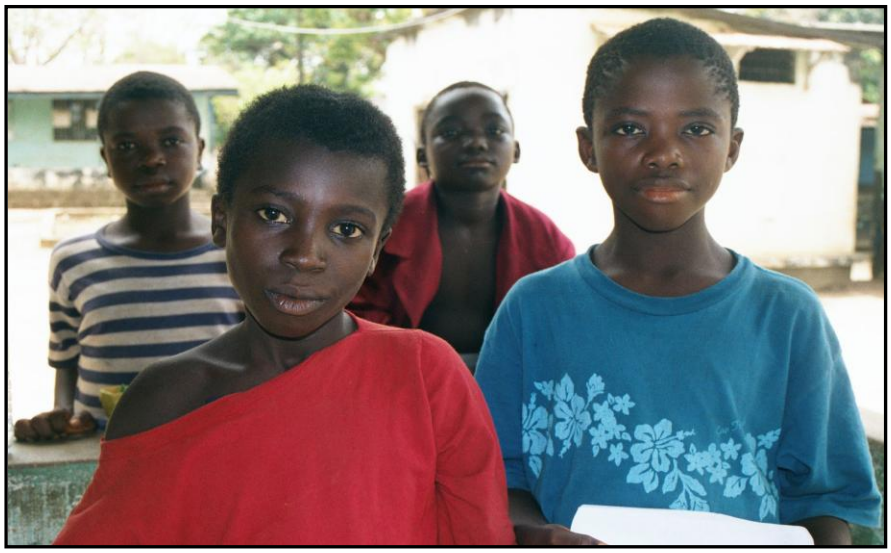
PSYCHOSOCIAL ADJUSTMENT AND SOCIAL REINTEGRATION OF CHILDREN ASSOCIATED WITH ARMED FORCES AND ARMED GROUPS: THE STATE OF THE FIELD AND FUTURE DIRECTIONS

A REPORT PREPARED FOR PSYCHOLOGY BEYOND BORDERS



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The photo on the cover is of former child soldiers at an interim care center in Kono, Sierra Leone. It was taken by Theresa Betancourt, and is reprinted here with her permission.

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ABOUT PSYCHOLOGY BEYOND BORDERS (PBB)

Psychology Beyond Borders is an international non-profit organization with a focus on the psychological impacts of terror attacks, armed conflicts, and natural disasters. The PBB mission combines psychosocial field work and research to contribute to the body of knowledge about the helpful or harmful effects of post-event interventions. PBB aims to help facilitate the most effective strategies for prevention, preparedness and response to traumatic events with the ultimate goals of alleviating psychological suffering and educating individuals and communities as well as informing public policy.

ABOUT THE RESEARCH PROGRAM ON CHILDREN AND GLOBAL ADVERSITY (RPCGA)

The Research Program on Children and Global Adversity (RPCGA) was launched in 2007 and is based at the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health. The RPCGA is devoted to applied research on the implementation of services and protections for children and families affected by armed conflict and those affected by HIV/AIDS. The goals of the RPCGA are to advance an evidence base regarding strategies and methods for closing the global implementation gap in child health and increasing protections and effective services for children in adversity.

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ACRONYMS

CAAFAG	Children Associated with Armed Forces and Armed Groups
CAFF	Children Associated with Fighting Forces
CBI	Classroom Based Intervention Program
CBR	Community-Based Reintegration Program
CC	Children's Club
CCF	Christian Children's Fund
CEIP	Community Education Investment Program
CREPS	Complimentary Rapid Education Primary Schools
CVT	Center for Victims of Torture
CWC	Child Welfare Committee
DDR	Demobilization, Disarmament, and Reintegration
IASC	Inter-Agency Standing Committee
ICC	Interim-Care Center
IPT-G	Group Interpersonal Therapy
IRC	International Rescue Committee
NET	Narrative Exposure Therapy
NGO	Nongovernmental Organization
PTSD	Posttraumatic Stress Disorder
RCT	Randomized Controlled Trial
RTP	Right to Play
RUF	Revolutionary United Front
SARC	Sexual Assault Referral Center
SWAY	Survey of War Affected Youth in northern Uganda
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency

EXECUTIVE SUMMARY

Of the many dangers of war, abduction and involvement with armed groups is considered particularly damaging to children. Over the past decade, children have been conscripted into fighting forces in 87 countries; it is estimated that at any given time, anywhere from 300,000-500,000 children are involved with fighting forces worldwide. Children affiliated with fighting forces take on a number of roles, from being forced into combat and the commission of atrocities, such as pillaging villages and participating in mass rapes, to working as porters, cooks, servants, human shields, mine sweepers, guards, and sexual slaves. Given the wide range of roles children fill as members of armed groups, the term "child soldier" itself has been criticized for promoting a misleading image of all child soldiers as boys with weapons. In fact, recent research has indicated that women and girls comprise a significant proportion of children involved with armed groups globally. In addition to being forced to act as combatants, women and girls abducted by fighting forces often face sexual violence, abuse and unwanted pregnancy, all of which involve serious health risks as well as social stigma and possibly isolation or abandonment. This reality has led many in the field to advocate for improved terminology.

This report reviews the current state of the field on the psychosocial adjustment, mental health and wellbeing of former child soldiers. In the first part of the report we review what is currently known about the effects of children's participation in armed forces on their psychological, economic and social wellbeing. In the second part of the report we discuss two main paradigms that dominate the field of service delivery for war-affected youth: the psychosocial approach and the clinical/psychiatric approach. We provide a brief review of a handful of available evaluations on the efficacy of mental health interventions for war-affected youth, which have implications for former child soldiers. We conclude with a series of recommendations on what future research and policy is needed to improve services for former child soldiers within a framework of holistic, integrated care for all war-affected children and families. Throughout this report, we integrate examples from our ongoing research in Sierra Leone as well as other available studies in the peer reviewed literature and reports from Nongovernmental Organizations (NGOs) and UN/Governmental Organizations.

THE IMPACT OF WAR AND VIOLENCE ON CHILDREN

Though empirical research on child soldiers is scant, studies to date help to illuminate the psychosocial impact of war and violence on this group of war-affected youth. These studies demonstrate that former child soldiers experience measured risk for mental health problems following their association with fighting forces during conflict (such as anxiety, depression, posttraumatic stress disorder (PTSD) and increases in aggression and hostility). These problems may persist for years, although with decreasing intensity. Surprisingly, when the psychological wellbeing and problems of former child soldiers are compared with those faced by children in the same geographic areas who were not directly associated with armed groups but were subject to the indirect effects, the results are similar with the exception of former child soldiers who were exposed to the most extreme forms of trauma. This suggests trauma, violence and loss are widespread in area of armed conflict and affect both child soldiers and youth not associated with armed groups.

Further, the research to date documents that one of the most devastating outcomes of child soldiering is the years of lost educational and economic opportunity that lead to difficulties in attaining key lifecycle milestones. Many of these former child soldiers reported these challenges to be more problematic than the actual experiences of the war. Despite the limited research that has explored the social aspects of child soldiers' reintegration, results suggest that a large part of former child soldiers are successfully able to adapt and function as civilians, and take on roles of husbands, fathers, mothers and community members. Youth with persistent mental health disorders may face a more difficult pathway to social reintegration.

Beyond this broad view of psychosocial wellbeing, research offers a much more complex perspective on the effects of violence on child soldiers, by demonstrating various factors and characteristics of child soldiers that shape pathways of risk and resilience. Among former child soldiers, determinants of psychosocial adjustment include the following:

- Exposure to violence across a range of severity and duration
- Method of joining armed forces (abduction, etc.)
- Roles within fighting forces (e.g., combatant, porter, "bush wife")
- Length of time spent with the fighting forces and age of abduction
- Family acceptance and support following return
- Community acceptance/stigma upon reintegration
- Opportunities for livelihoods and education
- Traditional healing ceremonies and spirituality
- Gender
- Personal responsibilities such as caring for small children and family members

GAPS IN CURRENT RESEARCH

There continue to be serious gaps in the research to date on the psychosocial adjustment of former child soldiers. In order to build an evidence base, research must explore the wider context of the family, community, social, political and economic environment to which former child soldiers reintegrated. Future research is needed which is:

- Longitudinal
- Gender sensitive
- Culturally informed
- Developmentally sensitive
- Integrative of evidence-based practice in interventions
- Informed from multiple perspectives (child, caregiver, significant other etc.)
- Able to unpack and explore the influence of different forms of exposure to violence
- Accounts for post-conflict stressors and contextual challenges in the lives of participants
- Utilizes relevant comparison or control groups
- Involves multiple sites to allow comparisons of results across sites

NGO PROGRAMS AND PSYCHOSOCIAL INTERVENTIONS

Two main paradigms, the psychosocial and clinical, dominate the mental health response for former child soldiers during and following demobilization, disarmament, and reintegration (DDR) programs. Most mental health interventions for such children and youth may be categorized according to these distinctions. In general, psychosocial interventions avoid using Western disease labels that may be inappropriate across diverse cultural settings. These are often interventions aimed at addressing children's greater psychosocial needs rather than focusing on particular disorders, attempting to strengthen a child's ability to interact with the outside world in a healthy manner. In general, psychosocial approaches focus on restoring connections to families and communities, recreating social networks, and providing children with greater capacity to deal with challenges they face during reintegration. Psychosocial interventions are rooted in the principle that reintegration is most likely to succeed in the context of community and family support, to the degree to which they are available. In contrast, clinical mental health interventions for war-affected youth require identifying those children with persistent mental disorders and focusing interventions on them. A main challenge to a clinical mental health approach in different cultural contexts is how to assess mental health disorders validly across different groups and link mental health needs to appropriate and effective care. Nonetheless, some categorization strategy is needed in order to establish the incidence and prevalence of disorders and identify mental health problems of greatest priority in these war-affected youth.

These two different approaches, while driven by different philosophies and field practices, should not be viewed as mutually exclusive. In fact, the greatest strength of these intervention strategies lies in using them in a complementary fashion. As suggested by the Guidelines on Mental Health and Psychosocial Support in Emergency Settings developed by the Inter-Agency Standing Committee (IASC), it is best to take a holistic approach that offers layered psychosocial supports and mental health services for children who are likely to have different reactions to war, different coping resources, social supports, and needs. This way of conceptualizing psychosocial needs and appropriate interventions in the field helps to move beyond the clinical vs. psychosocial debate and emphasizes how diverse kinds of responses from NGOs and agencies are useful and necessary.

EVIDENCE-BASED CLINICAL INTERVENTIONS

Most of the interventions found in the published literature are group treatment models, which if implemented sensitively, can go a long way towards addressing the human resources constraints inherent in the low resource settings of conflict or post-conflict countries. Some of these clinical interventions include:

- Group Interpersonal Therapy (IPT-G), a structured, time-limited therapy developed for the treatment of depression symptoms
- Short-term group crisis interventions, which use drawing, storytelling, free play and expression of feelings to focus on withstanding an identified crisis period
- Group interventions focused at developing mind-body techniques (including meditation) to reduce posttraumatic stress reactions

- Group therapy directed at war-affected mothers providing supportive group psychotherapy, psychoeducation and parenting support to mothers in order to target their depression as well as health and developmental outcomes in their young children
- A group intervention aimed at addressing current daily stressors facing children living in refugee camps
- Trauma/grief-focused psychotherapy administered by teachers within a school setting
- Classroom Based Intervention
- A group therapy developed for victims of torture which integrates components of a number of supportive group psychotherapy and cognitive behavioral techniques
- An individual intervention: Trauma Focused Therapy/ Narrative Exposure Therapy (NET) - a short-term therapeutic intervention that integrates components of cognitive behavioral therapy and storytelling

These interventions have been used in various war-affected communities including Kosovo, Bosnia, Sudan, northern Uganda and the Gaza Strip. Though we are not aware of any clinical interventions that have been developed specifically for the treatment of mental health symptoms and impairment in former child soldiers, we highlight in our report two models that may be promising in the context of former child soldiers: the Center for Victims of Torture model and the Classroom Based Intervention model. Both of these intervention models integrate components of supportive group psychotherapy and cognitive behavioral therapy which are indicated in the clinical literature as effective for addressing disorders such as depression, anxiety and some aspects of complex trauma. To date, no formal evaluations exist of any evidence-based mental health interventions directed at former child soldiers specifically.

EXISTING GAPS IN SERVICE DELIVERY PROGRAMS ADDRESSING DEMOBILIZED CHILDREN AND COMMUNITIES

As a whole, a great deal of the evidence presented in this report suggests that many former child soldiers manage to carry out productive, healthy lives, particularly when provided with some basic assistance to pursue schooling or develop a trade (basic psychosocial interventions). The main challenge that remains is in assessing and matching the appropriate level of care to the needs of the individual. Systems must be developed to ensure that all war-affected youth get basic services and that screening, referral and treatment systems are in place to ensure that individuals needing a higher level of mental health care receive it. In order to advance both psychosocial and clinical services for former child soldiers, several key principles are imperative. They include the following:

- Local communities need to be involved in the development and evaluation of interventions
- Interventions need to be provided to address risk factors and capitalize on protective processes and local healing traditions at all levels of the social ecology (rather than taking a deficit-oriented approach)
- More research needs to be directed at improving the measurement of mental health constructs cross-culturally to ensure better assessment and the matching of level of need to the level of service and improving evaluation

- With improved and locally-relevant evaluation and screening techniques, service providers must invest in evaluating the outcomes of their interventions
- We need to invest in the technical assistance, human resources, and financing of systems of prevention, protection, and care that will last beyond the typically brief period of humanitarian relief characteristic of emergency humanitarian response

Specific gaps in psychosocial and clinical services for former child soldiers and other highly-traumatized groups of war-affected children highlighted in the report include:

- Assessment and treatment planning
- Training, professional development and supervision of service providers
- Staff retention/burnout and self-care
- Developing systems of services for war-affected youth and families (post DDR strategies for providing services)
- Evaluating cost effectiveness of interventions

RECOMMENDATIONS

Our review of the state of the field of services and research for former child soldiers indicates a wealth of programmatic effort, but only nascent research. The field is experiencing a welcome period of growth in critical policy analysis, applied research, and evaluation of common interventions. The following recommendations point to a number of compelling new directions for service responses and research.

SERVICES AND PROGRAMMATIC RECOMMENDATIONS:

- Holistic, integrated systems of care are needed for all war-affected youth. We discourage service systems developed only for former child soldiers and urge investments in locally viable and sustainable systems of psychosocial and mental health interventions for all war-affected youth with particular expertise to respond to highly traumatized groups. Care should be provided on the basis of needs (distress and persistent impairment) and not labels.
- The subscription by organizations to the false dichotomy between psychosocial and clinical mental health responses for war-affected children must end. Both approaches can make significant contributions to the care of war-affected youth and should be used in tandem. Initial psychosocial responses may serve as the first line of defense and clinical approaches may then be focused on targeting youth whose distress and impairment persist once basic psychosocial responses are in place. The IASC guidelines and pyramid of humanitarian responses should be used as a framework for this response.
- Although labels and assumptions about particular subgroups of war-affected youth may be harmful, we must recognize that the risk of persistent mental health disorders is high in certain profiles of youth, particularly former child soldiers who perpetrated extreme acts of violence or were its victims (i.e., prolonged sexual violence). Mental health assessment must be improved to contain information about a young person's trauma history and its implications for their care.

- Particular steps must be taken to ensure that war-affected females, particularly those who were child soldiers, are provided with the appropriate social and economic supports to ensure healthy reintegration. Service providers must recognize the double indemnity that girl soldiers face as extreme levels of exposure to violence are often compounded by increased risk of sexual violence, unwanted pregnancy and its social consequences.
- Service systems should be developed to capitalize on indigenous supportive responses and capacities. Local staff should be trained and mechanisms for sustainable funding and supervision put into place to ensure that psychosocial supports and opportunities for mental health care do not vanish once the period of humanitarian emergency subsides. The development of service systems should involve close collaboration and leadership from local governmental and nongovernmental actors in order to build technical capacity, collaboration and referral networks and the political will to develop and sustain systems of care.
- Training of local staff cannot be implemented without commensurate attention to developing mechanisms for routine supervision and professional development of local staff. Such interventions may improve the quality of care by reducing burnout and improving staff recruitment and retention.
- Psychosocial responses and mental health care are most effective when integrated with other service systems such as schools and primary care.
- The development of systems of care for enriching psychosocial supports and mental health care must be accompanied by improved investment in child protective services and social welfare systems to ensure a social safety net for extremely disadvantaged families in regions ravaged by conflict.
- Investments must be made in evaluating both the implementation and the outcomes of psychosocial and mental health services. To date, there is very little evidence on interventions or packages of interventions that have been proven as effective for improving both psychosocial and clinical mental health outcomes in former child soldiers. Interventions with evidence of potential effectiveness for assisting war-affected children should be evaluated with particular attention to subgroups of interest (former child soldiers, children with significant trauma histories, etc.).

