Module 1: Impact of Armed Conflict on Children


1. Rationale

Though the impact of wars and political violence on children’s psychosocial wellbeing has been a focus of research since the Second World War, there are debates on how to best describe this impact. This module’s aim is to review existing scientific literature on this topic, and to come to an integrated model synthesizing part of this literature. We would also like to explain how this model has been of use for our practice.

2. The biomedical literature

The dominant focus of the scientific literature on this topic has aimed at describing the impact of armed conflict in terms of psychiatric symptoms. A large number of studies have looked at the consequences of political violence using classification systems developed in high-income settings, such as the Diagnostic Statistical Manual and the International Classification of Diseases. Such studies have generally found a relation between exposure to events associated with armed conflicts (witnessing killings, experiencing air raids, sexual assault, etc.) and subsequent psychological symptoms. The most widely reported symptom categories with children and adolescents are the Posttraumatic Stress Disorder (PTSD), major depression, (other) anxiety disorders, aggression, somatic symptoms, substance abuse (with adolescents), disturbed academic functioning, and interference in developmental tasks (e.g. bedwetting, clinging behavior). The impact of violence is described as multiple and besides PTSD other co-morbid common mental disorders are often found. In addition, there is now a growing body of literature that examines the biological underpinnings of fear and trauma. Technological advances have stimulated a host of new research.

3. Critique on the biomedical literature

Both within the biomedical literature as well as from other disciplines, there has been critique on this focus on describing the impact of armed conflicts in terms of individual symptoms (for good overviews see Boyden & de Berry, 2004; Stichick, 2001). Researchers working from an ethnographic approach have called the biomedical approach insufficient, because it neglects the
social and historical context. Current wars often take place in civilian-populated areas with the aim of warring parties to destabilize or dominate local social structures (e.g. systematically destroying religious structures, attacking an educated or dominant elite to change power structures, assuming control through instilling fear, e.g. by random torture and rape in villages). Describing the impact of armed conflicts on children must therefore take into account this damage to the “social fabric”. In addition, the social context can provide important resources to children in difficult situations, including support from family members, peers, school professionals and other community members, which are not sufficiently represented in a biomedical focus. Also, a biomedical focus neglects that children have an active role in changing their situations. Finally, a simple focus on how exposure events are associated with symptom categories, does not take into sufficient account the essential role of culture in how problems are experienced, how they are expressed, and how help is sought for problems.

4. A new direction

At the moment therefore, there seems to be a beginning movement away from a single focus on PTSD in the scientific literature (see Baker & Shalhoub-Kevorkian, 1999; Barenbaum, Ruchkin, & Schwab-Stone, 2004; Berman, 2001; Shaw, 2003). Stichick (2001), for instance, has called for a shift in focus from psychiatric symptoms to attention for, amongst others, a broader consideration of the impact of war, protective and mediating mechanisms, and the role of culture and gender.

There seems to be a small but emerging body of literature that takes into account protective processes at the individual as well as social levels, including the family, peers, school, and the community (for an excellent overview see Punamaki, 2006). Advances in statistics (e.g. multi-leveling techniques, which allow the examination of influences from for instance family, peer and neighborhood levels) have made it easier to examine the influence of the social context on children’s emotions, cognitions, and behavior.

The Psychosocial Working Group (2003) has constructed a useful framework for how to conceptualize the interplay between psychological (cognition, behavior, emotion) and social factors. This framework pays attention to the importance of context, of how people make meaning of events, of agency, and of the resources present in environments for people in situations of conflict to draw upon. The three main groups of resources mentioned in this framework are a) human capacity (the physical and mental health of community members and their skills and knowledge – human capital), b) the social ecology (social relationships within families, between peers, religious institutions, civic and
political authorities – social capital), and c) culture and values (cultural capital). These resources in turn are placed within a wider appreciation of economic, environmental, and physical resources that might or might not be available in a war-affected context.

New advances (i.e. mentioned neurobiological and statistical advances) and new thinking are paving the way for a possible integration of biological, psychological, and social factors that will enrich a fuller understanding of the complex process of how wars impact psychosocial wellbeing. While research in high-income settings in some areas is moving ahead in further multidisciplinary integration of such factors (e.g. in the case of developmental literature on resilience see Masten, 2001), the research on children in areas of armed conflict does not seem to have started this integration process yet.

