What can we do to support children who have been through war?

by Anica Mikuš Kos and Sanja Derviškadić-Jovanović

This article documents reflections on four years of psychosocial support given to young refugees from Bosnia and Herzegovina by members of the Center for Psychosocial Help to Refugees at the Slovene Foundation, Ljubljana. It suggests that the deleterious psychological impact of war on children is frequently exaggerated.

Claims as to the ravaging long-lasting psychosocial and psychological effects of war on children may be based on the over-generalisation of clinical findings. Clinical workers see only children suffering from psychological disorders - they do not encounter the huge number of children who have suffered much but whose mental health and psychosocial functioning have not been significantly affected. Some statements which have never been scientifically proven are repeated constantly and uncritically in the professional literature. Describing adolescents exposed to war events as aggressive, revengeful and hateful - without indicating how many are affected - is one good example. The Slovene screening of 15-year-old Bosnian adolescents[1], for example, does not confirm frequent aggressive and revengeful feelings in this population. Another example is the repeated statement that violence necessarily breeds violence. There are many nations which have manifested extreme violence or been victims of extreme violence but where violence has not become a recurring phenomenon.

The war experience certainly does influence a child's perception of the world and humanity and their social construction of reality, but this does not mean that the child is psychologically harmed. In most cases the psychological consequences of war on children are in the range of normal human feelings and memories. Astonishingly little attention has been paid by mental health professionals to the actual functioning of children who have experienced war. Their largely satisfactory social functioning and coping are therefore mainly underestimated and it is only in the last few years that issues such as protective factors and processes and resilience have appeared in the professional literature.

The immense protective function of good psychosocial functioning has also been overlooked. Good functioning evokes positive social reactions which enhance self-esteem. In contrast, inadequate social and school functioning evokes negative reactions, rejection, low self esteem and new stresses. A well-functioning child is contributing positively to their social environment whilst a badly functioning child provokes new adversities in their environment. Mental health programmes may often not be sufficiently concerned with promoting good functioning and coping with important life tasks in war-affected children.

Positive influences of war on personality, values, relations and behaviour are rarely quoted. The war experience can, however, enrich one's personality as any difficulty in life can. It can encourage empathy and positive social behaviour, enhance coping capacities and social maturity. Many well-adjusted Bosnian adolescents reported that the war experiences, related losses and the adversities of asylum life mobilised their strength and enhanced their personal and moral development.

The fact that the consequences of war on children may not be as psychologically devastating as presented by many professionals does not, however, mean that children do not suffer. Neither does it entitle us to remain inactive and to desist from helping children.

The philosophy and activities of the Center

In the spring of 1992 the Counseling Center for Children, Adolescents and Parents in Ljubljana initiated mental health and psychosocial activities for refugee children, adolescents and their families. In 1994 these activities were transferred to the Center for Psychosocial Help to Refugees at the Slovene Foundation. About 35,000 of the approximately 70,000 refugees who came to Slovenia were children. From the very beginning, we realised that the few mental health workers who were actively involved in helping refugees would not be able to treat thousands of frightened, anxious, depressed and traumatised children. Our first and main question was therefore how to provide some help to all children, or at least to the majority of children. Instead of screening and detecting traumatised children for whom we could not, in any case, provide adequate psychotherapeutic help, we developed population-oriented outreach models of psychosocial help.

Mobile mental health teams visited collective shelters for refugees on a monthly basis. Members of the team met with - sometimes very large - groups of parents and gave basic advice about children's needs. They emphasised simple measures such as holding a child's hand or singing to them before they fell asleep. Some pre-school children were very disturbed to learn that their houses in Bosnia had been destroyed and we counselled mothers to help the child construct a house from mud so that the child could see that a new house could be constructed.

The majority of our efforts were invested in the education of Bosnian children. We supported the Bosnian schools and refugee teachers working in these schools[2]. (A similar project has been run for kindergartens in collective shelters.) The basic aim was to create an emotionally safe and friendly environment in schools, to prevent further school-related traumatisation and to incorporate into schools mental health interventions from which all children could benefit. Teachers acted as psychosocial helpers. Half of the teachers were untrained and needed additional educational support. All of them needed some psychological instruction in order to support their pupils. Most importantly, all teachers needed psychological support for themselves. They too were refugees and were exposed to the same war-related traumas and adversities of asylum life as their pupils.