RESEARCH RECOMMENDATIONS:

- Longitudinal research is needed in order to truly unpack forces of risk and resilience contributing to social and emotional outcomes in war-affected youth in general and former child soldiers in particular.
- More research is needed to better understand the consequences of child soldiering from a comprehensive bio-psychosocial and developmental perspective.
- Further research is needed to broaden and deepen the understanding of the factors that help to protect child soldiers from the consequences of war and that foster resilience to violence. Attention to understanding pathways of recovery is critical.
- Future research may be improved by integrating qualitative and quantitative methods in order to improve the culturally valid measurement of mental health and related constructs.

- Operational research is important for understanding how services function in terms of providing viable, sustainable and effective systems of psychosocial and mental health care for war-affected youth and families. Again, qualitative and quantitative research with beneficiaries and providers from front line staff to higher level leadership can illuminate critical issues in the implementation of mental health care in low resource settings.
- Participatory methods such as participatory action research should be implemented to improve opportunities for local people to set research agendas and focus on problems of local priority. Young people themselves have an important role to play in helping to set research agendas and help collaborate in studies on the situation of war-affected youth.
- Future research will be improved if it brings together the academic and the policy/practitioner worlds. A more directed collaboration in gathering data and providing analysis is critical to advance both research and practice.
- Future research with child soldiers should utilize relevant comparison groups of war-affected youth who were not involved in the fighting forces. This will lead to better contextualizing of the effect of war and violence on psychosocial adjustment.
- Future intervention research should examine the efficacy of adapted evidence-based interventions for mental health problems such as mood and anxiety disorders and complex trauma in war-affected youth. Intervention research should also explore the impact of traditional healing approaches and examine their potential to be integrated into treatment models. In this way, the identification of core components of treatment models will be better grounded in evidence of “essential ingredients” for addressing distress and impairment in war-affected youth in different settings.
- Ethical research on war-affected youth must involve close collaboration with local service providers both for ensuring that findings may be translated into improved care as well as for providing a referral network for research participants who may require immediate medial or psychological support.
- Cost effectiveness research is needed in order to bolster policy arguments about the importance of preventative investments in child and adolescent psychosocial and mental health care by local governments and international funders.

PART A: AN INTRODUCTION TO THE PROBLEM OF CHILD SOLDIERING

1. WHAT IS A CHILD SOLDIER?

Armed conflict is dramatically altering the lives of children around the world. UNICEF reports that in the last decade conflicts have killed an estimated 2 million children, disabled 6 million, and displaced an additional 20 million [1]. The changing tactics and technology of warfare today have exacerbated hazards to children. Wars are increasingly fought within states and involve non-state actors, such as rebel or terrorist groups, who are less likely to be aware of or abide by humanitarian law providing for the protection of civilians. The ongoing presence of child combatants in wars from Afghanistan to northern Uganda is a testament to this fact [2, 3].

Of the many dangers of war, abduction and child soldiering are considered particularly pernicious to child mental health and development. However, research in this area is scant. In 2001 the first Global Report on Child Soldiers documented that girls and boys were abducted or forcefully conscripted into government forces and armed groups in 87 countries over the past decade. At any given time, it is estimated that anywhere from 300,000-500,000 children are involved with fighting forces [4].

Children affiliated with fighting forces take on a number of roles, from being forced into combat and the commission of atrocities, such as pillaging villages and participating in mass rapes, to working as porters, cooks, servants, human shields, mine sweepers, guards, and sexual slaves.

> *I went on errands, pounded rice, laundered and cooked. I was given a lot of work to do. At that time I was small and never did those things for my mother but I could not refuse [the rebels]. If I refused I would be beaten up.* (Female, member of the Revolutionary United Front in Sierra Leone) [5]

> *They give you a gun and you have to kill the best friend you have. They do it to see if they can trust you. If you don't kill him, your friend will be ordered to kill you. I had to do it because otherwise I would have been killed.* (Bernardo, Male, member of army-backed paramilitary group in Colombia)[6]

Given the wide range of roles children fill as members of armed groups, the term "child soldier" itself has been criticized for promoting a misleading image of all child soldiers as boys with weapons. In fact, women and girls comprise a significant proportion of children involved with armed groups globally. In addition to being forced to act as combatants, women and girls abducted by fighting forces often face sexual violence, abuse and unwanted pregnancy, all of which involve serious health risks as well as social stigmatization and possibly isolation or abandonment [4, 7-10].

For these reasons researchers and practitioners have argued for the use of terms such as "children associated with fighting forces" (CAFF) or "children associated with armed forces and armed groups" (CAAFAG) instead of "child soldiers" in order to better represent the situation of children affiliated with armed groups, without emphasizing those who served mainly as soldiers. Although we agree with these

criticisms of the term "child soldier," for the sake of readability and clarity of this report we use "child soldiers" to describe all children associated with fighting forces, regardless of their role while associated with fighting forces and armed groups.

Although there continues to be much discussion over what defines a "child soldier," this report will use the widely accepted UNICEF definition of "any person under eighteen years of age who is part of any kind of regular or irregular armed force in any capacity, including but not limited to cooks, porters, messengers, and those accompanying such groups, other than purely as family members. Girls recruited for sexual purposes and forced marriage are included in this definition. It does not, therefore, only refer to a child who is carrying or has carried arms." This definition of child soldiers includes those who are recruited forcibly as well as those who join voluntarily [11]. In this report we also use the terms CAFF to refer to children associated with fighting forces and ex-CAFF to refer to children who have been reintegrated back into their communities after spending time with an armed group.

2. PREVALENCE OF CHILD PARTICIPATION IN ARMED CONFLICT

It is extremely challenging to obtain accurate data on the prevalence of child soldiering worldwide. Thousands of children have exited fighting forces in the last five years as wars ended in countries such as Afghanistan, Angola, and Sierra Leone, yet thousands more have been drawn into new conflicts, for example in Cote d'Ivoire, Sudan, and Chad. It is estimated that nearly half a million children are involved with fighting forces worldwide at any given time [4, 12]. In 2005 it was estimated that children served as combatants in over two-thirds of current or recently ended conflicts. According to the Coalition to Stop the Use of Child Soldiers, the problem is most critical in Africa, where up to 100,000 children, some as young as nine, were estimated to be involved in armed conflict in mid-2004 [13, 14].

Child soldiering is not a problem unique to particular countries; it is a regional problem that feeds a cycle of violence and instability. Porous borders, limited opportunities for children and former child soldiers in particular, coupled with mass population movements and displacement leave entire regions unstable and ripe for the recruitment of children into armed forces [15-17]. It should be remembered, of course, that although children under age 18 are recruited regularly by paramilitary and rebel armed groups, national governments, including countries such as the United States and the United Kingdom that are not considered "totalitarian," also recruit youth under the age of 18 into military service.

3. CIRCUMSTANCES UNDER WHICH CHILD SOLDIERS ENTER FIGHTING FORCES

Many child soldiers are abducted and forcefully recruited into armed forces. Villages are raided and children are abducted in large numbers from their homes, schools, or work settings. In most cases, the recruiting forces threaten the child with death if he/she refuses to go along. In other instances, members of the child's family are threatened to be killed if he/she refuses to join. Often abduction itself is accompanied by witnessing terrible acts of violence [5, 16].

> *They had attacked my village and were burning down the town…when we were attacked and captured by the rebels, they killed my mother, uncle and brother right there but they took my sister and myself along with them.* (Female, member of the Revolutionary United Front in Sierra Leone) [18]

While forced recruitment is common, there are other situations in which children join armed forces "voluntarily." They may see joining an armed group as necessary for their survival [3]. Poverty, chronic hunger, insecurity, and the inability to provide for themselves and their families often compel children to join armed groups as they see the promise or the reality of an income or a means of protection [6, 15].

> *I had to run away to a forest with my friend to join the underground. I was 14 when I first held a gun in my hands. I love to go to school but for the poverty of my family I have to lift a gun. Now I am earning enough money with the help of the gun for myself and can send money for my family also.* (Male, Northeast India) [4]

Some children join armed forces to avenge the death or physical harm of family members or humiliations inflicted on their ethnic, racial, or religious group. Coupled with this may be a desire for power, status or social recognition, or social inclusion. Family and peer pressure to join for ideological or political reasons or to honor family tradition may also be motivating factors [15]. Still other children join to escape abusive family situations; girl soldiers have reported joining in order to escape domestic servitude, forced marriage, domestic violence, exploitation, or abuse. Finally, some children enlist due to ideological commitment to the cause.

4. AGES OF CHILD SOLDIERS

By definition, child soldiers are under age eighteen. Teenagers (age 13-18) are most often targets of recruitment because of their relative size and strength, their advanced mental and cognitive development, and their role in many societies (particularly those facing the difficulties of conflict) as being much like adults with responsibilities for helping to care for their families. Many younger children have been purposely recruited in some conflicts, such as Sierra Leone, Liberia, and the Democratic Republic of the Congo (DRC). Indeed, the age of recruitment for child soldiers appears to be trending downward worldwide. Smaller children are attractive to military leaders because they are easier to control. In combat situations, smaller children are often fearless and they are now able to wield increasingly light and cheap weapons such as the AK-47 assault rifle [20, 21].

5. GIRLS IN ARMED CONFLICT

The stereotypical view of child soldiers as teenage boys masks the widespread participation and recruitment of girls: according to some estimates, girls comprise up to 40% of child soldiers worldwide [9, 22] and were members of fighting forces in 38 countries from 1990 to 2003 [6].

The usual hardships of fighting and war are further compounded by gender-based violence. For girls in particular (although not exclusively), rape and sexual violence are common (and normalized) in many armed groups and throughout war-affected regions. Abduction puts girls at particularly high risk of rape and sexual abuse.

> *They would eat and drink, then they would call for you. They were so many. It was so painful… If you refused, they used sticks to whip you… They all had sex with me… A man would come, then another and another. I wasn't even the youngest. Some girls were even younger than me. Even the commanders called for you… They said they'd kill you if you ran away.* (Female, abducted at the age of 13 by an armed group in Burundi) [6]

In a minority of cases armed groups abduct girls, but prohibit sexual violence and exploitation of these recruits. Even in these groups, however, while sexual exploitation may not be overt, girls often become sexually involved with male fighters and commanders in order to gain protection and resources such as food and clothing, and to avoid the most dangerous or difficult tasks. These often abusive relationships, the legacy of years of sexual violence and the intricacies of young and unplanned motherhood, pose particular challenges to the successful reintegration of female former child soldiers. As our own research in Sierra Leone has demonstrated, girl soldiers may also face increased levels of community stigma upon return to their communities, grounded in perceptions that these girls are defiled and sexually immoral following their time with rebel forces [24].

6. DISARMAMENT, DEMOBILIZATION, AND REINTEGRATION INTO CIVILIAN LIFE

Disarmament, demobilization, and reintegration (DDR) refers to the process by which soldiers are returned to civilian life following conclusion of a conflict. DDR programs aimed specifically at child soldiers have been established in many countries, both during and following armed conflicts, including processes in Nepal, Mozambique, Angola, Liberia, and Sierra Leone.

The first step in DDR is disarmament, wherein soldiers turn in their weapons, which are then usually destroyed. The second step is demobilization, the formal disbanding of armed groups and release of combatants into civilian society. The third phase, reintegration, is a much longer and, from our perspective, the most difficult process. This is also the phase wherein psychosocial issues begin to take precedence. Reintegration can be a treacherous journey for young people carrying the invisible wounds of their war experiences while facing stigmatization, and lacking livelihoods, education, and skills needed to construct a positive role in society. Unsuccessful transitions into civilian life leave former child soldiers at increased risk of mental health problems, re-recruitment, and other forms of exploitation [19]. As such, reintegration programs must involve long-term solutions, such as skills training and job provision. Unfortunately, many DDR programs have been hampered by inadequate funds and other resources. In addition, despite growing recognition of girls' involvement in armed conflict, girls are often deliberately or inadvertently excluded from DDR programs [6].

Reintegration programs for children usually contain the following elements: 1) Immediate medical and psychosocial care through interim care centers to support children during transition and prepare them for reintegration into civilian communities; 2) Sensitization of communities via open community discussions regarding the return of ex-CAFF (to promote forgiveness and acceptance); 3) Family tracing, reunification and family reintegration assistance. Such assistance usually involves locating parents or other relatives, helping children readjust to living at home within the family structure; 4) Support to communities to assist them in supporting reintegration, such as through community-based systems of monitoring and problem-solving; 5) Provision of initial support for school fees or vocational skills training; and 6) Individual follow-up including efforts to teach conflict resolution skills and ensure that community sensitization events succeed [25-28]. In this context of interim care and community follow up, psychosocial support is commonly provided for some period of time. The focus of such support is to help former child soldiers to carve out new roles for themselves in the community and to construct civilian identities apart from their identities as soldiers. This support may include use of both Western and indigenous methods (including rituals and spiritual cleansing activities) to help heal the psychological trauma resulting from involvement in war.

PART B: A REVIEW OF THE LITERATURE

War and other conflicts destroy political, economic, and social institutions, and children often suffer the worst consequences. A growing body of research has described the psychological impact of war and violence on youth in general, focusing especially on the prevalence of internalizing (e.g., anxiety, depression), traumatic stress reactions (e.g., Posttraumatic Stress Disorder, or PTSD) and externalizing problems (e.g., aggression, hostility). In war-affected children overall, high rates of psychopathology have been found in diverse cohorts of children exposed to terrorist attacks [29], who witnessed deaths of family members [30, 31], or experienced displacement [32-35] and other war traumas. Among war-affected youth, children affiliated with fighting forces (CAFF) often experience more extreme violence and trauma and are forced into lengthy periods of deprivation, rape, torture, war injuries, substance abuse, and suicide [15, 17, 36]. These exposures present significant risks to their psychological wellbeing not only during the conflict but also post-reintegration [36-38]. Despite the wealth of research with war-affected populations, little is known about the long-term impact of participation in armed groups on children's reintegration and psychosocial adjustment. With a growing number of former child soldiers in various parts of the world, identifying the nature, magnitude and distribution of these effects is critical.

Much of the available research on former child soldiers has involved interview-based, ethnographic case studies [37, 39-41]. A great number of advocacy briefs, program summaries and policy analyses [6, 17, 42-47] have been prepared, but there is actually very little research on former child soldiers in the published, peer-reviewed literature. Appendix 1 lists the literature we reviewed for this report and documents the small number of empirical quantitative research studies that were found. As shown in the table, only a handful of survey-based quantitative studies exist [48-50].

Three very important notes are in order before we begin to summarize the literature in the field.

1. One very important measurement problem in the literature on child soldiers is the imposition of Western constructs of mental health (such as Posttraumatic Stress Disorder, depression, anxiety, etc.) that are rarely validated locally. Most studies use quantitative instruments based on Western mental health concepts such as those defined in the Diagnostic and Statistical Manual of the American Psychiatric Association/DSM-IV-TR (APA, 2000) or the International Classification of Diseases/ICD-10 (World Health Organization, 2006). These choices are usually based on prior assumptions as to what the major mental health problems will be and how they will manifest locally. Yet, it is not always known how appropriate such Western concepts and diagnostic criteria are in these settings. It may be that concepts central to diagnosing disorders such as PTSD and depressive disorders in American and European psychiatry (and by extension, instruments based on these concepts) are not easily compatible with local concepts.

2. A large methodological criticism of the studies to date is the rare use of representative samples and adequate comparison groups. Because of these issues, many of the studies we review here are limited in their ability to be generalized more broadly to other contexts. We illustrate later in the paper that researchers often report varying and at times even contradicting results. While this may be partly due to context, methodological issues are also at play.

3. The majority of studies in the field are cross-sectional, thus findings from these studies provide a window into the mental health and wellbeing of former child soldiers rather than representing trajectories of adjustment. Our ongoing research in Sierra Leone represents one attempt to understand the trajectory of psychosocial adjustment of former child soldiers. As far as we know only one other longitudinal study exists, which followed a small cohort of child soldiers from Mozambique over a period of 16 years and outlined some of the long-term effects of participation in armed forces [51].

1. THE PSYCHOSOCIAL ADJUSTMENT AND MENTAL HEALTH OF CHILD SOLDIERS

WHAT IS PSYCHOSOCIAL?

The diverse and often violent experiences of armed conflict have profound effects on child development and wellbeing. The term "psychosocial" is intended to underline the dynamic relationship between psychological and social effects, each continually influencing the other. "Psychological effects" are those that affect emotion, behavior, thoughts, memory, learning ability, perceptions and understanding. "Social effects" refer to altered relationships due to death, separation, estrangement and other losses, family and community breakdown, damage to social values and customary practices, and the destruction of social facilities and services. Social effects also extend to the economic sphere as many individuals and families become destitute through the material and economic devastation of armed conflict. Later in this report we will review how the term psychosocial is used in conceptualizing and implementing interventions.

