda or Bosnia] Come and meet another child from there…." without knowing that both children are from compatible subgroups, may be less than helpful! Issues to do with interpreters are fully discussed by van der Veer (1995).

Refugee children will probably have experienced stresses that most of us hope never to face. Many of them will cope reasonably well. Others will cope better if their mental health needs are recognised and appropriate help offered. Schools are in a vital position to ensure that such help is offered. Both in the provision of a good caring atmosphere and in seeking appropriate outside support, schools can make an enormous difference to the future adjustment of children who have been the unwitting victims of adults' failures to resolve differences other than by force.

Large scale interventions

Ten years on from the genocide in Rwanda and there have been many other wars and massive natural disasters. Hundreds of thousand of children have been made homeless and had to flee their birthplaces following tragedies like the earthquakes in Turkey, Greece, Taiwan, El Salvador and India or the floods in Mozambique and Bangladesh or the political upheavals in Kosovo or the fighting in Afghanistan, Chechnya, Sri Lanka or Algeria – to name but a few. What can be done to alleviate suffering on such a large scale?

Obviously, the first need is to ensure the safety of the children and to meet their physical needs – food, shelter, clean water and sanitation – while making sure they are in contact with their families. Then there is the need to provide some form of schooling both to continue to improve the skills of the children and to provide a much needed predictability and routine to their unsettled lives. When these basic requirements are met, then one can help to bring relief to their psychological distress.

As mentioned earlier, meeting the psychological needs of the children should be built in to all the emergency and rebuilding initiatives. Staff setting up tent cities – be they civilian or military – can be advised about the importance of play and education, as well as finding ways to reunite children with their families as they get lost in the vast impersonal rows of canvas. Those providing education need to have the sort of preparation and support we developed in Bosnia in order that they can provide some emotional first aid to children in their care.

Having had experience of working in such emergency situations, six of us (Atle Dyregrov, Rolf Gjestad, Leila Gupta, Patrick Smith, Sean Perrin and I) met in Norway in the summer of 1998 and discussed what we would recommend to those responding to another major disaster. From that brain storming session, we developed a manual for *"Teaching Recovery Techniques"* (Smith et al, 1999). We wanted to develop flexible materials that could address common early distressing reactions that would help children on the road to recovery. The intervention should be capable of

being delivered by sensitive people who get on well with children but who probably would have little or no child mental health experience. We strongly suggest that they organise so that there are two group leaders to a group of 10 children. The intervention consists of five half day modules for all children followed by a meeting for those who have been bereaved. A one session meeting for parents to explain the intervention and give them suggestions on helping their children is an essential element of the package.

The philosphy behind the manual is that wherever possible, the advice should be based on good empirical evidence. However, we recognise that children cannot wait while all the evidence piles up. Therefore, some of the suggestions are drawn from our own and others' clinical experience. Because of this, we see it as vital that whoever uses the manual must evaluate its effects. To that end, we provide the latest version of our core battery of screening and outcome measures and insist that those who use the package under licence (from the *Foundation for Children and War* which owns the copyright, see www.childrenandwar.org) send us their outcome data so we can adapt the package in the light of experience.

We had intended evaluating the package ourselves before releasing it to colleagues. However, the spate of natural disasters and wars at the end of the century forced us to licence some colleagues to use it first. At the time of writing, impressions and results are just being fed back to us. There is considerable enthusiasm and many positive comments from workers who have used it in Turkey. But cynics, including ourselves, may worry that anything seems better than nothing when chaos reigns. The spectre of possible harm arising from inappropriate applications still hangs over the enterprise. Thus, it was exciting to get the preliminary results from a study in Athens where the manual was implemented by mental health professionals who were largely unfamiliar with cognitive behavioural techniques. They found the suggestions and exercises brought immediate relief to children in the groups they ran and this was confirmed in the self-report questionnaire data from the children themselves (Giannopolou, 2000).

The five main sessions concentrate on helping children deal with the troubling symptoms of intrusion, arousal and avoidance. Children are taken through various warm-up exercises and helped to adopt a problem-solving and group-sharing approach to the difficulties. With regard to *intrusion*, they are taught about how traumatic reminders can upset them. They practice various imagery techniques to demonstrate to themselves that they can gain some control over the intrusive images that have troubled them. They are introduced to distraction techniques, dual attention techniques (similar to some of the EMDR techniques) and dream work – how to manage frightening, repetitive dreams. To reduce *arousal*, they are first helped to identify their reactions and then to be able to relax at will, using their own techniques where possible bolstered by breathing exercises and muscle relaxation. They are helped to schedule their activities, to look at better sleep hygiene and to develop and practice coping self statements. With respect to *avoidance*, the exercises introduce them to the concept of graded exposure, giving short practice in imaginal exposure followed by self reinforcement. They are encouraged to draw, write and talk about the incidents and above all are encourage to look to the future rather than the past.