A health education project was initiated in collective shelters and run by Bosnian refugee physicians. As refugee physicians were not allowed to work for payment in Slovenia, or even to practise their profession on a voluntary basis, they started to work as health educators. They discussed sex education with groups of adolescents. They visited chronically ill and handicapped people. They also talked with hundreds and hundreds of mothers about feeding children and the everyday problems of raising children. Discussion of health issues opened the way to discussing psychological problems linked to the war and to life in asylum.

The activities of the Center were much more of a psychosocial nature than of a psychological nature. We prioritised the normalisation of children's lives by incorporating them into schools and confronting them with usual developmental tasks, on the assumption that a structured and predictable part of life with achievement of normal developmental tasks will protect children's mental health. The major aim of the Center has therefore been to ensure a good and supportive school for refugee children, to help them to learn and to achieve academically. Attending a regular school means that the child maintains their social role - the role of pupil. Children who are still pupils have normal working obligations, tasks, functions and responsibility. Being successful in school enhances self esteem, which is of crucial importance for coping.

The impact of psychosocial interventions

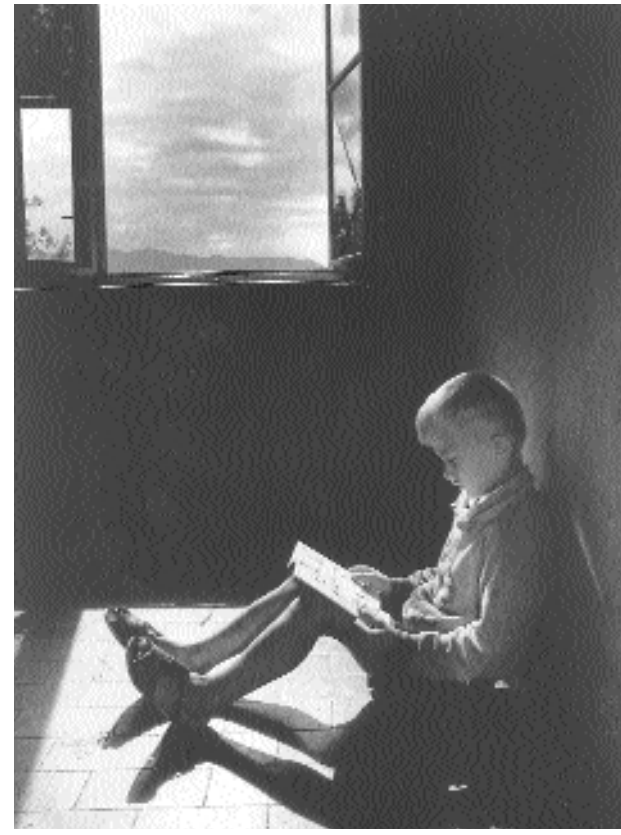
There are many unanswered questions concerning the impact of psychosocial programmes for children affected by war and reliable evaluation is problematic. Even if mental health workers had the time, energy and money in an emergency situation to conduct scientific evaluation, there would still be many issues which would not be satisfactorily clarified. The main methodological problem is the lack of controls or comparative groups. It would be unethical and practically impossible to create comparative groups for the sake of research in emergency situations. Comparing the mental health situation and social functioning of refugee children from the programme region and in a region with no programme, or in different countries with different psychosocial programmes, might be a possibility for evaluation. However, we know that the whole context of life influences the feelings, behaviour and coping of people and these vary in different regions and countries. Comparing before and after intervention does not help very much either because time is the most important healer. The state of mental health and psychosocial functioning improve in the great majority of children without psychosocial intervention. Even if we were sure that the intervention had made a difference, we could not prove which ingredient or which activity was the most beneficial.