This section examines the most relevant studies in the field, beginning with research that emphasizes the negative effects of war on former child soldiers. We then present compelling evidence that not all child soldiers exhibit negative maladjustment outcomes and that various factors during and following conflict can play a significant role in shaping the psychosocial wellbeing of these children.

1.1. PSYCHOLOGICAL EFFECTS

Using various measures of psychosocial wellbeing and mental health, a number of cross-sectional survey studies with former child soldiers have reported high levels of psychosocial problems following reintegration. For instance, Allen and Schomerus [48] collected data on a large (N=886), although non-representative, sample of combatants under 18 in Uganda. The report surveyed youth who had recently re-integrated into their communities after an often-brief stay at an interim rehabilitation center. Although the authors did not use standardized measures of mental health, they found high levels of psychological trauma and social dislocation among the former abductees. Also in northern Uganda, Derluyn et al. [49] evaluated 71 former child soldiers, using the Impact of Event Scale-Revised. Though this study has been critiqued due to its recruitment methods [52], the extremely high rates (97%) of posttraumatic stress reactions observed in their sample speak to the scale of the potential trauma. In addition, Bayer and colleagues [50] recently studied 169 former child soldiers in rehabilitation centers in Uganda and the Democratic Republic of the Congo and found that about one-third (34.9%) of the children interviewed met clinical symptom criteria for PTSD. Both studies provide a view into the severity and breadth of the challenges characterizing the psychosocial adjustment and mental health of former child soldiers.

It is important to note that these available quantitative studies involved data collection on samples of former child soldiers relatively soon after they returned to their communities or in a few cases while they were still undergoing the DDR process and were living in interim care centers. In contrast, research with former child soldiers in El Salvador has documented the extent of psychosocial problems nearly 10 years after the end of the war [28, 53, 54]. Although the study lacks data on mental health problems at the time of reintegration, it provides a valuable perspective on the enduring difficulties former child soldiers face. The authors interviewed 293 former child soldiers who had belonged to one of El Salvador's two armed groups (FMLN and the FAES) and explored the frequency with which the interviewees experienced mental and emotional problems resulting from their participation in the armed conflict. Although not all the interviewees showed signs of emotional problems, almost three out of five continued to have vivid memories and dreams of war-related violence, 20% suffered from constant insomnia and 16% had nightmares. In addition, 39% said that they felt tired and depressed quite often; a similar number of interviewees felt nervous; and 37% said they were easily annoyed and angered. These numbers are striking, given the amount of time that had passed since the end of the war.

To understand the long-term impact of participation in armed forces and processes of mental health adjustment over time, longitudinal studies are needed. In one of the first studies of the long-term psychosocial wellbeing of former child soldiers, Boothby [51] followed 39 male former combatants from Mozambique over a period of 16 years (from 1988 to 2003). Despite the small sample and qualitative focus of much of the study, results suggest that though a majority of the sample of former child soldiers made significant progress in returning to civilian life, none were able to fully escape their violent pasts. In 1988, while at the Lhanguene rehabilitation center in Mozambique, all of the boys experienced recurrent thoughts and memories of traumatic events, and the majority still did so 16 years later. In addition, 50% of the participants still reported emotional and physical reactions when reminded of hurtful or traumatic events. Overall, psychological distress symptoms persisted; the number of former child soldiers experiencing them as adults, however, was considerably lower than those who experienced them as children [55].

In our own research in Sierra Leone we interviewed 266 former child soldiers (male and female) at re-entry into their communities. Three years later, we were able to re-interview 133 youth from this original sample. Using a locally validated measure of psychosocial adjustment developed by the Oxford Center for Refugee Studies, we found that the average psychosocial problem scores in our sample remained stable between baseline and follow up two years later [56]. Overall, the former child soldiers reported similarly high rates of symptoms of depression, anxiety and hostility from baseline to follow up. Additionally, average levels of confidence and prosocial (positive) behaviors did not change significantly over time. However, subgroup analyses demonstrated that intimate victimization and perpetration were important predictors of deterioration in mental health over time (i.e., increased levels of depression and anxiety from time 1 to time 2). Such findings have important implications for planning and implementing mental health services. In particular, categorical programs targeting children by subgroups or category (i.e., all former child soldiers) are called into question. Improved assessment and screening is necessary to ensure that services are targeted towards youth with persistent indicators of distress and impairment rather than making assumptions merely by category or label.

At follow up in 2003/2004 we also added a group of self-reintegrated youth, increasing the total sample to N=266. We added additional measures of mental health problems to help examine particular constructs such as trauma in more detail. Consistent with the studies described above, we documented very high rates of depression 3-4 years following reintegration. Using standard clinical cut points for anxiety and depression on the Hopkins Symptom Checklist, 59% of our sample of 266 former child soldiers interviewed in 2003-2004 met standard diagnostic criteria for depression, and the same percentage met standard diagnostic criteria for anxiety. Similarly, the prevalence of symptoms of PTSD was significant in our sample: using the PTSD Reaction Index developed by researchers at UCLA, 37% of the sample met standard diagnostic criteria for Posttraumatic Stress Disorder [24].

The studies summarized above indicate a number of important points. First of all, on average, many former child soldiers show patterns of distress that are stable, if not somewhat improved over time. However, significant numbers of former child soldiers are likely to endure serious psychological problems not only immediately after coming home from war, but for many years after the traumatic war experiences. An important limitation of the research discussed thus far is that the results reported for former child soldiers are not contextualized with a comparison group of war-affected children and youth who were not exposed to participation in armed forces.

Few studies provide this type of rare comparison. In our longitudinal study in Sierra Leone, our baseline interviews with former child soldiers were compared to assessments of 135 community youth who were not associated with the RUF. Our data indicate comparable rates of psychosocial problems, including depression, anxiety and hostility, among former child soldiers and children not associated with armed groups [56]. We also found no significant differences between former child soldiers and the comparison group in terms of positive psychosocial adjustment outcomes, such as confidence and prosocial behaviors [19]. These findings point to the pervasive impact of the war on the lives and psychosocial wellbeing of all children and adolescents in war-affected regions.

Perhaps the most thorough and methodologically sound research that compares the psychosocial wellbeing among formerly abducted youth to other war-affected youth is the Survey of War Affected Youth (SWAY) in northern Uganda [57]. This is a representative survey of 741 youth (14-30 years of age), 462 of whom were once with the Lord's Resistance Army. Like the majority of studies with former child soldiers, the youth provided data on their war experiences (i.e., self reported and retrospective) as well as their current wellbeing. Measures of violence, social support, hostility and distress were adapted from the Harvard Trauma Questionnaire, and the Northern Uganda Child and Youth Psychosocial Adjustment Scale.

The SWAY study found less support for the prevailing view that participation in an armed group leads to broad-based psychological distress and aggression. When compared to children never abducted by fighting forces, average levels of psychological problems among former combatants appeared mild to moderate, with serious distress concentrated in the minority of participants who personally experienced extreme violence (including perpetration of violence) which represented roughly a sixth of the abductees in their sample. In addition, the correlation between abduction and aggression was weak or non-existent [57, 59].

At least one additional study compares the psychological impact of participation in armed forces on children and adolescents to the impact of war on children not associated with fighting forces. In Nepal, Kohrt [60] surveyed 140 returned children and 142 children never associated with armed groups. Similar to SWAY's results, Kohrt found that returned children exhibited moderately higher functional impairment and moderately higher psychosocial problems (aggression, depression, anxiety, and posttraumatic stress) as compared to never-associated children. Similar to our results in Sierra Leone, the study also found that never-associated children and returned children did not differ on positive psychosocial wellbeing measures or on conduct problems.

1.2. EDUCATION AND LIVELIHOOD OUTCOMES OF CHILDREN ASSOCIATED WITH FIGHTING FORCES

Few studies have explored in detail the impact of participation in armed conflict on children's education and livelihoods following reintegration. The most detailed analysis of this aspect of reintegration is provided by the SWAY study from northern Uganda. Annan and Blattman [61] found that the most serious impact of abduction had to do with the education and earnings of former child soldiers. The longer time children spent in the captivity of a rebel group rather than in school or acquiring employment experience, the larger the gap in education outcomes, as compared to children not associated with fighting forces. Further, those who were abducted at younger ages were altogether less likely to return to school after abduction.

Because of schooling loss as well as serious injuries suffered during the war, on average former abductees were half as likely to be engaged in skilled work. These constraints further reduced by a third the average wage earned by these adolescents post reintegration.

Research on former child soldiers from El Salvador reinforces the concerning patterns of economic and educational outcomes [53, 62]. Ten years after reintegration, the study found that over 50% of the male participants worked as farmers, almost 70% of the females were housewives, and only 5% of interviewees were employed in a job or trade. The significance of the majority working in farming or in the home is reflected by the fact that 51% did not have their own income and almost all interviewees reported that poverty and lack of economic stability was their primary concern. In general, former child soldiers had very low income levels compared to the standard income for other families in El Salvador.

In his longitudinal study of former child soldiers in Mozambique, Boothby [51] attempted to describe the economic outcomes of the 39 participants in his sample in terms of the extent to which this group of former child soldiers had been able to overcome the time spent away from fulfilling normal life milestones in rural Mozambique. Several indicators were employed to explore this question: household income, housing and food security, as well as children's health and educational status. Contrary to results from the SWAY and El Salvador studies, Mozambican child soldiers in Boothby's study, despite disruptions to their life trajectories, appeared to fare as well as, and often better than, national averages for these socio-economic and child welfare indicators. Ninety-one percent of the former child soldiers had owned their home, virtually the same as the national average of 91.7%. While all of these former child soldiers were engaged in farming, 63% of them also earned additional income from wage labor endeavors, higher that the national average of 38% for off-farm activities by rural inhabitants in Mozambique [51, 55].

It should be noted, however, that while the former child soldiers in Boothby's study appeared to be doing well, all reported that their daily economic situation has been, and continues to be, one of the major obstacles in their transition to civilian life, a finding that resonates with the results from the El Salvador study. It appears that one of the most devastating outcomes of child soldiering is the years of lost educational and economic opportunity that also makes it difficult to attain key lifecycle milestones. Many of these former child soldiers reported these challenges to be more problematic than the actual experiences of the war.

1.3. SOCIAL REINTEGRATION OF CHILDREN ASSOCIATED WITH FIGHTING FORCES

Overall, existing research lacks an understanding of the effects of participation in armed conflict on the social reintegration of child soldiers. In previous sections we discussed studies that recorded high levels of hostility among returning child soldiers [19, 56]. In addition, Bayer [50] studied community reconciliation among former child soldiers in Uganda and the DRC. The former child soldiers in his study who showed clinically relevant symptoms of PTSD had significantly less openness to reconciliation and significantly greater feelings of revenge than those with fewer symptoms. This finding suggests that posttraumatic stress reactions might hinder children's ability to deal with and overcome emotions of hate and revenge upon returning home and may contribute to patterns of aggression and hostility among these youth. In our own study in Sierra Leone we too found a positive association between PTSD symptomatology and average levels of hostility.

In a recent study of gangs in El Salvador, 10.2 percent of gang members were former combatants [53]. In addition, 13% of former child soldiers interviewed 10 years after reintegration admitted knowing former child soldiers who participated in delinquent activities and gangs. On the other hand, in terms of social roles, 79% of former child soldiers interviewed in El Salvador reported being fairly or very satisfied in their civilian roles as fathers, mothers, workers, and community members. Satisfaction with their roles in civilian life is also reflected in data showing an expression of future orientation: despite chronic poverty, 89% of former child soldiers surveyed were optimistic about the future.

The longitudinal study of Mozambican former child soldiers also confirms this pattern of overall positive social reintegration. Almost all 39 of the "Lhanguene boys" were married and the overwhelming majority of their spouses characterized them as "good husbands." Most wives approved of the roles and commitments their husbands had in their relationships, house maintenance, and childcare and support [51]:

> *My husband helps me with the children. When I ask for money, he gives it to me if he has any. He doesn't spend it on drinking like some other husbands.*
>
> *He often looks for work. Usually, he does not find any, but when he does it helps us a lot.*
>
> *He is a good man. He is kind to me and takes good care of our daughters.*

Boothby's Mozambique study also collected qualitative data about the parenting styles of former child soldiers and found that former child soldiers were in general supportive and engaging in interactions with their children. Moreover, all of the former child soldiers who were parents wanted their children to

experience a better childhood than they had had. Most saw schooling as the "best way" to ensure a "good future" for their children. Indeed, 75% of this group's school-aged children were attending primary school, which was considerably above the national average of 52% [51].

In sum, not much quantitative research has documented the psychological, economic and social adjustment of former child soldiers. The research that has been conducted to date demonstrates that these children experience real mental health problems following their association with fighting forces during conflict. These problems plague them for years, although some problems attenuate with time. Surprisingly, when the psychological wellbeing and problems of these former child soldiers are compared with those faced by children in the same geographic areas who were not directly involved in the conflict but were subject to the indirect effects, the results are similar with the exception of former child soldiers who were exposed to the most extreme forms of trauma. This suggests trauma, violence and loss are widespread in area of armed conflict and affect both child soldiers and youth not associated with armed groups. Later sections of this report offer a much more complex view of the effects of violence on child soldiers, by demonstrating the factors and characteristics of child soldiers that lead to better or worse psychosocial adjustment.

Further, the research to date documents that one of the most devastating outcomes of child soldiering is the years of lost educational and economic opportunity that lead to difficulties in attaining key lifecycle milestones. Many of these former child soldiers reported these challenges to be more problematic than the actual experiences of the war. Despite the little research that has documented the social aspects of child soldiers' reintegration, results suggest that that a large part of former child soldiers are successfully able to adapt and function as civilians, and take on roles of husbands, fathers, mothers and community members. However, youth with serious mental health disorders may face a more difficult pathway to social reintegration.

2. DETERMINANTS OF PSYCHOSOCIAL OUTCOMES

JAMES, A 22-YEAR-OLD FORMER CHILD SOLDIER FROM SIERRA LEONE

James was abducted into the fighting forces at the age of 11 by a commander from the Revolutionary United Front (RUF) in Sierra Leone. He spent 2 years in captivity during which time he was trained as a soldier. He was forced to fight in battles; if he refused the rebels would beat him and threaten to kill him. James was sexually abused while with the RUF and was forced to take drugs before battles. He tried to escape but was unsuccessful. At age 22, James now lives with his uncle and step-aunt. He was not accepted well when he first returned to his community. He was provoked and "called names." Upon a follow-up interview two years later, he feels that people are starting to accept him and treat him better. At home James feels misunderstood – his step-aunt yells at him, calls him a "rebel," and often withholds food from him. James is in second grade and he feels like he is "too old for school." James tries to do the "right things" but often he gets into fights because he "gets mad from the inside" and loses control over his actions. Often he sits and thinks about the difficulties he experienced while with the rebels and he feels "lonely and lost".

MARIAMA, A 17-YEAR-OLD ADOLESCENT FROM SIERRA LEONE

Mariama was 10 years old when she and her sister were abducted by the RUF and stayed with the rebels for 5 years. While with the RUF, Mariama was forced to do domestic work and did not participate in armed combat. Her sister provided support and care for her and intervened on her behalf when soldiers would try to hurt her. Mariama was happy to return home. She was welcomed by her community with a series of ceremonies that made her feel "happy." She was reunited with her mother and sister and was able to start school right away. At the time of our last interview in 2003, she had a stable home and attended school regularly. She has many friends who help her not to think about the past and a supportive family who encourage her to continue her schooling. With the help of her teacher, Mariama passed three grade levels in one year. She feels proud of her accomplishments at school. Mariama is hopeful for her future and career. She wants to become a doctor.

As the two vignettes of participants from our study in Sierra Leone indicate, not all child soldiers are affected by war in the same way. Mariama and James differ in regard to the nature, duration and severity of their war experiences. They also differ in regard to their post-war situations - they differ by gender, accumulation of post-conflict difficulties, and access to peer, family and community support. Former child soldiers have complex and diverse experiences both during and after the war, and these experiences likely shape their psychosocial outcomes and adjustment trajectories [45, 63-65].

In the following sections we focus first on describing available evidence of the impact of war exposure and experiences on the psychosocial wellbeing of former child soldiers. Next, we discuss the post-conflict factors that may exacerbate or ameliorate the effects of war and violence on individual mental health and reintegration outcomes.

