



Coalition to Stop the Use of Child Soldiers

International Secretariat

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This document is part of the Coalition's psychosocial web page. For more information on the psychosocial impact of armed conflict upon children go to: www.child-soldiers.org/resources/psychosocial

Psychosocial web page Editor's introduction

In the January, 2006 edition of our psychosocial webpage, we introduce two new papers. The first: **Girls Formerly Associated with Fighting Forces and Their Children: Returned and Neglected (2006)** is by Susan McKay, Malia Robinson, Maria Gonsalves and Miranda Worthern. The second: **Children Affected by Armed Conflict: After Survival – What Next? Issues for Mental Health Services in England** is by Dr. Guinevere Tufnell.

The paper by McKay, Robinson and colleagues successfully outlines the considerable challenges facing girl mothers leaving fighting forces who seek to reintegrate into their communities in southern and western Africa. Often stigmatised and rejected by their communities, these girls struggle to find ways to earn a living to support themselves and their children in the face of economic and sexual exploitation.

The paper derives from a conference held on girl mothers (Bellagio, 2005 - see link below Editor's introduction). It is based on participatory research and papers presented there, and on the ensuing workshop discussions. It also draws on the extant literature, and the authors' own expertise and research in this area.

Given the integrative task facing them in writing this paper, the authors are to be congratulated on successfully allowing the voices of the girl mothers themselves to be heard. In spite of the physical and psychological sequelae of their experiences of extreme violence, the girl mothers speak of their own resilience, and demonstrate insight into their situations and a willingness to help themselves. They call for improved support from their communities so that they can better care for their children and earn their own living. They speak of a need for a healing period prior to reintegration, as well as access to public medical services, education and skills training. The authors succinctly outline key themes, issues and priorities for programming in this area based on an awareness of changing family structures, child protection issues and community concerns. Importantly, they draw attention to the plight of the children of girl mothers whose needs remain largely unknown, in spite of the child protection focus of agencies working with their mothers. Of particular note is their conclusion that formal DDR processes are not appropriate for girl mothers, and that community based programming offers the potential for a way forward in reintegrating this particularly 'at-risk' group. Given the knowledge gaps in this field, another identified way forward is the expansion of our outcomes evidence base by means of research collaboration between practitioners in the field and research experts acting in a facilitative and consultative role.

The second article focuses on issues related to meeting the needs of war affected children within the context of English mental health services. It is written by an eminent British child psychiatrist, Dr. Guinevere Tufnell, who works in a specialist post-traumatic centre in London providing assessment and treatment for refugee war affected children and their families. This highly specialised service sees psychologically distressed children who have survived severe

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and multiple traumatic events. Over the last four years the service has worked with more than 200 war affected children who have come to the UK as refugees, some with their families, others unaccompanied by adults. Using a clinical example of Mohammed, a former child soldier from Somalia as an illustration, Guinevere highlights the psychological and social difficulties these children face when they arrive in England and try to adjust to their new lives. She also discusses the clinical dilemmas and service issues facing clinicians who try to meet these children's psychological needs against a background of poorly resourced and inadequate services provided for them in England. The article's conclusions are based on Guinevere's extensive clinical experience with war affected children when they find themselves in England. She asserts that psychological support is only one aspect of what children affected by war need in order to enhance their resilience and enable them to adjust to life in a new country.

Dr. Linda Dowdney, Editor.

The Bellagio Conference Report can be accessed at:
<http://uwacadweb.uwo.edu/MCKAY/Documents/Bellagio.pdf>



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CHILDREN AFFECTED BY ARMED CONFLICT: AFTER SURVIVAL – WHAT NEXT? ISSUES FOR MENTAL HEALTH SERVICES IN ENGLAND

GUINEVERE TUFNELL (2005)

ABSTRACT

Many of the refugees who come to the UK are children affected by war or armed conflict. Our service has seen more than 200 such children over the past four years. Some children arrive in the UK with their families while others are completely alone. All those referred to our specialist service have survived severe and multiple traumatic events. On arrival in this country they expect to reach safety. However, they often find themselves in situations which they experience as unsafe, insecure and socially isolated. Local services struggle to meet their needs. A few are referred for specialist psychological help. How appropriate is this and what kind of psychological help do these young people need?