In other words, this is a psycho-social-educational programme. It is designed to be delivered by people with a minimum of experience, but who are supervised by someone with more mental health expertise. Under the auspices of the *Foundation for Children and War* we intend developing and refining the package as there is clearly a great demand for effective, low-cost interventions that can be used with large numbers of children following catastrophes of all sorts.

Mental health services

Having emphasized that during war and in response to major natural disasters the need is to re-establish good functioning social infrastructures to help children's lives to return to as near normal as possible, there will also be a need for more sophisticated child mental health services for a minority of children.

It needs to be said that whatever services are developed, they should be evidence based – even where the evidence base is far from complete. Thus, ironically, we know a great deal more about treating stress reactions in individuals and in small groups and so it is not surprising that when clinicians ventured out to advise on helping children affected by war that they should draw on this experience and literature. Unfortunately, that gave the impression that such clinicians saw all children's distress as indicating major psychiatric problems. Equally unfortunately, there is an even greater dearth of examples of community based interventions that have been properly evaluated. Thus, at the present time, mental health professionals working in war affected areas are trying to implement programmes that are based on good research evidence but are adapted for delivery to large numbers.

Against this background, let us briefly consider some of the evidence for the effectiveness of treatments for stress reactions in children.

Crisis Intervention: Critical Incident Stress Debriefing

Debriefing was originally developed to assist emergency personnel adjust to their emotional reactions to events encountered in the course of their rescue work. It makes use of group support techniques within a predominantly male, macho culture where expressing and sharing feelings is not the norm. The technique has now been adapted for use with children following a wide variety of traumas (Dyregrov, 1991). However, the very nature of refugee children's experiences means that it is unlikely that classical debriefing techniques will be used in the place of sanctuary. Even so, the technique is nowadays so wisely discussed following a major incident that for the sake of completeness it is described here.

Within a few days of an incident, the survivors are brought together in a group with an outside leader. During the introductory phase, the leader sets the rules for the meeting emphasizing that they are there to share feelings and help each other, and that what goes on in the meeting is private. The information should not be used to tease other children. No one has to talk, although all are encouraged to do so. They then go on to clarify the facts of what actually happened in the incident. This permits the nailing of any rumours. They are asked about what they thought when they realised

something was wrong, and this leads naturally into discussions of how they felt and of their current emotional reactions. In this way, children share the various reactions they have experienced and usually learn that others feel similarly. The leader labels their responses as normal (understandable) reactions to an abnormal situation. Many children are relieved to learn they are not the only ones experiencing strange feelings and so are relieved that there is an explanation and that they are not going mad. The leader summarises the information arising in the group, and educates the children into what simple steps they can take to control some of their reactions. They are also told of other help available should their distress persist.

There is evidence that this structured crisis intervention is helpful in preventing later distress in adults (Dyregrov, 1988; Duckworth, 1986; Robinson & Mitchell, 1993; Canterbury & Yule, 1999). However, recent criticisms have been raised about the lack of proper randomized control trials. Some studies which have not used the CISD model but have rather used individualised crisis interventions have not only failed to find evidence in favour of early intervention with adults but even claim that some people are made worse by early intervention (Wessely, Rose & Bisson,1997; Rose & Bisson, 1998). Indeed, a three year follow up of 30 RTA survivors given a one hour "debriefing" by a researcher within 24-48 hours of the accident found them to have more problems than 31 survivors not given the intervention (Mayou, Ehlers & Hobbs, 2000). Thus, both the nature of the crisis intervention and its timing are crucial issues that require further careful study.

Fortunately, the situation with children is a little more optimistic. Yule and Udwin (1991) describe their use of critical incident stress debriefing with girls who survived the sinking of the Jupiter. Self-report data 5 months after the incident suggest that this reduced levels of stress, particularly those manifested in intrusive thoughts (Yule, 1992). Stallard and Law (1993) show more convincing evidence that debriefing greatly reduced the distress of girls who survived a school bus crash. However, we still do not know when best to offer such debriefing to survivors of a disaster, nor indeed whether all survivors benefit.

Group treatment

Where natural groupings exist in communities and schools, it makes sense to direct some therapeutic support through such groups (Galante & Foa, 1986; Farberow & Gordon, 1981; Ayalon, 1988; Yule & Williams, 1990; Yule & Udwin, 1991). The aims of such therapeutic groups should include the sharing of feelings, boosting children's sense of coping and mastery, sharing ways of solving common problems. Although no examples have been published to date, it would seem appropriate to offer group treatment to refugees who have experienced broadly similar events.

Gillis (1993) suggests that it is optimal to work with groups of 6 to 8 children. His experience following a school sniper attack was that it was better to run separate groups for boys and girls because of the different reactions they had to the attack. Boys showed more externalising problems and girls showed more internalising ones.

Different authors have imposed varying degrees of structure on their groups, with Galante and Foa (1986) adopting a fairly structured approach where different topics were tackled at each meeting, while Yule and Williams (1990) describe not only a very unstructured, problem-solving approach but also ran a parallel group for the parents. Different incidents will require different approaches.