2.1. WAR EXPOSURE

> *"My friend, his brain was shattered and there were worms. . . ."* (Sri Lankan male)
>
> *"After the attack we came back to our village. Our lane was full of dead bodies. The houses were still burning. The whole village had this smell . . . the smell of dead bodies"* (Sri Lankan female) [66]

Studies with former child soldiers are consistent in reporting very high levels of exposure to violence among children associated with fighting forces. War exposures from our study in Sierra Leone reveal high levels of violence experienced by former child soldiers that is representative of that reported in many other studies. For instance, we found that 70% of the sample had witnessed beating or torture of others, 63% had witnessed violent death, 77% had witnessed stabbing, chopping or shooting at a close distance and 52% witnessed massacres of many people. These rates of exposure to violence were comparable among females and males.

While average percentages vary by country, overall, research in Uganda, the DRC, Sierra Leone and Angola have reported high rates of former child soldiers being forced to kill other people, including in some cases family members or friends. For instance Bayer [50] found that 64% of the former child soldiers from the DRC and 36% of Ugandan child soldiers interviewed had killed someone personally during their time

with the fighting forces. Moreover, females have been shown to commit violence at surprisingly high rates as well [50, 57, 67]. In our study in Sierra Leone, we found comparable rates among males and females in terms of having killed a stranger or a loved one.

Aside from committing violence, a vast majority of former child soldiers in many parts of the world have had violence inflicted upon them. Typically violence inflicted on children associated with fighting forces includes beatings, imprisonment, forced labor, witnessing of killings, sexual abuse, and injuries. In our research in Sierra Leone, 62% of participants reported being beaten by armed forces and 39% were forced to take drugs regularly (a tactic often used by armed forces to give children a "high" that makes them more fearless in their participation in battles). In addition, 27% of participants reported being injured or developed a disability as a result of their time with the fighting forces.

Few studies include a substantial number of females, and it is therefore difficult to find accurate examinations of sexual abuse by gender, beyond anecdotal and qualitative reports [8, 10, 68]. The studies that do exist show disturbingly high rates of gender-based violence. In our research in Sierra Leone, more than a third of the sample reported having been raped/sexually abused by armed forces, with females reporting sexual abuse at six times the rate for males. Bayer [50] reported even higher rates of sexual abuse in his study: 57% of female participants in Uganda and the DRC combined. Derluyn et al.'s [49] study in Uganda recorded sexual abuse among 35% of the female participants. It is important to note that while it may be taboo to discuss in many cultures, boys may also experience some degree of sexual abuse, as evidenced by our study in Sierra Leone, where 6% of male participants reported being sexually abused.

Differences in violence exposures among conflicts are to be expected as not all wars are fought in the same way. In addition, cultural differences may also play a role in determining how males and females participate in wars. Despite contextual differences, however, we see very high levels of violence exposures overall, among both males and females.

Violence exposure appears to have a strong impact on psychosocial wellbeing. In the SWAY study, Annan and Blattman [69] found that high levels of violence committed and violence experienced were associated with higher rates of emotional distress. Research with Nepalese former child soldiers further substantiates an association between the number of traumatic war experiences and psychosocial outcomes [61]. Kohrt [60] found that children who experienced more traumatic events were more likely to have symptoms of posttraumatic stress and impaired daily functioning compared to children with exposure to fewer traumatic events.

Contrary to these findings, two studies looking at the cumulative effect of war experiences on the psychosocial adjustment of former child soldiers did not find positive association. Bayer [50] recorded no significant relationship between total number of traumatic experiences and PTSD symptoms. Similarly, in Derluyn's [49] study of Ugandan child soldiers, the number of traumatic experiences and the kind of the trauma experienced seemed to have little effect on the posttraumatic stress reactions.

These differing results may be due to the fact that not all war stressors are equally detrimental to children's psychological wellbeing. Simply totaling all war-related exposures as a scale together may in fact hide the specific impact of certain experiences. Our study of psychosocial outcomes among former child soldiers in Sierra Leone provides a new level of complexity to the relationship between war exposures and mental health adjustment. Rather than adding up all war exposures as a single continuous score, we chose to examine the association between total war exposures and mental health outcomes by disaggregating the construct of exposure to violence into four concrete categories. These categories were: 1) witnessing of violence (e.g., witnessed the death or beating of someone); 2) being a victim of common RUF-related violence (e.g., being beaten or chased by fighting forces); 3) intimate victimization (e.g., rape or being forced to take drugs) and 4) involvement in/perpetration of violence (e.g., injured or killed a stranger or took part in process). Our analysis shows that in fact not all forms of violence exposure lead to higher levels of psychopathology in children associated with the fighting forces [24]. In particular, we found that intimate victimization and perpetration of violence were the strongest predictors of symptoms of depression, anxiety, hostility, and PTSD. These two categories of war exposures appear to be more traumatic for children and thus have a stronger impact on psychosocial adjustment post conflict.

Research with former child soldiers in El Salvador found another interesting pattern related to violence exposures and mental health [54]. Participants were not asked about all war experiences they endured, but instead were asked about the worst experience they had suffered during the war. The different responses allowed four categories to be created from these negative experiences: the death of significant individuals or family members; attacks or clashes; being injured in combat; or being permanently wounded. Amongst these, participants who identified the death of family members as their worst experience reported the highest average mental health problems. The group who reported the second highest level of mental health problems were those who experienced permanent wounding or injury in combat. In fact, the rankings for these two groups of individuals were significantly different from the other categories and again point to the particularly toxic nature of intimate trauma.

2.2. METHOD OF JOINING THE ARMED FORCES AND ROLES WITHIN THE ARMED FORCES

Few studies have explored the relationship between the role children played while associated with armed groups and the adjustment outcomes they report. In many conflicts, children were assigned multiple roles over the course of their association with fighting forces, while in others children were recruited and trained for specific purposes only [5, 16, 17]. Some of these roles have been shown to have different impacts on psychosocial wellbeing. For instance, Kohrt [60] found that children who served as combatants experienced more psychosocial distress at the time of reintegration than children who served as messengers, spies, or guards. This is not surprising, since children acting as combatants were likely exposed to more violence and traumatic events.

As previously discussed, children join the fighting forces for a number of reasons, including by abduction, threats, pressure, and voluntarily (i.e., because they believe in the cause of the war). Research indicates forced abduction as the norm in some conflicts, such as Sierra Leone and Uganda, while in other conflicts, like those in Nepal and El Salvador, many young people joined armed groups absent abduction. We are familiar with only one study that explored the relationship between the manner in which children join the armed forces and their post-conflict psychosocial functioning. In Nepal children who reported being coerced

and forcefully conscripted into the armed groups (43%), children who felt pressured to join (38%), and children who joined because of poverty (24%) were much more likely to have psychosocial problems after their return to the community as compared to children who joined the armed group voluntarily (28%) [60].

Ideological commitment among child soldiers is related not merely to the manner in which a young person comes to be part of a fighting force, but it also appears to be related to psychosocial outcomes following the conclusion of a conflict. One small study with child soldiers in Sri Lanka explored the impact of ideological commitment on posttraumatic stress symptoms [66]. The study focused on eighteen men and two women who had joined different Tamil armed groups in Sri Lanka between the ages of 13 and 17 years. Using the Impact of Events Scale to measure posttraumatic symptoms and qualitative methods to investigate the participants' ideological commitment, the study found that ideological commitment was a predictor of better mental health when exposure to violence was less intense. In other words, ideological commitment may have a significant protective impact on the development of severe posttraumatic symptoms among former child soldiers, particularly in the context of low intensity violence. However, particular events of exposure and time elapsed since combat-life appeared to have moderated this positive effect among the Sri Lankan child soldiers, a finding that emphasizes the strong impact of extreme violence exposure.

2.3. LENGTH OF TIME WITH THE FIGHTING FORCES

The duration that child soldiers spend with fighting forces appears to vary from conflict to conflict and these differences may play a role in the post-conflict adjustment of child soldiers. For instance, in Uganda a large number of the reported abductions were extremely short in length. Eleven percent of male abductions and 26% of female abductions were only one or two days in length [61]. Moreover, 28% of male abductions were less than two weeks. As a comparison, our data in Sierra Leone documents much longer average length of stay with the fighting forces – an average of 2.6 years among males and 3.1 years among females, with some young people reporting being with the fighting forces for over 8 years [24].

A number of studies have reported significant differences in mental health outcomes based on length of captivity, while other studies have not found associations between these two variables. For instance, in Sierra Leone we found that longer average length of abduction was associated with higher levels of symptoms of anxiety, depression, hostility and PTSD among former child soldiers [24]. In addition, the longer a child remained in captivity the greater the likelihood that he/she was involved in committing violence against others. In their research with male former child soldiers in Uganda, Annan and Blattman [69] confirmed this general pattern by documenting that the longer youth stayed with the LRA the higher the likelihood that they were given a gun (and potentially participated in battles), and the higher the likelihood of psychological maladjustment.

Boothby's [51] longitudinal study of former child soldiers affirms the impact of length of time spent with the armed forces on former child soldiers' psychological wellbeing. This research indicated that children who spent six months or less as a child soldier exhibited less severe symptoms and behavioral problems at the Lhanguene Center compared to those who spent one year or longer with the armed group. This trend continued into adulthood: adults who spent six months or less as a child soldier experienced psychological distress less often and less severely than those who spent one year or longer.

In contrast, the length of abduction was not found to be associated with mental health outcomes in studies of former child soldiers in Uganda, the DRC, and Nepal. Although Bayer and colleagues [50] found a strong relationship between length of abduction and number of traumatic events a child experienced, they were not able to show an association between length of abduction and levels of distress or openness to reconciliation. In addition, Kohrt [60] documented a wide range of time children spent with armed groups - from one month to almost five years - but no association between the length of time children spent with armed groups and their psychosocial distress.

2.4. AGE OF ABDUCTION

In our research in Sierra Leone, we found no significant association between the age at which a child joined the fighting forces and post-conflict psychosocial adjustment. Age of abduction was not strongly associated with war experiences children reported, suggesting that both younger and older children were equally likely to participate in violence and to endure abuses. Derluyn et al. [49] and Santacruz and Arana [54] also found weak associations between age of abduction and psychosocial distress in samples of child soldiers in Uganda and El Salvador.

RESILIENCE AND PROTECTIVE FACTORS

It is difficult to imagine how many child soldiers and war-affected children are able to be functional despite all they have endured, but it is important to recognize the role of protective factors that may mitigate the effects of potentially harmful experiences. The support of family, community and peer groups as well as educational and livelihood programs and traditional healing ceremonies may all help former child soldiers maintain moderate to high levels of functionality. In the section that follows, we will discuss the programs and services that are being conducted to assist former child soldiers globally. In Part D we will also discuss the impact of NGO-organized programs and psychosocial interventions on the wellbeing of returning child soldiers.

2.5. FAMILY ACCEPTANCE AND SUPPORT

Support from family members is among the most potent protective factors in the psychosocial adjustment and mental health of former child soldiers. The majority of qualitative [5, 51, 70-72] and quantitative studies [19, 54, 69] provide evidence of the integral role of the family in the reintegration of former child soldiers and their long-term mental health outcomes. Overall, research demonstrates that most families are generally willing to accept returning child soldiers and provide needed support and care. For instance, in northern Uganda, Annan and Blattman [61] found that family acceptance was remarkably high. Over 94% of the youth report being accepted by their families without insult, blame or physical aggression, and only 1% of youth report that their family was unhappy or unwelcoming upon their return. Studies from Sierra Leone, El Salvador, the DRC, Angola, and our own research in Sierra Leone also found relatively high levels of family acceptance.

Ten years after reintegration, researchers asked former child soldiers in El Salvador what factors had helped them overcome difficulties in their social and emotional transition to civilian life [54]. Four out of every five respondents indicated that, of all the factors that could have facilitated their process of reintegration, family was the most useful. In Boothby's longitudinal research with Mozambican child

soldiers, participants reported that they learned positive behaviors from their families and communities after they returned home from the war. The few former child soldiers who were deemed to be socially dysfunctional in the last wave of data collection reported that they had few if anyone to advise or support them. Boothby [51] concluded that the re-establishment of relationships with positive adult role models facilitated former child soldiers' transitions from survival-seeking behavior to security-seeking behavior and mitigated the cycle of violence.

A number of studies to date evidence the empirical link between family acceptance and support and subsequent psychosocial outcomes. For instance, studies in Uganda [61], Sierra Leone [19] and El Salvador [54] have demonstrated that former child soldiers with high family connectedness and social support were more likely to have lower levels of emotional distress and better social functioning. In our research in Sierra Leone we also found that family connectedness is linked to community acceptance. Our data revealed that children who were not well received by their families also faced higher community discrimination upon return, possibly indicating that family rejection signaled to the community that the child was dangerous or "unstable" [5]. These dynamics were further supported by our quantitative data.

One aspect of family relationships that may be pivotal to the psychosocial adjustment of former child soldiers is whether they are able to re-enter their own immediate families or whether they are placed with distant relatives or foster families, most often because their immediate relatives have been killed or displaced. We are familiar with two studies that examine the impact of family placement on the wellbeing of former child soldiers. Alexander [47] found that former child soldiers from Sierra Leone who were placed in foster care reported feeling unequal treatment and discrimination both within the community and in their homes. They described having to do more chores than the biological children of the adults and receiving less support in terms of food, clothing, and educational materials. While 85% of children living with a biological parent said they were happy with their family situation, only 30% of children living with "[an]other caretaker" said they were happy with their living situation.

Results from El Salvador, on the other hand, present contrasting views. Verhey [62] reported that almost equal proportions of children placed with their immediate families and with foster parents felt accepted and cared for. Much more research is needed on this topic to better understand the role of children's placement in their subsequent social and emotional wellbeing, especially in the context of different cultures.

2.6. COMMUNITY ACCEPTANCE/STIGMA

When discussing former child soldiers' reintegration and adjustment, it is critical to consider the way communities treat these children upon their return and the role community connectedness plays in mediating the negative effects of violence. Both qualitative and quantitative studies have emphasized the mechanisms by which communities can have both positive and negative impact on the psychosocial wellbeing of former child soldiers. In certain contexts, community members may be open to accepting a child back despite his/her war experiences, while in other contexts, community members may be scared or fearful of former child soldiers due to the atrocities these children may have perpetrated in their own communities.

In a number of contexts, including Sierra Leone, El Salvador, and Uganda, former child soldiers who indicated that they were easily accepted back into their communities had significantly lower levels of psychosocial problems as compared to those who experienced rejection and difficulty with reintegration [19, 54, 61, 62]. Lack of acceptance can take many forms, including insults and blame that community members may place on child soldiers. In Uganda, Annan and Blattman [61] reported that youth who were insulted or blamed described the experience as extremely painful. Those who were insulted by the community were three times more likely to have negative social behaviors and high emotional distress even when the insulting had ceased. Similar patterns emerged from our qualitative data in Sierra Leone and from data from Mozambique and Angola [25, 73, 74]. In Sierra Leone, despite sensitization campaigns in villages, a widespread initial community response was fear toward and alienation from the returned child soldiers. Our qualitative data revealed that adolescents who participated directly in combat and girls who were sexually abused more often reported experiencing stigma upon their return, confirming findings from previous research in the field [75-77].

> *Well they looked upon us negatively even when we were passing around there was no respect for us. People were pointing fingers at us saying that this one killed my father; this one killed my mother; that other one burnt down our house.* (Male, Sierra Leone) [18]

Lack of community acceptance during the initial phase of reintegration is potentially a critical risk factor because of the vulnerability of child soldiers, as they re-enter their community. Because most youth had already been victimized and mistreated during their time with the fighting forces, the attitudes with which they are accepted in their home community can be especially important and essential in a child's healing process.

2.7. OPPORTUNITIES FOR LIVELIHOODS AND EDUCATION

Economic issues weigh heavily on former child soldiers who often return to situations of chronic poverty, and limited employment opportunities. In this context, skills training opportunities have been shown to have a number of positive effects on the psychosocial adjustment of former child soldiers. In her groundbreaking report on war-affected children, Machel [20] emphasized the important link between literacy/skills learning and economic security for returning child soldiers, factors that often determine the successful social reintegration of returning children and prevent re-recruitment. Although no hard empirical data documents the importance and effectiveness of educational and skills training programs in regards to the psychosocial wellbeing of former child soldiers, a number of qualitative and observational studies report on this issue [67].