5. An integrative model for practice

A pragmatic model that we have used to inform practice is the model of ecological resilience (see below). This model builds upon a) empirical findings on risk and protective processes for children in areas of armed conflict specifically, and the psychological literature on children in adversity more generally (e.g. stress/coping research, research on children affected by communal violence in high-income settings) and b) an ecological model (Bronfenbrenner, 1979).

The main message of this model is that children’s psychosocial wellbeing in situations of political violence depends on a dynamic process that includes a system of factors, both individual (for instance children’s gender, temperament, pre-war neurobiological variables, attachment relationships) and social (e.g. communicative processes in the family, possible family problems such as domestic violence or substance abuse, the existence of a supportive peer network, a continuing positive school environment, etc.). In this model, the child is part of a family and peer/school system, that itself is part of a community. Problems in the wider community can affect the child’s psychosocial wellbeing, and vice versa. For instance, in Indonesia, many people’s plantation gardens were destroyed during communal violence. This meant that for many families it was difficult to earn money, and children would often drop-out of school because of that. Dropping out of school gave many children a certain “poverty status” with their peers, and teachers would sometimes scold families. A form of stigmatization and lack of self-esteem because of their changed economic position then affected children and families. Within each social-ecological domain, we can expect factors that strengthen psychosocial wellbeing as well as factors that can impact psychosocial wellbeing. These can differ in importance per age group, for instance in school-going children we can expect that supportive peer
relations would be more important. A current problem in the political violence literature, however, is that there is only a small body of evidence on protective and risk factors to guide psychosocial programming (Layne et al, in press).

The model depicted in figure 1.1. has informed our practice in a number of ways. First, if one sees the impact of armed conflict on a child as an aspect of a wider influence on a system in which they live, intervention should also be holistic and carry multiple components. That means, for instance, that we would not focus only on children’s mental health, but also need services in place that can deal with family problems (e.g. domestic violence, substance abuse), problems in the school situation (e.g. abusive teachers, drop-out problems), and problems in the community (e.g. lack of income generation opportunities, religious tensions).

Second, depending on different elements of the dynamic process, children’s psychosocial wellbeing can be relatively little impacted, to extremely impacted. Therefore, one type of service, for one type of complaint will not do. From a public health perspective, we need to incorporate services at different prevention levels. We need to include services in our program that a) are aimed at preventing psychosocial problems from occurring (e.g. by strengthening social relations in a community or raising awareness about psychosocial problems that could occur), b) are aimed at working with at-risk groups (e.g. targeting children that are screened to be in psychological distress, but have not developed disorders), and c) are aimed at working with children and families that have specific problems that need specific services (e.g. a child with major depression).

Third, the model specifies the importance of culture, for instance through seeing the influence of beliefs about the supernatural. An often-heard problem in Burundi was the increase of accusations of witchcraft and spirit possession. This could be a sign of deteriorated trust between community members because of experiences in the civil war. Many of the key informants we spoke to felt that previous communal bonds had deteriorated. On the other hand, there was also a big increase in non-conventional churches in the same time that could signal a way of community members wanting to re-establish that trust. Working together with churches to support this process, would be an avenue for psychosocial intervention, which would have been missed if we had worked from a purely individual trauma perspective.
Figure 1.1: Ecological Resilience

- **Child**
  - Gender, Age, temperament, attachment, etc
  - Primary and secondary appraisal
  - Coping repertoire

- **Family**
  - Family functioning
  - Received and perceived Social support
  - School as predictable environment
  - Support from peers/teachers

- **Peers**
  - Coping repertoire

- **School**
  - Social capital/collective efficacy
  - Beliefs, rituals and healing traditions

- **Wider community**
  - Social support

- **Supernatural**
Related to this point, the model gives an understanding not only of risk factors, but also of resources that can be utilized in programming. Children are seen as part of a system in which they themselves have influence, and that needs to be taken into account. If we work with resources that are already available, we a) avoid the risk of introducing new approaches that actually threaten available resources, and b) the chances that an effort is sustainable increase.

Finally, the model shows that we need to work not only with the individual impact of war, but also with the impact on social levels. For instance, in Northern Sri Lanka, many schoolteachers and community leaders felt that children’s moral development had been threatened by the armed conflict. Such a problem would need to be addressed not only at the individual level, but also at the school and community level.

Internal Links

See publications:

External Links

http://www.unicef.org/graca/

www.childreninarmedconflict.org

6. References