INTRODUCTION

I work in a small part time mental health team, based in London, which specialises in the treatment of children suffering from post-traumatic stress disorder. About three years ago we began to receive a steady stream of referrals of children and young people who were the survivors of armed conflict. Some were referred for assessment by solicitors who requested psychiatric reports for use in asylum proceedings. Most of these were at the appeal stage, having had their initial application for refugee status refused. A significant group were unaccompanied children, some of whom had been child soldiers. In this article I want to give some impression of the needs of these young people, and also raise some of the issues that confront the clinicians to whom these children are referred for help. Let me start by telling you about just one of the young people that came to our clinic. His story is typical of the stories told to us by children affected by war, and illustrates both the enormity of what they have experienced, as well as the challenges that we face when trying to help them.

THE STORY OF A CHILD SOLDIER

Mohammed (not his real name), aged 16, was referred to the child and family service at our clinic after having attempted to kill himself for the second time. He was a tall, slim boy with a gentle, withdrawn manner, an almost inaudible voice and a broad but

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apprehensive smile. Mohammed had come to the UK from Somalia at the age of 15. He told me that his father and mother were from different clans and had separated around the time of his birth. He had lived with his mother until the age of six, when his home was torched by soldiers and his pregnant mother was raped and killed. He managed to escape from the burning building and lived on the street, surviving as best he could, often being victimised by local children because his mixed parentage denied him membership to their clan. When Mohammed was older – he did not know the age he was - he was abducted by an armed gang and forced to become a "soldier". His initial resistance ceased after being beaten with wire, raped and forced to witness the torture and murder of his best friend. He was forced to commit acts which he found too terrible to describe. A long time later – he was unable to say if it was weeks, months or years - he somehow managed to escape with the help of a family friend who paid for him to travel to the UK.

On arrival in the UK, Mohammed found himself alone at the airport without papers, money or contacts. He spoke no English. He was allowed to enter the country and eventually made contact through the clan network with some distant relatives, themselves refugees, who allowed him to live with them. During the day, his behaviour was disturbed by terrifying flashbacks, while at night he and the household were kept awake by his nightmares. Mohammed's initial application for refugee status was refused and he tried to kill himself. An appeal was made and, two years after his arrival in the UK, he was granted leave to remain until he was 18. For a while, he felt safe and began to be able to go out on his own, to attend college, and to play football in the local park. However, he remained very disabled by continuing flashbacks and nightmares, was unable to make friends and started to experience difficulties in his relationships with his relatives.

TREATMENT

When I first met Mohammed, I took a careful history from him with as much detail as he was able to give, knowing that I was likely to be asked for a report in support of his asylum claim. Mohammed spoke fairly good English, but was almost inaudible and very withdrawn. It was clear that, in psychiatric terms, he was suffering from both post traumatic stress disorder and depression. Over the 2 years that I worked with him, I had to work hard to keep him engaged and to build a relationship that would allow us to work towards the changes that he wanted: getting rid of the nightmares and flashbacks, getting a basic education and a qualification that would allow him to work, creating an identity and a life in the UK. Our work together covered many issues. First, I attempted to assist him to create a more supportive social network with the help of relatives, social services, and the college. I liaised with his solicitor and wrote reports in support of his asylum application. I prescribed medication to reduce his symptoms of PTSD and depression. We also worked on increasing his ability to take control of his life, to gain confidence and to reduce his nightmares and flashbacks. Mohammed's preoccupations were mostly about the present: terrifying isolation, lack of personal meaning and identity, despair about the future. The war had not only orphaned him at a very young age, but had also taken from him his family, his clan membership, his role in life and his country. He felt deeply alone. He was unable to make relationships with other young people his age because of his fear of repeated victimisation. He would cross the road to avoid young men who looked as though they might be from his country. He spoke of being unable to make contact with other people his own age because to do so would entail having to talk about his past and his family. He did not wish to be reminded by young



people in a similar position to himself of the traumatic experiences of the past. At the same time, he felt he had nothing to offer to young people who had grown up in the UK in loving families and in a country at peace.

Mohammed frequently forgot to attend his therapy sessions at the clinic, but made some progress with becoming more stable and able to function. He continued to suffer severely from reliving traumatic experiences - but our work on these was limited by the lack of safety and stability in his situation, his reluctance to think about the horrors that he had experienced in the past and his need to focus on survival in the present.

When he reached his 18th birthday, his social worker omitted to complete complex paperwork required for transferring him to the agency which provides support for adult asylum seekers. As a result, there were several weeks when he was unable to obtain any money or other benefits. His place at college was suspended and he feared that he would lose his accommodation. At the same time, he was informed that he no longer had leave to remain in the UK. Meanwhile, his solicitor had moved on and he had no legal representation. At this point, he became understandably preoccupied with how he could avoid being sent back to Somalia, where he was convinced that he would die. He told me that if he was forced to return, he would kill himself. The only alternative would be to try to “disappear”. Shortly afterwards, he stopped coming to our meetings and did not reply to my letters.