In a number of contexts, including Sierra Leone, Mozambique and Uganda, child soldiers who received education or skills training were able to acquire a job more easily. In their research in Uganda, Annan and Blattman [61] found that the economic returns on educational opportunities were substantial in their sample, such that the more years of education young people had, the better the chances were that they were engaged in gainful work. Another extremely important benefit of education and skills training is that young people can gain respect from their families and communities as persons who are capable of helping their families. Indeed, many former child soldiers in Mozambique indicated that obstacles to reintegration often stemmed from economic difficulties and their inability to help others when asked for money or other

necessities. When asked what external assistance could have been provided by the Lhanguene initiative, most former child soldiers reported that they wished they had received a professional skill set that would have made them viable contributors to their family economy [51]. Further, former child soldiers face issues of status and identity once back from war. Many are already perceived as "rebels" and "trouble for the community." A man who has a job or is in school to get a better education is viewed differently by neighbors and community leaders; in this way education and skills training could lessen the stigma and suspicious attitudes former child soldiers may face upon return. We found this link to be true in our study of former child soldiers in Sierra Leone: young people who were engaged in educational activities reported lower levels of perceived stigma and discrimination in their community.

Beyond the important livelihood benefits of education, attending school and training programs can help former child soldiers to attain a sense of normalcy and safety in their everyday lives, even when they have suffered losses [78, 79]. In our research in Sierra Leone we explored the link between participation in educational activities and psychosocial adjustment. Although we did not find an association between education and decrease in negative mental health outcomes, we found that children who were engaged in educational activities reported higher levels of confidence and prosocial behaviors [67]. Annan and Blattman also reported that in their sample higher education was associated with less risky income-generating activities for youth [61].

Finally, a young person who has a job and earns an income is viewed in many communities as eligible to take on the roles of a husband and father. Entry into such roles enables young people to redefine themselves and to shift their identity from soldier to civilian [16, 80]. All these benefits have strong implications for psychosocial wellbeing of returning young people.

2.8. TRADITIONAL HEALING CEREMONIES AND SPIRITUALITY

Traditional healing and cleansing ceremonies can be an important part of promoting reintegration and lessening psychological distress for former child soldiers. They can be ceremonies of welcoming, cleansing, and healing [60, 73, 81, 82]. Traditional healing can reduce the stigma and isolation of youths by communities that think of them 'contaminated' by their war experiences [82]. Ceremonies are diverse and can include ritual washing, fumigation [15], animal sacrifice [60], and presentation to the community [82]. Traditional healing can include pacification of or communication with spirits, including ancestors or the spirits of the people that a soldier has killed in war [39, 73, 61].

In Nepal, researchers found that traditional ceremonies took place mostly on the level of the family, rather than with the community as a whole. For example, *bhaakal garne* includes the welcoming of children home with an animal sacrifice as thanks for wish fulfillment. Community members speculate that this ceremony makes the child feel welcomed back into their family [60]. In the Acholi culture in Uganda, ceremonies were performed to free the youth from *cen*, or haunting spirits [61]. In Angola, ceremonies involve cleansing the youth of "the 'contamination' of war and death and the sin, guilt, and avenging spirits of those killed by a child soldier" [81]. Girls who are victims of sexual violence during war often experience significant discrimination upon return to the community and are often considered impure or bad luck. Cleansing rituals can be an important component of girls gaining acceptance by the community [8, 82, 83].

Much of the data regarding the efficacy of traditional healing is qualitative, and the effectiveness of these ceremonies in lessening distress and improving functioning in former child soldiers has had mixed outcomes [61]. Community members in a survey in Nepal stated: "The children do not believe in such things...they consider it superstition" [60]. Data from Uganda did not find a significant difference in the presence of nightmares in youth who did or did not receive a cleansing ceremony [69]. In regions where spiritual beliefs are heterogeneous, overuse of these ceremonies, especially if they are not aligned with children's beliefs, may not be helpful and could be detrimental to youths. Many children abducted by the Lord's Resistance Army in Uganda were compelled to participate in rituals against their will as part of the LRA; pressuring former child soldiers to take part in traditional rituals as ways of healing could be harmful in such a post-conflict situation [61].

Traditional healing practices for former child soldiers highlight indigenous ways of addressing trauma. Psychosocial interventions can benefit by understanding traditional beliefs about trauma and healing, and traditional and "Western" biomedical interventions can come together in a multifaceted approach to healing [73, 85].

2.9. PARTICULAR EXPERIENCES OF FEMALE CHILD SOLDIERS

Despite evidence that females are highly represented in the ranks of children associated with fighting forces, the empirical literature is severely lacking when it comes to understanding the war experiences and reintegration outcomes of girl soldiers. In the handful of empirical studies of child soldiers which exist today, the mental health outcomes of females have not been well documented. Boothby's 16-year study of Mozambican former child soldiers involved an all-male sample [51]. More recent studies documenting the mental health adjustment of children associated with fighting forces in Uganda [49] and the Democratic Republic of the Congo [50] involved relatively small samples of females or did not present findings disaggregated by gender.

In our research in Sierra Leone we found significantly higher levels of psychosocial problems (including depression, anxiety and PTSD symptoms) among females as compared to males. Sixty-eight percent of females as opposed to 55% of males met standard criteria for depression, and 75% of females and 51% of males met the criteria for anxiety. Surprisingly we also found higher levels of hostility and aggression among females and lower average levels of confidence and prosocial behaviors. In a study with former child soldiers in Nepal, Kohrt [60] also found that females were more vulnerable to mental health problems and reported lower functioning following reintegration as compared to males. These results suggest that gender is an important factor to consider in terms of the psychosocial reintegration of former child soldiers, both with respect to understanding their experience and providing appropriate assistance.

Aside from differences in mental health outcomes, males and females also differ in the way they are welcomed back in their communities. The consequences of sexual violence against female child soldiers during the war (physical injury; sexually transmitted infections, including HIV; traumatic stress) are often long-lasting. Many females either give birth to babies in the bush or return to their communities pregnant. This poses particularly difficult challenges to reintegration, as these girl mothers often face higher levels of stigma and non-acceptance, especially if their "bush husbands" continue to have any involvement in their lives. Many girls who return pregnant or with children do not feel able to return to their families and cannot

(or do not want to) live with the fathers of their children, leaving them to care for themselves and their children alone and often unassisted [9, 23, 82]. In Nepal, female former child soldiers were stigmatized by the community because of perceived violations of Hindu purity and sexual activity while associated with armed groups. In our sample, girls reported lower levels of family acceptance and higher levels of community discrimination as compared to males [24].

In addition to the challenges to psychosocial wellbeing mentioned above, girls also face greater obstacles to schooling, literacy, and economic opportunities, and are more likely to experience difficulty with domestic violence and family conflict. Research demonstrates that girls face extreme challenges to healthy adjustment and social reintegration. Not only do they often experience levels of violence during war comparable to boys, they often face more stigma and disapproval, fewer livelihood opportunities and significantly more psychosocial problems. More research exploring further how the war experiences and post-conflict reintegration of child soldiers is shaped by gender is needed in order to inform the development and implementation of improved interventions for female former child soldiers.

Girl soldiers, and especially those with children, are often the group least served by formal DDR programs: many of these programs are designed with boy soldiers in mind and are not tailored to the particular needs of girls. In fact, some programs predicate services upon the surrender of weapons, which may leave children of either gender who were not directly involved in fighting with little opportunity for formal assistance [14, 62]. Some programs, however, do offer assistance designed to meet the needs of girl soldiers with children, offering schooling and skills training alongside childcare, a model which should be evaluated, and if successful expanded to encourage greater community involvement as well as assistance with family reunification and conflict resolution [65, 74].

2.10. NGO PROGRAMS AND PSYCHOSOCIAL INTERVENTIONS

Although formal intervention research on child soldiers is slim, research points to a variety of NGO psychosocial programs and interventions that might be beneficial for former child soldiers. This research will be discussed in detail in Part D of this paper.

3. GAPS IN EXISTING RESEARCH

Although much has been learned in recent years about children exposed to violence, including child soldiers, significant research gaps remain, the identification of which may help to build a more complete and rigorous science base in this area.

Much of the research to date emphasizes the diversity of experiences of child soldiers both in terms of the nature of their involvement with armed groups as well as their experiences after release. One of the main problems is that the literature in the field of child soldiers is focused mainly on calling international attention to the issue of child soldiering by describing the prevalence of the problem worldwide and documenting the terrible acts of violence to which children are exposed while with the fighting forces. In light of important policy and legal initiatives in the field, this type of research is of course critical. However, when it comes to understanding the long-term effects of child soldiering and ways to help these children upon their return to

communities, research is scant. The studies we summarized in this report are a good beginning in building the evidence base regarding the impact of child soldiering on the psychosocial wellbeing of young people. But much more targeted research is needed to understand the complexity of the experiences of child soldiers in the context of their lives. Below we outline a few important areas in which further research is necessary.

3.1. UNDERSTANDING THE NATURE OF EXPOSURE TO VIOLENCE AND TRAUMA

The measurement of violence in relation to psychosocial outcomes among former child soldiers remains problematic. Very few studies have disentangled the effects of different types of violence on child soldiers. The war experiences children endure differ in terms of the types of violence (physical, psychological), specific acts, including perpetrating violence, severity, frequency and timing. These are critical dimensions to untangle in order to understand which war-related violence experiences result in serious mental health problems. Another issue that has not been examined is how children who perpetrated violence resolve their experiences (i.e., how they think about accountability) and how these resolutions impact their reactions and subsequent mental health problems.

3.2. VIOLENCE EXPOSURE WITHIN THE CONTEXT OF OVERALL POST-CONFLICT ADVERSITY

To date, there has been little measurement and accounting for the impact of post-conflict adversity child soldiers may face (i.e., adversity encountered after the DDR process). Many qualitative studies describe the various problems former child soldiers face upon return, including poverty, lack of education, and lack of family or community acceptance. These challenges undoubtedly pose threats to children's positive adjustment and social reintegration.

3.3. VIOLENCE EXPOSURE OF CHILD SOLDIERS CONTEXTUALIZED BY THE VIOLENCE ALL YOUNG PEOPLE FACE IN WAR TIME

Few studies have measured exposure to violence among former child soldiers within the context of violence experienced by war-affected youth who were not involved in the fighting forces. This has lead to focusing mainly on the terrible things child soldiers have endured without providing the broader context and understanding that a large part of war-affected youth experience extremely high levels of trauma and violence without being involved in an armed group. In fact, as discussed above, the studies that have examined this issue have found very similar patterns in post-conflict psychological wellbeing between former child soldiers and other war-affected youth except with regard to the small percentage of former child soldiers who experienced the most extreme forms of trauma.

3.4. IN-DEPTH UNDERSTANDING OF THE EFFECT OF AGE OF ABDUCTION AND LENGTH OF TIME WITH ARMED GROUPS

More research is needed to disentangle the impact of age of abduction (or joining an armed group) and length of time with the fighting forces on children's psychosocial adjustment. Currently the evidence points to length of abduction as important in predicting a higher degree of maladjustment, but the complexity of these two variables needs further investigation, particularly within the context of developmental trajectories of children.

3.5. BROADEN AND DEEPEN UNDERSTANDING OF THE IMPACT OF PARTICIPATION IN ARMED CONFLICT ON PSYCHOSOCIAL ADJUSTMENT

There is a pressing need for research to broaden and deepen our understanding of the effects of exposure to armed conflict on children. Research to date has largely focused on outcomes in terms of mental health symptoms and psychopathology. More research is needed to better understand the consequences of child soldiering from a comprehensive perspective (bio-psychosocial and developmental).

The following questions remain largely unexplored:

- What are the functional consequences of exposure to violence? How does exposure to violence impact school readiness, educational achievement, economic stability, employment, and job performance?
- What are the consequences of exposure to violence on the ability to form and maintain relationships? How does exposure to violence affect peer interactions, dating behaviors, attitudes toward the opposite gender, intimate relationships, or functioning as parents?
- What are the consequences of participation in armed conflict on moral development and social responsibility? What is the relationship between exposure to violence and juvenile or adult crime?
- What are the consequences of participation in armed conflict on risk for substance or alcohol abuse? How is this affected by age and duration of exposure, and gender?
- What are the medical/health consequences of exposure to armed conflict? Are there particular medical/health problems that occur with unusual frequency in children who served in armed groups? How is this affected by gender, age and duration of exposure?
- There is a need for better research on gender differences in the consequences of exposure to armed conflict that provides a meaningful understanding of gender differences. How is vulnerability and resilience affected by gender? How might treatments take these differences into consideration to achieve better success?
- Research needs to broaden and deepen our understanding of factors that help to protect child soldiers from the consequences of participation in armed conflict. In particular, what are the protective factors, assets, etc. at the child, family and community level that foster resilience in the face of violence? Does faith/religion modify the individual response to violence? What meaning is attributed to the conflict? How are mental health and healing understood? Research also needs to explore in more depth the mediating or moderating effects that culture and socioeconomic status exert on the psychosocial adjustment of former child soldiers. Overall attention to understanding pathways of recovery and maladjustment is critical.

3.6. LONGITUDINAL RESEARCH

In order to answer the questions outlined above, research on the reintegration of child soldiers needs to measure stability and change in psychosocial wellbeing over time. More studies looking at trajectories of risk and resilience will push the field forward and provide a much-needed perspective on how best to address the needs of former child soldiers.

3.7. BETTER CROSS-CULTURAL MEASUREMENT OF MENTAL HEALTH CONSTRUCTS

In addition, there is also a need for better research instruments that provide a broader degree of assessment and measurement of the consequences of exposure to violence among child soldiers. The use of both qualitative and quantitative methods is recommended to achieve this [83].

3.8. COMPARATIVE PERSPECTIVE AMONG CONFLICTS

Future research on former child soldiers could provide a much-needed comparative perspective. There is a need to develop a comparative analysis between different conflict situations, in order to understand adjustment outcomes in varying contexts. What kinds of social, cultural, political, and economic dynamics make possible the differences and/or commonalities? How can experiences from one region/country say something about, or help explain other regional and country experiences? How can lessons learned in one particular context be useful for other social settings and situations?

3.9. AVOIDING DUPLICATION OF RESEARCH

There is a need to synthesize the existing research (both published and unpublished "grey literature") on the situation of former child soldiers in order to not duplicate existing findings and well-known outcomes and to go beyond what is already known in the field. Systematic reviews of research on war-affected youth in general and former child soldiers in particular will allow researchers to identify gaps and program developers and policy-makers to use what is already known.

3.10. ENGAGE ACADEMICS AND PRACTITIONERS

Further, there is a need to bring together researchers from both the academic and the policy/practitioner worlds, and from diverse disciplinary backgrounds. A lot of the literature on former child soldiers is produced by practitioners, field staff or advocacy initiatives who are not always trained researchers and therefore not always successful in collecting thorough and reliable data. These types of studies are mostly based on internally commissioned reports by various United Nations agencies and nongovernmental organizations (NGOs) and unfortunately they are often not easily found by external researchers. On the other hand, the research produced by academics very often fails to reach policy-makers and practitioners. A more directed collaboration between academics and practitioners in gathering data and providing analysis is critical to move the field forward.

Overall, in order to build an evidence base, research must explore the wider context of the family, community, social, political and economic environment to former child soldiers reintegrated. Future research is needed which is:

- Longitudinal
- Gender sensitive

- Culturally informed
- Developmentally sensitive
- Integrative of evidence-based practice in interventions
- Informed from multiple perspectives (child, caregiver, significant other etc.)
- Able to unpack and explore the influence of different forms of exposure to violence
- Accounts for post-conflict stressors and contextual challenges in the lives of participants
- Utilizes relevant comparison or control groups
- Involves multiple sites to allow comparisons of results across sites

PART C: APPROACHES TO PROVIDING PSYCHOSOCIAL ASSISTANCE FOR FORMER CHILD SOLDIERS

Two main paradigms, the psychosocial and clinical, dominate the mental health response for former child soldiers during and following DDR programs. Most mental health interventions for such children and youth may be categorized according to these distinctions.

1. PSYCHOSOCIAL APPROACH TO THE MENTAL HEALTH OF FORMER CHILD SOLDIERS

In general, most psychosocial interventions avoid using disease labels on the principle that many Western disease labels may be inappropriate across diverse cultural settings [84] or that interventions associated with these labels are not assumed to always be a good fit across diverse cultural settings. Psychosocial interventions are often aimed at addressing children's greater psychosocial needs rather than focusing on particular disorders, attempting to strengthen a child's ability to interact with the outside world in a healthy manner. Psychosocial interventions are rooted in the principle that reintegration is most likely to succeed in the context of community and family supports, to the degree to which they are available [85]. Thus, psychosocial responses emphasize local participation and restoring indigenous protective processes. In general, psychosocial approaches focus on restoring connections to families and communities, recreating social networks, and providing children with greater capacity to deal with challenges they face during reintegration [2, 84, 86, 87].

In the context of former child soldiers, it is useful to consider psychosocial responses in two stages: 1) DDR-related programs aimed at providing immediate assistance to former child soldiers and 2) post-DDR programs that aim to provide follow up and long term-stability.