It is the opinion of the authors that psychotherapeutic skills and other specialised professional knowledge have been of much less importance in our work with refugees then in normal working conditions. Establishing a good relationship and displaying a caring attitude and concern for the basic material needs of refugees play a much more important role. For example, supporting Bosnian teachers was of the greatest importance in our programmes but the majority of supportive interventions did not warrant the designation of psychotherapy. Material help was a part of the support: raising money for a Bosnian school's excursion, thereby maintaining a traditional end of term event, or finding a hearing apparatus for a hearing-impaired child in order to enable him to follow the class like his classmates.

In many cases, our professional titles and positions have primarily provided a greater social power in advocating normalisation and improvement of everyday life conditions of refugee children. You do not need to be a psychiatrist or a psychologist to recognise the importance of a good school for the quality of children's lives. But the Slovene experience shows that there is a far greater chance of establishing a project which will raise the psychosocial quality of the school if such a project is proposed by mental health workers whose specialised opinion is given weight in this context.

Natural healing processes versus professional therapy

There is a tendency for the mental health profession to underline its own importance in situations of armed conflict and in the lives of refugees, and to overestimate the impact of therapeutic



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interventions. We are much inclined to forget that millions of people have survived wars in the psychological sense without any professional help. Many ingredients of psychotherapeutic interventions are available and used in normal everyday life. We should be asking ourselves which ingredients of our interventions are professional-specific, and cannot be substituted by natural social interactions.

Some of the most basic psychotherapeutic principles - providing a secure environment in which the child can talk about the traumatic experience; giving the child the opportunity to share their experiences with others; giving the chance to realise that their reactions are normal and commonly experienced by peers in a similar way; helping the child to develop feelings of security and reinforce their self-esteem - can be provided by people who are a part of the child's natural support network. In natural social groups, people comfort each other and provide mutual support, debrief and correct the perception of traumatic events through discussions. In catastrophes affecting a huge number of people, such as wars, people do not need psycho professionals to learn that their reactions to loss and trauma are normal processes and common to people who went through the same hell.

The professional assumption is that through therapy, meaning is given to the traumatic experience and the experience is integrated into the continuity of one's life. We consider that both processes are immanent to the human nature and that they happen in any case. Meanings and explanatory models are quickly produced and spread in disaster situations. Many parallel explanatory models are available and everybody adapts and elaborates the meaning according to their needs and experiences. The explanatory models are a part of culture, of the national character, of beliefs, of national history. The war is characteristically seen by Bosnian children in depersonalised terms. Sometimes they seem to perceive the war as a natural catastrophe caused by a special unfortunate combination of forces which stimulate violence. Bosnian people often speak about war in the detached way which might be applied to floods or earthquakes.

We mental health professionals also sometimes seem to forget that many people have the capacity to register, to perceive and to understand the psychological processes and psychosocial interactions as well as we do. Indeed, their descriptions and interpretations are often much more vivid, precise and rich than those expressed in sterile professional vocabulary. We have frequently been impressed by the capacity of refugees with little formal education, to perceive, to understand and to express.

"We are not crazy. What we feel is not abnormal - the situation is crazy and abnormal. Our reactions are human and normal."

When offered psychological help, practically illiterate peasants politely explained: "We are not crazy. What we feel is not abnormal - the situation is crazy and abnormal. Our reactions are human and normal." Many poems written by Bosnian children and adults describe their state of mind in a much more illustrative and authentic way than psychiatric textbooks.

Among the most impressive lay observations we have heard concerning Bosnian children was that of a Bosnian teacher who explained to professional psychologists: "Our children are not disturbed. There is a deep sorrow for losses and anguish for native land in their souls." Only some years later psycho professionals discovered that the great majority of refugee children from Bosnia functioned well, and that the symptoms listed in various check lists were astonishingly infrequent. However, there was 'something' in these children which could not be reached, described and presented in the classic language of our profession - this 'something' was exactly hidden sorrow and longing.

Further observations regarding mental health service intervention

One measure of the impact of mental health interventions is the number of users. A very small number of war-affected children are receivers of psychotherapeutic interventions even when these are available. However, many costly mental health programmes are dealing with an epidemiologically negligible number of traumatised and otherwise psychologically affected children without ever raising a single question about those children who will never be recipients of any intervention. Whilst helping just one child is already a good thing, resource allocation is an important issue: what is the most just, equitable, rational and economic way of spending available funds for the protection of children's mental health and development?