Group approaches seem to be very therapeutic for many children but not all problems can be solved in the group. Gillis (1993) suggests that high risk children--those whose lives were directly threatened, who directly witnessed death, who were physically injured, who had pre-existing problems or who lack family support--should be offered individual help. More generally, children whose problems persist despite group help should be treated individually.

Individual treatment

To date, there is little evidence that drug treatments have a central role, so the focus has been mainly on cognitive behavioural treatments that aim both to help the survivor make sense of what happened and to master their feelings of anxiety and helplessness.

Asking children to draw their experience often assists recall of both the event and the emotions (Blom, 1982; Newman, 1976; Galante & Foa, 1986; Pynoos & Eth, 1986). Drawings were not used as "projective" techniques, but as ways of assisting talking about the experience. However, there is evidence from a large study of 600 primary school children in Bosnia that structured art therapy does not help reduce the symptoms of distress (Bunjevac and Kuterovac, 1994).

Most survivors recognize that sooner or later "they must face up to the traumatic event". The problem for the therapist is how to help the survivor re-experience the event and the emotions that it engenders in such a way that the distress can be mastered rather than magnified. Therapeutic exposure sessions that are too brief may sensitize rather than desensitize (Rachman, 1980) so therapist may need to use much longer exposure sessions than normal (Saigh, 1986). Fuller suggestions of useful techniques to promote emotional processing are given elsewhere (Perrin, Smith & Yule, 2000; Rachman, 1980; Saigh, 1992; Smith, Perrin & Yule, 1999;Yule 1991).

Exposure under supportive circumstances seems to deal well with both intrusive thoughts and behavioural avoidance. The other major symptom of child PTSD that requires attention is sleep disorder. A careful analysis will reveal whether the problem is mainly one of getting off to sleep or in waking because of intrusive nightmares related to the disaster. In the former case, implementing relaxing routines before bed and masking thoughts with music may help. In the latter, there are now some promising cognitive behavioural techniques for alleviating nightmares (Palace & Johnston, 1989; Marks, 1978; Halliday, 1987; Seligman & Yellen, 1987).

Ayalon (1983) suggests the use of stress-inoculation techniques (Meichenbaum, 1975; Meichenbaum & Cameron, 1983), among many others, to prepare Israeli children to cope with the effects of "terrorist" attacks. These ideas seem eminently sensible, but their implementation awaits systematic evaluation.

As with the treatment of PTSD in adults, the most effective treatment is generally agreed to be exposure-based cognitive behavioural therapy (Cohen, Berliner and March, 2000). In adults, Eye Movement Desensitization and Reprocessing therapy (EMDR) is the second most endorsed intervention. There is increasing evidence of its efficacy with children and adolescents. For example, in a recent trial of EMDR given to a consecutive series of ten children who developed PTSD following road traffic accidents, Ribchester (2001) reported that all ten became asymptomatic following an average of 2.3 sessions.

While the number of well designed treatment trial with children lags behind that of interventions with adults, nevertheless the indications are very strong that the same two major therapeutic approaches are also applicable to young persons.

Prevention

Most would agree that prevention is better than cure and so more emphasis on preventing accidents (and war) would help put many of us out of business. In the meantime, we can at least help key institutions - notably schools - prepare for how they may respond to the sorts of crises that hit them.

Anne Gold and I counsel schools to be *"Wise Before the Event"* (Yule & Gold, 1993). Head Teachers and senior staff should develop contingency plans to deal with the aftermath of possible disasters. I am proud to say that this booklet was presented to every school in the UK by the Calouste Gulbenkian Foundation and we have had very positive feedback on its usefulness.

Conclusions

While the first casualty of war may be "truth", the mental health of our future generations is also severely compromised. It is now recognised in international agreements that children are badly affected by war and that nations have a duty to alleviate the effects on their mental health. This paper has argued that much can be done by ensuring that educational and recreational opportunities are re-established as a matter of priority. Good mental health services are not merely confined to clinics. Large scale programmes to educate adults and children play an important part.

There is also a great need to develop, test out and evaluate large scale interventions that can be delivered via the school system. I have described the development of such a programme that has managed to reduce distress among child survivors of major earthquakes as well as child asylum seekers. The techniques utilised in that programme have their roots in cognitive behavioural and other evidence based techniques. The aim has been to develop training packages that can be implemented by adults with a minimal level of mental health experiences. Child mental health specialists have a vital role to play in developing ever more effective and efficient interventions, but they need to realise that working with survivors of war and disaster in chaotic community settings is very different from running an appointment-based clinic-based service in a settled urban community. More training

and materials are needed to help professionals mobilise in times of emergency and deliver appropriate interventions.

Great strides have been made in learning how best to alleviate the distress caused by disasters and war. Provided funding organizations recognise that funds are required to develop programmes, to develop better measures and to evaluate field trials so that lessons learned can be incorporated in the next generation of interventions, then at least we can help alleviate the dreadful effects of war even if we cannot prevent it happening.

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