While DDR-related programs are likely to target former child soldiers specifically, post-DDR psychosocial interventions will likely involve all war-affected children rather than singling out former child soldiers. When providing psychosocial services for children who have already returned to their communities, using the label of "child soldier" could be dangerous for two reasons. For those children and youth who were abducted, a return to their community of origin is not always easy, particularly if they have been within armed groups for a significant period of time. The "child solider" identification could bring further stigma and negative reactions from their community, thus slowing the reintegration process. In addition, services provided to child soldiers only could become problematic at the community level as it may appear that child soldiers are favored among other war-affected children who may be in need [15, 26, 27, 61].

Thus, post-DDR psychosocial approaches focus on most or all the affected population regardless of individual differences in war-related exposures or traumatic stress reactions. Psychosocial services are often provided to all war-affected youth as preventative measures or to support healthy reintegration.

Psychosocial initiatives related to DDR programs for child soldiers include preliminary child tracing, family and community sensitization programs, foster placement, spiritual support by religious leaders or elders,

and some community follow up and monitoring. These initiatives, often serving all returning child soldiers, have greatly improved psychosocial dimensions of DDR programs, including the establishment and implementation of services at interim-care centers (ICCs).

AN EXAMPLE OF A SENSITIZATION PROGRAM FROM SIERRA LEONE

The sensitization process happens before child soldiers are returned to their communities. In Sierra Leone, the process used by local International Rescue Committee (IRC) personnel included a highly participatory, two-day workshop in each chiefdom (county) with a focus on peacebuilding and conflict resolution. Community members participating in the workshop identified local causes of conflict and traditional ways of resolving conflict (including approaching someone through an elder, showing remorse, and bowing and lying on the ground in front of someone you have wronged). Participants discussed forgiveness and acceptance. They were asked to develop a role play of rebels attacking a town, abducting children, giving them drugs, and forcing them to fight. During the debriefing period after the role play, participants were asked what they saw and experienced in real life. Typically, this was the point in the workshops when attitudes began to change. The IRC staff discussed with participants how to help children during a crisis. They explained the assistance network and the interim care centers. At the end of the workshop, a child welfare committee was formed. In turn, these chiefdom-level committees helped organize and conduct similar workshops at the neighborhood level.

Only anecdotal and qualitative evidence is available for the success of these sensitization workshops. Many of the participants in our study from Sierra Leone said that one the things that helped them most in the process of entering their communities was the work NGOs had done to prepare their communities for their return.

Post-DDR psychosocial programs promoting the mental health of child soldiers and war-affected youth in general include access to education, efforts to increase economic opportunities, provision of skills training, and school-based interventions promoting coping capacity. Many NGOs also organize post-conflict psychosocial interventions aimed at engaging children in creative activities (music, dance, drama) and recreational activities (games and sports) that tend to emphasize cooperation, imagination, and the development of other social, emotional and cognitive skills. These activities also provide children with the opportunity to relax and have fun in a safe environment and are designed to contribute more generally to children's overall psychosocial development. Many psychosocial interventions are commonly designed and implemented by non-mental health professionals.

Other post-conflict psychosocial initiatives also include interventions aimed at normalizing and improving systems and structures within communities that benefit both former child soldiers and war-affected youth in general. Such initiatives are focused less at the individual child and more at the overall environment in which these children live by strengthening the outside systems and social networks that can support children, thus improving their psychosocial outcomes [84]. Examples of such interventions include rehabilitation of schools, training of teachers and community social workers to recognize symptoms of distress among youth and provide supports, and reestablishment of community-based organizations that could provide needed monitoring and supervision of children at risk.

2. CLINICAL APPROACH TO THE MENTAL HEALTH OF FORMER CHILD SOLDIERS

In contrast to the psychosocial paradigm, clinical mental health interventions for war-affected youth require identifying the children with persistent mental disorders and focusing interventions on them. A main challenge to a clinical mental health approach in different cultural contexts is assessing mental health disorders validly across different groups and linking mental health needs to appropriate and effective care [83]. Nonetheless, some categorization strategy is needed in order to establish the incidence and prevalence of disorders and identify mental health problems common in different populations of war-affected youth for planning purposes (and for raising awareness of the issue). Another important feature of conducting clinical evaluations is the need to identify impairment in day-to-day functioning associated with distress [85]. For children, functional limitations may take many forms from school difficulties (when school access is available) to problems in meeting day-to-day family or community responsibilities. Without question, we know that trauma-related mental disorders are common consequences of war and terrorism [88, 89]. These disorders cause intense suffering and dysfunction resulting in effects beyond the individual, to the family, community and society at large. The literature also suggests that many mental health disorders appear to occur across cultures and across different groups of war-affected youth. What remains to be determined is the best approach to treatment. The answer to this question will vary by culture and context, but lessons learned in one population may well be applicable to others [15, 90].

In the rehabilitation of former child soldiers, clinical interventions are likely to focus on war-affected youth who continue to demonstrate mental health distress or impairment following front line normalizing psychosocial interventions. As our prior literature review has indicated, some former child soldiers may experience severe mental health problems (mental health disorders akin to depression, traumatic stress reactions, adjustment disorders, and other locally-described syndromes). These clinical mental health problems may result in significant impairments in day-to-day functioning such as school failure, family placement problems, difficulties in relationships, work difficulties, poor parenting, etc. The aim of clinical interventions is to screen, assess and identify those with mental health disorders and provide them with specific treatments to reduce symptoms and impairment in a targeted fashion. Such interventions are usually tailored to a child's individual trauma history and target specific psychopathology [84, 85]. Such interventions often employ individual or small-group counseling and encourage a longer-term relationship between the child and the therapist. Counseling sessions are designed with a particular therapeutic goal in mind, and the mental health professional uses specified treatment models, often involving some kind of exposure therapy and encouraging emotional expression.

Focused clinical interventions require longer-term availability of mental health professionals (or at least highly trained lay mental health workers), thus necessitating a certain level of infrastructure that may or may not be present in a developing country context. This capacity, however, can be developed with sufficient time, commitment, and resources.

3. AN INTEGRATED APPROACH TO PROVIDING PSYCHOSOCIAL SERVICES FOR FORMER CHILD SOLDIERS

Psychosocial and clinical mental health approaches should not be viewed as mutually exclusive or competing. Neither one is inherently better than the other. Their appropriateness will vary by context and feasibility issues, including resources. Even though they are guided by different philosophies and field practices, there is a lot of synergy between them. In fact, the greatest strength of these intervention strategies lies in using them in a complementary fashion [85].

As suggested by the Guidelines on Mental Health and Psychosocial Support in Emergency Settings developed by the Inter-Agency Standing Committee (IASC), it is best to take a holistic approach and organize mental health and psychosocial support as a layered system of complementary supports that meet the needs of different groups of children and adolescents [91]. In emergencies, including post-war contexts, people are affected in different ways; they have different coping resources, social supports and needs. Thus they require different types of emotional assistance. This may be best illustrated by a pyramid.

The bottom layer of the pyramid is the largest in terms of the number of war-affected children it accounts for (approximately half of the affected population). This layer consists of youth who may have experienced shock, grief, family and economic losses, and other stressors but are relatively resilient and function normally as defined in the social context [86]. The wellbeing of these children should be protected through the re-establishment of security, basic services, and appropriate opportunities for education, work and income generation. As Wessells discusses, a common misconception is that very few former child soldiers fall into this layer of the pyramid. In fact, as our review of the literature indicates, this layer includes many former child soldiers, particularly those who were not in armed groups for long, who suffered less exposure to death and traumatic experiences, or who have strong coping skills and sources of support upon return [86].

The second layer represents the emergency response for a smaller number of children and adolescents - often around 40% of the war-affected population. These children and youth, despite being affected by the war, are relatively functional but are often at risk of deteriorating if they do not receive appropriate support. In the context of child soldiers, this layer might include children who experienced moderate levels of violence and/or face various problems upon return, such as community stigma or disruptions in their family system. These children would benefit from help in accessing greater community and family supports, traditional healing ceremonies and other non-formal supports and psychosocial activities such as school-based interventions, and work within the community to address their immediate sources of vulnerability [86, 91, 92].

The third layer of the pyramid represents perhaps 10-15% of war-affected youth. This layer includes children who have experienced serious trauma and exhibit high levels of depression, anxiety and other significant difficulties in daily functioning. Such problems require specialized services, a higher level of mental health care and specialized support such as individualized case management. These children are likely to need long-term mental health care and follow up. In the context of former child soldiers, severely

abused girls and boys, who may have also been exposed to extreme levels of trauma (both perpetration and victimization) and continue to exhibit distress and impairment would fit in this layer of the pyramid. This multi-layered view of psychosocial needs and interventions helps to move beyond the clinical vs. psychosocial debate and emphasizes how diverse kinds of responses from NGOs and other agencies are useful and necessary in the field [86, 91].

In the process of ensuring the successful reintegration and rehabilitation of former child soldiers immediately following DDR, psychosocial approaches aimed at family tracing, community reintegration, and basic needs for food, shelter, health care and education all create a stabilizing environment for former child soldiers. This is an important first step for promoting the mental health of this group of war-affected youth [28, 62]. For many, this first step may be adequate to ensure a successful adjustment and reintegration. These programs alone, however, will not be adequate for everyone [16, 65]. Post-DDR psychosocial programs are important in that their provision may lead to improvements in general symptoms among both persons with and without specific disorders. Without providing these psychosocial responses, it is impossible to sort out those youth who require a higher level of mental health care. Once front-line psychosocial responses and supports are in place, those individuals whose needs are not met by these restorative community-level interventions can be identified. Former child soldiers who continue to manifest psychopathology after a period of stabilizing interventions will likely require a higher level of mental health care [90]. The progression of implementing psychosocial and then clinical interventions should not be absolute. Prior to ensuring that the stabilizing psychosocial interventions have been implemented, young people with evident mental illness or those with severe profiles of risk (i.e., survivors of sexual violence, torture or those who perpetrated extreme acts of violence) who demonstrate symptoms and impairment should be treated with clinical interventions according to available resources. Similarly, robust psychosocial interventions should continue after screening and treatment of mental disorders has begun. Decision-making about how to combine these approaches should be directed by local circumstances and local participation.

This pyramid demonstrates the need for balance among diverse kinds of psychosocial approaches and for coordination across levels, especially because movement between levels can occur in both directions. For instance, children who had been in the top layer and needed immediate clinical attention, but whose condition stabilized or improved may become able to benefit from community-based activities. On the other hand, former child soldiers in the middle layer who were left unsupported and who may have improved with proper care may instead move into the top layer of very high vulnerability.

As Wessells [86] points out, agencies that focus on different levels of the pyramid need to work together because the interventions conducted at different levels complements and supports those conducted at other levels. For instance, NGOs who provide community-based or school-based psychosocial supports often come into contact with severely affected former child soldiers who should be referred to providers of more specialized assistance. Effective referrals are critical and become very difficult if there are few or no programs at the upper level of the pyramid or if there is no communication among agencies working in this arena.

DETERMINING CLINICAL NEED AMONG WAR-AFFECTED YOUTH

In order to deliver services effectively, it is crucial to be able to correctly identify youth's psychosocial and mental health needs. Assessments must be completed in a thorough, participatory and timely manner, involving the community, NGOs, and government and/or UN bodies. Assessments should be a collaborative and continuing process. In addition, assessments should gather information on both needs and resources available in the lives of young people that can be built on [91].

Methods of data collection are varied and can be tailored to the local context. These include key informant interviews, focus group discussions, brief surveys and reviews of agency data such as intake records conducted for child tracing. After an initial "rapid" assessment of a situation, usually conducted between one and two weeks, more detailed assessments should be conducted. Findings related to mental health and psychosocial needs should be shared with relevant partners and stakeholders to serve as resources in the planning and implementation of programs [91].

The debate as to the appropriate role of psychosocial and psychiatric/clinical interventions post disaster is irrelevant without the tools to detect clinical need [93, 94]. Applied research is needed to determine beneficiary needs per locally relevant standards and terms. Such applied research can be used to develop locally valid and appropriate measures of constructs under study. Examples of such approaches exist [58, 83, 95]. Measures derived through the application of mixed methods may then be employed in evaluations and intervention trials to evaluate the efficacy of interventions directed at target issues.

4. AN ECOLOGICAL VIEW OF SERVICES FOR FORMER CHILD SOLDIERS

Trauma, psychological adjustment, and the mental health of children in war, including child soldiers, must all be viewed as embedded within the social ecology – the nurturing physical and emotional environment that includes and extends beyond the immediate family to peer, school and community settings and extends to cultural and political belief systems [96, 97]. For child soldiers, war represents not only the risk of personal physical endangerment, but also to the context of child development itself and an extreme disruption of their life course. For the developing young person, wars herald the loss of security, predictability and the structure of daily life. Because of war, essential community services and institutions, such as schools, health systems and religious institutions are damaged or purposefully destroyed, and family and social networks are shattered. This damage to the social infrastructure, poverty, tension, mistrust, and the loss of loved ones/undermined social networks lingers on post conflict and shapes the process of reintegration and rehabilitation for child soldiers [3, 78, 98].

Aside from the importance of providing services for children who may be at different layers of the mental health pyramid, it is also critical to develop services that strengthen and involve different levels of children's social ecology (the individual, the family, the peer group, the community, the culture at large). Ultimately, interventions for former child soldiers must involve careful assessment of the context and the population being served in order to plan for appropriate services. Depending on the situation, an appropriate response might involve largely individual-focused interventions, while in other contexts a family- or community-based intervention might have stronger impact. Ideally, a combination of psychosocial and clinical responses will offer support to different levels of the social ecology of the child.

PART D: PSYCHOSOCIAL SUPPORT FOR FORMER CHILD SOLDIERS

1. ORGANIZATIONS PROVIDING SUPPORT FOR FORMER CHILD SOLDIERS

Appendix 2 summarizes some of the key organizational actors in the field of psychosocial interventions for war-affected children, including former child soldiers. These agencies focus on three main areas of work: 1) policy development and advocacy/awareness-raising; 2) project implementation and service provision, and 3) research. Of the groups that provide services on the ground, each has a particular focus with regard to the psychosocial-clinical intervention spectrum: for example, Médecins Sans Frontières (Doctors Without Borders) Netherlands provides trauma-focused clinical services and trains therapists, while Save the Children focuses to a greater extent on psychosocial development through promoting normalcy and stability in family and community life. The majority of implementing agencies working with former child soldiers and other war-affected children have adopted a focus on psychosocial rather than clinical interventions, as a more individualized, clinical approach is more resource intensive and thus often less feasible. As seen in Appendix 2, the majority of organizations provide more than one type of psychosocial support in the context of war-affected youth. For instance, World Vision offers community development, sensitization and peace-building initiatives as well as educational and psychosocial support for war-affected youth. It is common for the agencies to cover at least two of the pyramid layers discussed above – often providing economic/livelihood opportunities for child soldiers along with community-based psychosocial and emotional support. Very few organizations cover all three layers of the pyramid.

2. PSYCHOSOCIAL AND CLINICAL INTERVENTIONS FOR WAR-AFFECTED YOUTH

Using our own knowledge of the field and recommendations from colleagues, we reviewed the literature on evidence-based psychosocial and clinical interventions for war-affected youth. As discussed above, the majority of psychosocial and clinical programs are aimed at war-affected youth more broadly, with the exception of DDR-related programs that are specifically aimed at former child soldiers.

EVALUATING PSYCHOSOCIAL AND CLINICAL PROGRAMS

Certainly a number of standard evaluation approaches may be employed to assess the effectiveness of both psychosocial and psychiatric/clinical interventions to assist former child soldiers. In any evaluation, it is critical that the goals of the intervention and appropriate target outcomes be specified. In psychosocial programs, evaluation may target outcomes that are complex to assess, particularly across different cultures and settings such as “hope”, “problem solving” or “community acceptance”. In contrast, a distinguishing feature of clinical/psychiatric approaches is the specificity of interventions, which are usually designed to target a particular mental health problem or set of problems and associated impairment (i.e., depression, trauma, suicidal thoughts).

Increasingly, clinical and psychiatric approaches are under pressure to consider “evidence-based treatments” [99]. In research terms, basic criteria have been established for assessing the degree of “evidence” for a treatment’s efficacy (i.e., how effective an intervention is proven to be in experimenter-controlled conditions) and effectiveness (i.e., how effective an intervention is in real-world settings under

less controlled conditions). The optimal criterion is the existence of at least one, and hopefully numerous, confirmatory randomized controlled trials (RCT) demonstrating that a treatment significantly improves outcomes (from improvement in symptoms to meeting criteria for "recovery") from the targeted mental health disorders. Other lesser but important levels of evidence include the existence of at least one study using a quasi-experimental design, at least one observational study and, in the least, anecdotal evidence and support of the practice by expert clinical opinion [100, 101].