Mental health professionals sometimes offer their traditional clinical models of help insensitively and without understanding of context. Professionals may show a lack of flexibility for adapting their clinical models and concepts to new situations. When they finally realise that these do not work they quit the scene with indignation. Some mental health workers seem to embrace principles of community work. They change their vocabulary - they speak about community and population-oriented programmes - but their basic paradigm remains the same. They remain oriented only towards the inner processes without paying the necessary attention to the broader social context.

An impressive number of mental health workers remain uninterested and not at all involved in helping refugee children in their country. They are apparently unbothered by the fact that there are thousands or tens of thousands of these traumatised children. Besides the issue of professional morals, it is surprising that there is such a formidable lack of professional interest in a local situation from which mental health workers can learn a lot.

In some cases research on psychological traumas in peace time (street violence, traffic accidents or other accidents) is uncritically transferred by foreign experts to war-affected and refugee populations, with complete neglect of the contextual differences. Post-traumatic stress disorder (PTSD) is the standard diagnosis and the effects of complex traumatic situations and processes, losses and of chronic asylum adversities are neither understood nor accounted for in interventions.

Therapeutic treatment programmes for traumatised children frequently have a much higher funding priority than popu-

lation-oriented programmes aimed at helping a large number of children by improving their education and psychosocial quality of life. Moreover, all too frequently 'suffering' is unfortunately not a sufficient argument to attract programme funding. To raise funds hard diagnoses are needed, among which the most potent and fashionable is PTSD. In the first two years of war in former Yugoslavia, the question: "How many children suffer PTSD symptoms?" was asked far more frequently than the question "How many children are sad, desperate, deceived, humiliated, scared?" Our practice showed that some programmes were necessarily disguised and renamed as therapeutic programmes in order to obtain funding.

Suggestions stemming from the Slovene experience

- Mental health protection of children affected by war should be primarily based on population-oriented outreach models. Adequate moral, organisational and financial support should be given to such models of psychosocial help. The leading strategy should be the WHO 'Health for All' strategy.
- Programmes should be of a broad psychosocial nature and should be comprehensive. They cannot be isolated from other programmes which improve the quality and normalisation of children's lives.
- The function and role of mental health workers in this context should be of broad social and psychosocial dimensions.
- Effective services and programmes for refugee children with multiple needs should be comprehensive, accessible, flexible, contextually and culturally appropriate, and run in cooperation with regular services in the country of asylum.

In conclusion, the main objectives of assistance to war-affected children should be:

- to reduce children's suffering and prevent their further traumatisation
- to support and develop their natural support system
- to help establish an environment which will enhance psychological recovery and normal development
- to establish a structured daily routine and normality in daily life with normal developmental tasks
- to support their education and academic achievements
- to enable children to reconstruct their social world
- to increase the children's coping capacities
- to provide opportunities for therapeutic help for seriously disturbed children

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Although these two people are named as authors, in reality they only compiled the ideas and experiences of about twenty Slovene mental health workers and hundreds of Bosnian refugees: teachers, physicians, mental health workers, but largely wise persons who have reflected, spoken and - most importantly - acted in the interest of children affected by the war.

A full version of this paper is part of the collection of papers in the book *They Talk We Listen*, published by the Center for Psychosocial Help to Refugees at the Slovene Foundation, Ljubljana (1997). The book gives a comprehensive account of the situation of refugees in Slovenia and the activities of the Center. Available from Slovene Philanthropy, Levstikova 22, 1000 Ljubljana, Slovenia; fax: +386 61 1212 605; email: anica.kos@guest.arnes.si

Notes

1 Slodnjak V (1998) 'Psychosocial functioning of refugee adolescents in Slovenia' in *Refugees in Slovenia*, University of Ljubljana, Ljubljana, pp 85-104.

2 The Bosnian school in Slovenia is presented in: Mikuš Kos A 'School as psychological protection of children' in *They Talk We Listen* (see above) pp97-115.

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