CLINICAL SERVICE ISSUES

Mental health services for young people in the UK have, historically, developed in a somewhat piecemeal fashion in response to the needs of local indigenous populations and without a great deal of strategic planning. The recent publication of the Government’s National Service Framework (NSF) for Child & Adolescent Mental Health Services has filled a major strategic gap. It recognises the need for service planning, and includes provision of mental health services for refugees and asylum seekers. However, for clinicians working in the field, the NSF lacks clarity about what resources are needed and will be provided for this group, and what contribution mental health services should make to the support and treatment of young people like Mohammed. These are children whose lives have been affected by war throughout most of their childhoods. Because of this, they have been deprived of their basic human rights, have survived terror and torture, and have had to learn to survive without being provided with the care and education we consider crucial for our children.

QUESTIONS AND PREOCCUPATIONS

The evidence base currently available provides rather limited guidance as to what types of psychological intervention are most effective for children affected by war. Furthermore, opinions are very divided as to whether mental health services are appropriate or not. For example, a recent article documenting high levels of post-traumatic stress in child soldiers in Uganda, in the British journal *The Lancet* (Derluyn, Broekaert, Schuyten, *et al*, 2004), was followed by an intense debate in the correspondence columns. Susan McKay and Michael Wessells in the May 15th issue of the same journal raised some of the main issues:



"Use of the diagnosis of post traumatic stress disorder as a starting point is problematic because it pathologises and stigmatises children, imposes categories formulated by westerners and limits the conceptualisation of the kinds of support that are needed. We doubt that the measurement of trauma by means of individualistic psychological tools is appropriate in the ... cultural context.... Trauma is a small part of a much larger set of psychosocial, economic, ethnic and political stresses which are continuous and challenge the rubric "post-traumatic"." (Lancet, 2004, p.1646).

McKay and Wessells point to the lack of security, food, education, health care, and support for children affected by war and to what they see as a danger that research on children's mental health "could lead policy leaders and donors to conclude, erroneously, that counselling is the top priority in supporting the children". There was also criticism of the lack of quality control in research studies, the ethical problems of research with such vulnerable children, and the need for culturally appropriate interventions and for interventions which emphasise resilience and strengths. However, other responders from countries where children face recruitment into armed groups, or with many children directly affected by war, felt that these children were in urgent need of psychological help and rehabilitation. There is a tone of passionate concern in much of the debate about the needs of war-affected children, reflecting the outrage and distress that will be familiar to clinicians in England who are struggling to provide the help these children need in the face of inadequate resources and lack of government support.

It seems clear that, although mental health problems are often not the most important difficulties faced by these children, there is, nevertheless a significant psychological component to what is needed once they are out of immediate danger. Children who have been exposed to war will have experienced repeated trauma, loss of crucial attachments, and are likely to have learned to use violence as the only means of survival and of resolving conflicts. What kind of citizens will these children be when they grow up? How will they, without psychological help, be able to form the close relationships that sustain families and their own growing children? What is clear is that the clinic-based services which serve local peace-time populations in the UK well are not well placed to meet the needs of child soldiers from war-torn countries from around the world.

So what pattern of service needs to be developed in order for these children to be rehabilitated? It is clear that if children do not feel safe and secure, they are not able to put the past behind them or to begin to develop the trust and the attachments that they need in order to recover. These children need to build resilience and to be helped to create a new life by means of befriending, social and creative activities, and education. In the UK we have only just begun the debate about how these services can best be provided.

CONCLUSIONS

Based on our team's experience, we can conclude the following with regard to war affected children who come as refugees to England:

- Many children affected by war have significant mental health needs in addition to all their other difficulties.



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- Some child soldiers have been trained to perpetrate torture and abuse and to use violence as a means of survival. When this occurs, it is likely to make it more difficult for them to adapt to peace time and to form loving and trusting relationships.
 - Child soldiers are likely to have been severely traumatised by their experiences. They are at high risk of developing post traumatic stress disorder and depression. Without help, these problems are likely to be long lasting.
 - A child's need for safety and security must be met before any mental health needs can be met effectively. Many of the children who reach the UK as refugees lack these key factors.
 - Psychological treatment is most effective when it identifies strengths as well as vulnerabilities, enhances resilience and is provided as part of a wider package of support including access to education and supportive social networks.

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