In low-resource settings these criteria are difficult to achieve in evaluation of psychosocial and clinical interventions. To date no "evidence-based" interventions of the highest level have been documented for assisting former child soldiers. Improving this evidence base is a major priority for future research in this field.

2.1. PSYCHOSOCIAL INTERVENTIONS

In reviewing NGO and agency reports (see Appendix 2), as well as a number of training manuals (see Appendix 3), for both psychosocial and clinical interventions, we identified a range of relevant programs, including ones that targeted former child soldiers in particular. Most programs specific to former child soldiers were DDR-related or took place immediately after a child reintegrated into their community. Post-DDR programs, as discussed above, were focused on war-affected youth in general. By and large, psychosocial programs were described in unpublished/grey literature and manuals that were often found in internal reports of nongovernmental and multinational organizations providing services on the ground. Perhaps due to the non-academic nature of most of the interventions and manuals reviewed, very few of these psychosocial programs were evaluated adequately. Reports on these psychosocial initiatives were most often descriptive, containing information of the number of beneficiaries, location and timeframe of the programs, but no data on outcomes. Thus, although process indicators of implementation (a potential marker of feasibility) are evident in many reports, no outcome data was available to inform a critical analysis as to the success of these interventions.

DDR-related psychosocial programs ranged from community sensitization (described in an earlier section of the report) and family tracing, remedial education, skills training, provision of loans and land grants, provision of school fees, and reconciliation initiatives. In certain post-conflict countries, like Sierra Leone and Liberia, a variety of NGOs offered many if not most of these programs, while in countries like Angola and El Salvador few initiatives were in place to support the psychosocial reintegration of child soldiers. Below we highlight two examples of promising psychosocial assistance programs related to the reintegration of child soldiers that we believe have particular potential for expansion and application in low-resource settings. The first example, the Christian Children's Fund's (CCF's) youth reconciliation and skills training program in Sierra Leone, presents an approach that aimed to build bridges between war-affected communities and former child soldiers who might otherwise face significant stigma upon reintegration. The second example of UNICEF's Community-Based Reintegration Program (CBR) is a comprehensive, multi-layered intervention, whose core components are well targeted to the needs of former child soldiers across many layers of the social ecology. Given heavy emphasis on local staffing and leadership both programs have a great deal of potential for being adapted and replicated in other low-resource settings.

EXAMPLE: CCF'S YOUTH RECONCILIATION AND SKILLS TRAINING PROGRAM IN SIERRA LEONE

In Sierra Leone, to aid the reintegration of child soldiers and also young adult soldiers, CCF employed a holistic, community empowerment approach, with education for peace interwoven into the project. In the first phase of the project, each of 15 communities held open meetings to discuss the end of the war, what it meant for villagers, concerns about child wellbeing, and how to move forward. These discussions, which helped people develop positive attitudes about the future, frequently identified villages' needs for schools or health posts that had been damaged or destroyed during the war. CCF's Sierra Leonean staff helped to facilitate discussions in which the communities prioritized these needs and selected a project such as building a school or health post. In the next stage, the returned child soldiers and village youth carried out the project. As the youth worked, they earned a small stipend, which was crucial because many former youth soldiers said that without an income they would have returned to the bush to fight again. The building was a cooperative endeavor by former child soldiers and village youth, who spoke of the experience as an opportunity to see each other as human and approachable. This activity transformed many villagers' attitudes toward the former child soldiers, whom they came to see as people who had much to contribute to the community. Also, the physical construction had a powerful effect, as many villagers said that they experienced increased hope because they now saw tangible signs of progress and venues for supporting their children. In the third stage, former boy and girl soldiers received training in skills such as carpentry, tailoring, and tie-dyeing that market research had indicated were sources of jobs locally. They apprenticed under the direction of a master artisan who also served as a mentor and moral guide.

This project was subsequently expanded into other provinces and enjoyed considerable success, including visible reductions of fighting and increased integration of former child soldiers into their villages reported by both child soldiers and village members. Despite dire predictions that villages would never accept back the youth who had attacked them, over 90% of reintegrated child soldiers said they had a civilian identity and hope of a positive life as civilians. Communities, too, said they saw the former child soldiers not as troublemakers but as youth who had a spirit of community service.

EXAMPLE: UNICEF'S COMMUNITY-BASED REINTEGRATION PROGRAM (CBR)

The Community-Based Reintegration (CBR) program sought to provide educational and psychosocial support to demobilized children, and to establish and support community-based child protection systems in all districts of the country. Working with international and local partners, UNICEF created and supported a number of structures while implementing activities to support the healthy reintegration of children. At the community level, the CBR included Child Welfare Committees (CWCs), which were community groups composed of local leaders, teachers, women and youth representatives who assisted with family tracing. CWCs also followed up with children in their homes, schools and children's clubs and promoted sensitization on children's rights issues within the community. CWCs were available to intervene in cases of child abuse and exploitation. At the peer level, Children's Clubs (CCs) offered recreational and educational opportunities to all children within the community. At the family level, the CBR provided follow-up and monitoring services in homes and schools. In order to implement this part of the model, social workers monitored former child soldiers in these settings first on a monthly basis and then adjusted services based on their needs and progress over time. A number of educational and vocational initiatives were also a part of the CBR. For instance, Community Education Investment Program (CEIP) Schools were established in

program sites. In this model, school fees were waived for demobilized children and they were provided with a uniform, bag and other school supplies. In addition, materials such as notebooks, pencils, and paper were provided to the school for all children in attendance. The CBR model also included a number of Complimentary Rapid Education Primary Schools (CREPS) that offered a compressed primary school program designed for older children. Finally, the CBR program included skills training and apprenticeship programs. These interventions were supported by curricula developed with trainers and social workers to ensure proper monitoring and skills development.

Over five years of implementation 7,204 former child soldiers entered the CBR Program. An assessment conducted in 2006 compared CBR beneficiaries to a control group not participating in the program. They found beneficiaries to be more optimistic about the future, to show greater self-confidence, and to be more involved in school groups than children who did not go through the program. The two groups were not statistically different in terms of school attendance, substance abuse, or involvement in paid work [47].

Overall, our review of post-DDR psychosocial programs serving war-affected youth at large indicates that NGOs have implemented a variety of initiatives aimed at improving the general coping capacity and wellbeing of war-affected youth, including former child soldiers. Many psychosocial initiatives often include a partnership between international NGOs and local NGOs and CBOs at the grassroots level. These partnerships are critical in order to strengthen the local capacity to sustain relevant programs. For instance, in our recent assessment of service delivery programs for war-affected youth in Sierra Leone, we found that over 70% of 130 organizations we researched currently working on the ground are local. Many of them started immediately post conflict and worked in collaboration with larger international NGOs on various reconstruction projects. As the work of international NGOs phased out (2-3 years post conflict), the majority of local organizations developed their own agendas and started implementing small-scale projects with war-affected youth.

Many psychosocial programs we reviewed provided some kind of educational support for youth. As an example, in the DRC, CARE International works to promote basic education, especially for girls and vulnerable children (child soldiers, displaced and poor children). The project's objectives are: 1) to ensure that of all school children, vulnerable children, are provided with alternative and non-formal education opportunities in order to develop to their full potential; and 2) to reintegrate back into formal primary education systems children who dropped out of school for various reasons during the war. Similar programs are offered by local and international NGOs in most post-conflict settings. In addition, many skills training/vocational programs are implemented to help young people with learning marketable skills and gaining employment. The WAYS program in Liberia is one example that provides basic literacy and numeracy training, vocational skill training, small enterprise development, and other income-generating services. The WAYS program's services are overseen by USAID's Liberia mission and have been implemented by NGOs, most of them Liberian [103, 104].

Overall, it is difficult to establish the effectiveness of these programs in terms of their impact on the psychosocial wellbeing of war-affected youth. Most of the programs reviewed here report hard data regarding the number of beneficiaries they serve every year and some may even report some outcomes data specific to certain program goals (e.g., the percentage of participants who secured employment

following the program), but few if any measure specific psychosocial indicators. Most programs, however, provided anecdotal evidence related to the positive effects of education and skills training activities on the wellbeing of their participants including higher levels of hopefulness and positive outlook for their life, social respect and stability. Future program evaluations of such psychosocial interventions could be strengthened by including explicit measures of these constructs of interest.

Many post-conflict programs also provide basic or supportive counseling services (a step towards specific clinical interventions, but often with less specificity as to the symptoms and impairment being targeted). Centers often serve both boys and girls, although some counseling initiatives focus primarily on girls and young women who are victims of sexual violence. One example of a successful counseling program for females are the Sexual Assault Referral Centers (SARC, or "Rainbo Centers") established in Sierra Leone by the International Rescue Committee (IRC) and the government. The three centers offer free medical psychosocial and legal support. From March 2003 to September 2005, the Centers provided services for 1,769 survivors of sexual assault, 75% of whom had been raped. Each Rainbo Centre is closely connected to a government hospital and provides free and confidential counseling, forensic medical examination and treatment, transport, food, clothes and legal advocacy. The centers were singled out by the UN High Commission for Refugees (UNHCR) in 2004 as one of seven "best practice" gender-based violence programs worldwide [105].

In addition to the types of psychosocial programs described above, many initiatives provide recreational activities for war-affected youth. For example, Right To Play (RTP), a well-known NGO offering services to war-affected youth in many post-conflict settings, uses sport and play to promote opportunities for development, health and peace. Right To Play's sport and play programs focus particularly on fostering: 1) healthier, educated children; 2) empowered individuals and communities; 3) safer, more peaceful communities; and 4) improved health and healthier lifestyle behaviors. According to their internal evaluation, community leaders, parents and teachers have reported that as a result of RTP's programs, violent behavior has dropped among participants. In addition to offering an alternative to idleness, which often leads to violence, RTP's sport and play programs teach important conflict resolution skills including teamwork, fair-play and communication. School attendance in many of the communities where RTP is operating has increased, and teachers attribute this increase to the draw of RTP's sports programs. Children are less likely to skip school when the opportunity to play and participate in sports is integrated into a school's curriculum. Special sport and play activities over and above the core sports curriculum have also been reported to serve as an effective motivator for improved performance and increased attendance in school.

Finally, we would like to highlight another type of psychosocial initiative that has been utilized in various post-conflict contexts, in which programming is aimed toward strengthening a community's potential to respond to the psychosocial needs of war-affected children and adolescents. In our review of relevant programs, we found a large number of manuals and internal reports describing the training of local mental health outreach workers, the training of trainers, and overall efforts to facilitate on-the-ground program staff, volunteers, and laypersons to provide community responses in order to mitigate the negative mental health effects of potentially traumatic events (see Appendix 3). These initiatives are important to highlight, despite the lack of empirical evidence for their effectiveness in various war-affected communities. Investing in

proper training and sustained supervision of local counselors and social workers is critical to improving local capacity and strengthening psychosocial responses.

2.2. CLINICAL INTERVENTIONS

We analyzed the peer-reviewed literature, as well as the relevant grey literature, for models of evidence-based clinical interventions. Overall, we found only a handful of published evaluations of mental health interventions for war-affected children. It is worth noting that most of these interventions are group treatment models, which if implemented sensitively, can go a long way in addressing the human resources constraints inherent in the low-resource settings of conflict or post-conflict countries. Some of these clinical interventions include:

- Group Interpersonal Therapy (IPT-G), a structured, time-limited therapy developed for the treatment of depression symptoms [95, 106];
- Short-term group crisis interventions, which use drawing, storytelling, free play, and expression of feelings to focus on withstanding an identified crisis period [33];
- Group intervention focused at developing mind-body techniques (including meditation) to reduce posttraumatic stress reactions [107];
- Group therapy (including supportive group psychotherapy, psychoeducation and parenting support) for war-affected mothers and their young children [108];
- Group intervention aimed at addressing current daily stressors facing children living in refugee camps [109];
- Trauma/grief-focused psychotherapy administered by teachers within a school setting [110];
- Classroom-based intervention [111-113];
- Group therapy for victims of torture that integrates components of a number of supportive group psychotherapy and cognitive behavioral techniques [114];
- An individual intervention: Trauma Focused Therapy/ Narrative Exposure Therapy (NET), a short-term therapeutic intervention that integrates components of cognitive behavioral therapy and storytelling [115]; and
- A four week trauma healing intervention integrated with basic education and recreation in a refugee camp setting (Rapid Ed) [23].

These interventions have been used in various war-affected communities including Kosovo, Sudan, Uganda and the Gaza Strip. (A summary is available in Appendix 4.) The evidence base regarding these interventions indicates that research to build the evidence base on mental health interventions for war-affected youth is just now emerging [85]. Across these published studies, sample sizes ranged from N=314 (IPT-G) to N=6 (NET). With the exception of the Group Crisis Intervention, the available evidence suggests that most of these intervention models may in fact be effective in decreasing specified mental health problems among participants. Overall, more research is needed to establish with certainty the efficacy of these treatment models for war-affected youth. Future research must also attend to adapting and evaluating the effectiveness of these interventions in additional conflict-affected settings and with diverse populations. Intervention appropriateness and effectiveness is certainly likely to vary by gender, level of trauma, pre-existing mental health conditions, contextual stressors, and degree of training and support of

staff to ensure adherence to the treatment models. Where available, we have endeavored to obtain manuals for these different intervention models (see Appendix 4).

We are not aware of any clinical interventions that have been developed specifically for the treatment of mental health symptoms and impairment in former child soldiers. Of the interventions briefly discussed above, we would like to highlight three models: the Center for Victims of Torture model [114], the Classroom Based Intervention Model [111], and Rapid Ed/Trauma Healing Intervention [23] as promising, holistic clinical interventions in the field. Each of these intervention models integrate components of supportive group psychotherapy and cognitive behavioral therapy, which are indicated in the clinical literature as effective for addressing disorders such as depression, anxiety and some aspects of complex trauma (all mental health problems in war-affected youth in general and former child soldiers specifically). To date, no formal evaluations exist of any evidence-based mental health interventions directed at former child soldiers specifically.

EXAMPLE: CLASSROOM BASED INTERVENTION (CBI)

The Classroom Based Intervention Program (CBI), developed by the Boston Center for Trauma Psychology, is an evidence-based psychosocial intervention for children and adolescents exposed to trauma [111-113]. Drawing from the literature on PTSD, depression, and anxiety disorders and based on the theory of classical conditioning, CBI aims to identify and strengthen existing coping resources and strategies among traumatized youth in order to improve psychosocial outcomes over time.

CBI has been manualized and may be delivered in school or camp settings as a group intervention. It is delivered in 15 sessions over a 5-week period. The highly structured expressive-behavioral activities included in the intervention are designed to reduce traumatic stress reactions, anxiety, fear, and depressed mood through playing, learning, and creative problem-solving. In addition to the immediate reduction in traumatic stress reactions, CBI is designed to provide long-term positive effects including increased ability to problem-solve, increased hope and sense of safety, increased self-esteem, as well as positive views of the self and community. Expected behavioral outcomes include decreased aggression, fewer sleep disturbances, greater ability to concentrate, increased hope, improved self-control, and a willingness to engage in longer-term positive relationships with others.

CBI has been implemented successfully in Sudan, Burundi, Sri Lanka, Turkey, Indonesia, Afghanistan, the Palestinian Territories, and other locations. A recent randomized controlled trial involving over 600 children in the West Bank and Gaza found a significant positive impact of CBI on children's coping capacity, problem solving skills, and overall mental health wellbeing (including fewer depression and anxiety problems) in male and female war-affected children ages 6-12, and female adolescents ages 12-16 [111]. No significant positive impact was found on boys ages 12-16. Two more RCTs were recently completed in Indonesia and Burundi and results are forthcoming [116].

In the West Bank and Gaza, over 1,400 school counselors and social workers have been trained in CBI techniques, and over 100,000 children completed the full 15-session program, making CBI in the West Bank and Gaza the largest scale psychosocial support program known to date in development assistance.

CBI received endorsement and support from the Ministry of Education, and the United Nations Relief and Works Agency for Palestinian refugees (UNRWA) also introduced it in its schools.

EXAMPLE: PLAN INTERNATIONAL'S RAPID-ED PILOT PROJECT INTERVENTION

Gupta and Zimmer [23] recently reported on a mental health intervention conducted in 1999 for internally displaced refugee children affected by the war in Sierra Leone. In this pilot project, Plan International (an international NGO) worked in collaboration with Sierra Leone's Ministry of Youth, Education and Sports as well as the United Nations Education, Scientific, and Cultural Organization (UNESCO) to integrate a trauma healing module into a refugee-based educational program.

Integrated into the camp's Rapid-Ed curriculum, the trauma healing module was administered by trained teachers within the context of basic education and recreation activities. Its eight 60-minute structured healing activities focused on symptoms of traumatic stress reactions linked to compromised learning, including difficulty concentrating, nightmares, flashbacks and hypervigilance.

A total of 315 Sierra Leonean youth ages 10-18 years old living in displacement camps in Freetown participated in eight 60-minute trauma healing sessions over the course of the four week intervention. Exposure and posttraumatic reactions to war-related experiences and violence were assessed at baseline as well as approximately five weeks after the intervention had ended. At baseline, boys and girls both reported an average of 25 war-related exposures; 80% experienced a death in the family; and 50% had witnessed the killing of a loved one or family member. Children reported high levels of intrusion, arousal, and avoidance symptoms at pretest.

Follow up assessments indicated that young people participating in the intervention demonstrated significant reductions in intrusion and arousal symptoms and improved optimism about the future. Ninety-six percent of the participants reported significant reduction in concentration problems, sleep problems, nightmares and intrusive images. Moreover, the most dramatic decrease in arousal problems occurred among intervention participants who had reported difficulty concentrating in school at baseline.

This study did not utilize a randomized control or comparison group to examine the extent to which posttest effects could be attributed to the intervention, so results must be interpreted with reservation. That said, this intervention offers a promising integrated curriculum that was associated with measurable improvements in symptoms that may compromise learning in war-affected children.

EXAMPLE: THE CENTER FOR VICTIMS OF TORTURE MODEL IN WEST AFRICA

The Center for Victims of Torture integrated model combines components of cognitive behavioral therapy and supportive group psychotherapy. The 10 week intervention includes the provision of psychological and psychosocial services to address mental health problems experienced by refugee survivors of torture and war trauma. The intervention also aims to build on local strengths and assets to enhance community capacity to meet the mental health needs of torture survivors and other refugees through the provision of training and supervision for local refugee counselors. Although the model has not been used specifically with former child soldiers, its has been used with West African war-affected populations in Guinea, Cote d'Ivoire and Sierra Leone with documented success [114].

Between 1999 and 2005, the Minneapolis-based Center for Victims of Torture (CVT) [117] operated what they described as a "relationship-based supportive group counseling" intervention for Sierra Leonean and Liberian torture survivors in refugee camps in Guinea [114]. CVT-Guinea, as the program was known, had three primary objectives: "(a) the provision of psychological and psychosocial services to address mental health problems experienced by refugee survivors of torture and war trauma; (b) the enhancement of community capacity to meet the mental health needs of torture survivors and other refugees through the provision of training and supervision for local refugee counselors; and (c) the raising of awareness about torture, war trauma, mental health, and related issues throughout the camps through a combination of training community leaders and conducting camp-wide sensitization campaigns" (p. 924).

CVT-Guinea recruited paraprofessional counselors from within the refugee camp population and trained them in areas related to mental health, group counseling, assessments, and group dynamics. Counselors (referred to as psychosocial agents, or PSAs) received ongoing supervision and training by expatriate mental health specialists as they worked together to administer a group treatment model that integrated western and local therapeutic strategies for healing. A three-stage model for trauma recovery included safety, mourning, and reconnection. All clinical interventions were catered specifically to the realities facing refugees in this setting.

Each group was comprised of approximately ten participants of similar age, gender, and degree of traumatic experience. Over approximately ten weeks, the groups met in weekly sessions lasting approximately two hours. Two PSAs led the groups, with one serving as an interpreter for the clinical supervisor. Over the six years of the intervention, CVT-Guinea provided counseling to over 4,000 refugees and other support services to an additional 15,000.

The team recorded certain information about the participants at intake (demographic information, trauma history, symptoms of mental health disorders, measures of social support, etc.) and then at several intervals over the course of the next 12 months. Stepakoff and colleagues [114] reported "significant reductions in trauma symptoms and increases in measures of daily functioning and social support during and after participation in groups" (p. 921) while also finding meaningful reductions in trauma symptoms following participation. The authors did not publish quantitative results. To date, our team has been unsuccessful in obtaining further detail on the quantitative program evaluations from this program, although a recently published article alludes to their existence [114].

The group format and ability to integrate components dealing with severe traumatic events in a culturally-sensitive fashion make it particularly compelling to consider in future intervention research with former child soldiers. Furthermore its use of well-trained and well-supervised lay professionals in the delivery of care make it further compelling as a potential model for adapting and testing in other West African settings where financial and human resources are limited.

3. EXISTING GAPS IN SERVICE DELIVERY PROGRAMS ADDRESSING DEMOBILIZED CHILDREN AND COMMUNITIES

As a whole, a great deal of the evidence presented in this paper has suggested that many former child soldiers manage to carry out productive, healthy lives, particularly when provided with some basic assistance to pursue schooling or develop a trade (basic psychosocial interventions). The main challenge that remains is in assessing and matching the appropriate level of care to the needs of the individual, in the context of the culture and the conflict. Systems must be developed to ensure that all war-affected youth get some basic services and that screening, referral and treatment systems are in place to ensure that individuals needing a higher level of care receive it.

In order to advance both psychosocial and clinical services for former child soldiers, several key principles are imperative. First, local communities need to be involved in the development and evaluation of interventions. Second, interventions need to be provided to address risk factors and capitalize on protective processes and local healing traditions at all levels of the social ecology (rather than taking a deficit-oriented approach). Third, more research needs to be directed at improving the measurement of mental health constructs cross-culturally to ensure better assessment, matching of the level of need to the level of service and improving evaluation. Fourth, with improved and locally relevant evaluation and screening techniques, services providers must invest in evaluating the outcomes of their interventions. This effort is imperative for developing an evidence base of interventions that are safe and effective for serving a range of war-affected children and families. Fifth, we need to invest in the technical assistance, human resources, and financing of systems of prevention, protection, and care that will last beyond the typically brief period of relief characteristic of emergency humanitarian response. Efforts to develop context and culturally-relevant and sustainable systems of care will require close collaboration with local government, international donors and agencies, and civil society.

Across both psychosocial and clinical services for former child soldiers and other highly traumatized groups of war-affected children, a number of specific gaps bear attention in the years to come.

3.1. ASSESSMENT AND TREATMENT PLANNING

Targeted intervention must be guided by good, individualized assessment and intervention planning. Current services, such as those provided by interim-care centers serving former child soldiers do demonstrate efforts at assessment. The difference is in how assessments are used to inform care. It is typical for intake workers at ICCs to complete an “intake form” or other document describing the history and specific challenges facing an individual child in care. However, these assessments are often treated as bureaucratically necessary steps. They are not used as an opportunity to inform and guide individual services. In fact, many assessments of former child soldiers, including those indicating problems related to mental health and functional impairments are completed and then more or less put on the shelf. Thoughtful, individualized assessment could advance mental health services a great deal, particularly if key treatment goals were defined, outcome targets specified, and progress tracked on a routine basis (i.e., child x will reduce instances of nightmares from once per night to once per month, etc.).

3.2. TRAINING, PROFESSIONAL DEVELOPMENT, AND SUPERVISION OF SERVICE PROVIDERS

Services to support the healthy reintegration and rehabilitation of former child soldiers are characterized by very real human resources challenges. Developing high quality care and professionalism requires more than training. Addressing human resources issues to provide care entails a focus on recruiting, training and then supervising and maintaining the professional development of more mental health workers to meet the demands. Trained lay people may play a very large role in building the ranks of mental health or psychosocial services staff in low-resource settings. However, such intervention is by nature incomplete if not matched with appropriate clinical supervision and a clinical "chain of command". A clinical chain of command means putting structures into place so that cases requiring a higher level of mental health care may be referred up a chain of command (and skill) and handled by a more skilled clinician if needed. In low-resource settings, such systems of care may be characterized by front-line trained lay people, then professional mental health workers such as social workers or counselors or psychiatric nurses, and then psychologists and psychiatrists at the top of the chain where available. Such a chain of command should ensure that front-line workers never have to handle clinically complex or emergency situations in isolation. Such a team approach is intended to build in better back up and clinical supervision at each level of the services chain. In low-resource settings, well-trained and supervised lay people can provide a great deal of supportive front line care. Indeed, recent research in northern Uganda [106] has indicated that trained lay professionals can provide effective care for symptoms of depression when given intensive training as well as routine group and individual supervision. Involving trained lay people also builds local capacity and has the potential to increase the level of skilled individuals who can be absorbed and supported by sustainable systems of care. When service systems are built in a participatory fashion, an opportunity is presented to ensure better culturally informed care. Involving people from the local community in the planning, shaping and implementation of services can go a long way in ensuring local appropriateness and increasing engagement and retention in services.

3.3. STAFF RETENTION/BURNOUT AND SELF-CARE

Front-line mental health staff who work with highly traumatized youth are engaged in work that is physically and emotionally taxing. In many war-affected countries, the training and involvement of local staff is an important step in ensuring local leadership and capacity building. However, the involvement of local staff must also be implemented with awareness that work with war survivors is likely to trigger a number of personal issues and even personal trauma experiences among local workers who are war survivors themselves. In such settings, the importance of high-quality and frequent supervision and support cannot be understated. The failure of many NGO "psychosocial trainings" in war-affected regions is that they provide a brief period of training (often ranging from a few days to a few weeks) by an outside mental health professional only to release a newly minted "local mental health worker" to manage often enormous caseloads of very intense mental health needs. These mental health needs are further compounded by extreme environmental stressors such as poverty, corruption, ethnic or cultural tensions, and limited economic and educational opportunities. This is a recipe for burnout and poor quality care. In low-resource environments, the lack of jobs creates a dangerous incentive for even the most burned-out staff to stay on the job without complaint. The result is poor quality care for highly traumatized youth. Certainly the contextual issues of providing services for war-affected youth in low-resource settings cannot be changed quickly, but the difficulties of navigating these systems must be anticipated and staff must be given frequent and adequate support. Interventions for reducing staff burnout include ensuring routine individual and group

supervision, and encouraging opportunities for self-care of front-line staff such as retreats, opportunities to take a "mental health day" after a difficult period of work, staff recognition awards, and opportunities for further training and professional development.

3.4. DEVELOPING SYSTEMS OF SERVICES FOR WAR-AFFECTED YOUTH AND FAMILIES (POST-DDR STRATEGIES FOR PROVIDING SERVICES)

Many post-conflict countries that have had DDR programs for former child soldiers are characterized by agenda-setting problems familiar throughout the developing world. Often times, the services system is a fragmented world of well-intentioned but disjointed NGO programs. Government projects are developed in a clientilist and uncoordinated way, often in response to the priorities and interests of international donor organizations, rather than the pressing needs of domestic constituencies.

In an encouraging trend, investments in lasting positive and productive opportunities for youth have more recently taken greater priority in post-conflict peacebuilding, with new funding and initiatives for youth employment and livelihoods starting to come on line. However, there is a consistent failure of development agendas to invest in developing systems of care beyond primary health care and education (i.e., child protection, social welfare systems). For instance, the experience of child soldiering is often accompanied by medical needs that will require care and follow up (i.e., injuries, disfigurement, sexually transmitted infections, pregnancy, gynecological injuries). Overall, short-term humanitarian psychosocial and mental health interventions must be translated into sustainable investments in developing and sustaining a local system of child and family services that can endure beyond the immediate emergency phase. The lack of a specific political mandate, the enormity of problems on the ground, and inadequate support from dedicated but technically ill-equipped government leadership in the child protection and social welfare sectors has meant that the majority of high-risk youth are often left to fend for themselves.

In Sierra Leone, for instance, despite millions poured into the DDR process at its peak, the annual operating budget of the Ministry of Social Welfare was a mere $270,000. Although a new child rights bill passed the Sierra Leone Parliament in 2007 spelling out new parameters to improve child protection in the country, it remains a largely unfunded mandate. In the absence of ongoing funded programs, formerly engaged and highly trained child protection and social welfare staff have sought employment abroad. This situation has the potential to squander the tentative investments made in reintegration and rehabilitation of war-affected youth to date including the energetic but ill-sustained international DDR efforts and the precedent-setting but purely legal work of the Special Court for Sierra Leone.

If such issues are taken seriously, any outside intervention must attend to building local capacity, and if the intervention is one run by an outside humanitarian aid organization, the implementers must anticipate the reality of a day when they will no longer be. Operational agencies must ask hard questions about what can be done to ensure local leadership and ensure sustainability of high-quality mental health care by local agencies and governments once foreign organizations have moved on. This often means a good hard look at financing as well as policy issues. This is where research can help. Evidence of the prevalence and persistence of mental health problems, naturally occurring protective processes, as well as interventions that can help improve mental health outcome are all needed to ensure that these issues are given priority investment. Such research has yet to be done well in low-resource settings.

Mental health practitioners need to be careful not to contribute to the "humanitarian cycle," whereby well-intentioned professionals travel to the most recent crisis location, and then the next, and so on to provide care or training. Without attention to long-term sustainability issues and how trained local staff might be supported and provided with high-quality supervision, even the most well-intentioned outside effort may be misguided. Field experience has taught us that one of the greatest contributions "outside" mental health specialists can make is to employ their significant skills as facilitators to help those who naturally play a role in the lives of children (teachers, religious leaders and community mentors) to get back to doing so in an effective and sustainable manner. What is most needed is a focus on improving outcomes and developing a system of care that can operate in a holistic, sustained and integrated way. In order to monitor the outcomes of care, investments are needed in improved and locally-valid assessment and treatment planning along with improved clinical training, supervision, program evaluation, management, professional development, and sustainable funding.

3.5. EVALUATING COST EFFECTIVENESS

Investment in preventative interventions might stave off higher costs down the road by avoiding the need for higher-level services, juvenile justice or corrections efforts, loss of productivity due to years of lost schooling or limited economic contribution. Nonetheless, the argument for the cost effectiveness of mental health interventions for former child soldiers has received very little attention. In global health, a number of key leaders have drawn attention to the concept of "value" (health outcomes per dollar invested). Without strong mental health assessment, treatment planning and outcomes evaluation, such calculations cannot be made. However, such evidence is of utmost importance for making arguments about investing in service delivery programs for demobilized children and their families to policymakers and funders.

PART E: RECOMMENDATIONS

Our review of the state of the field of services and research for former child soldiers indicates a wealth of programmatic effort, but only nascent research. The field is experiencing a welcome period of growth in critical policy analysis, applied research, and evaluation of common interventions. The following recommendations point to a number of compelling new directions for service responses and research.

1. SERVICES AND PROGRAMMATIC RECOMMENDATIONS

- Holistic, integrated systems of care are needed for all war-affected youth. We discourage service systems developed only for former child soldiers and urge investments in locally viable and sustainable systems of psychosocial and mental health interventions for all war-affected youth with particular expertise to respond to highly traumatized groups. Care should be provided on the basis of needs (distress and persistent impairment) and not labels.

- The subscription by organizations to the false dichotomy between psychosocial and clinical mental health responses for war-affected children must be ended. Both approaches can make significant contributions to the care of war-affected youth and should be used in tandem, with initial psychosocial responses serving as the first line of defense and clinical approaches targeting youth whose distress and impairment persist once basic psychosocial responses are in place. The IASC guidelines and pyramid of humanitarian responses should be used as a framework for this response.

- Although labels and assumptions about particular subgroups of war-affected youth may be harmful, we must recognize that the risk of persistent mental health disorders is high in certain profiles of youth, particularly former child soldiers who perpetrated extreme acts of violence or were its victims (i.e., sexual violence). Mental health assessment must be improved to contain information about a young person's trauma history and its implications for their care.

- Particular steps must be taken to ensure that war-affected females, particularly those who were child soldiers, are provided with the appropriate social and economic supports to ensure healthy reintegration. Service providers must recognize the double indemnity that girl soldiers face as extreme levels of exposure to violence are often compounded by increased risk of sexual violence, unwanted pregnancy and its social consequences.

- Services systems should be developed to capitalize on indigenous supportive responses and capacities. Local staff should be trained and mechanisms for sustainable funding and supervision put into place to ensure that psychosocial supports and opportunities for mental health care do not vanish once the period of humanitarian emergency subsides.

- Training of local staff cannot be implemented without commensurate attention to developing mechanisms for routine supervision and professional development of local staff. Such interventions may improve the quality of care by reducing burnout and improving staff recruitment and retention.

- The development of service systems should involve close collaboration and leadership from local governmental and nongovernmental actors in order to build technical capacity, collaboration and referral networks and the political will to develop and sustain systems of care. The development of systems of care for enriching psychosocial supports and mental health care must be accompanied by improved investment in child protective services and social welfare systems to ensure a social safety net for extremely disadvantaged families in regions ravaged by conflict.

- Psychosocial responses and mental health care are most effective when integrated with other service systems such as schools and primary care.

- Investments must be made in evaluating both the implementation and the outcomes of psychosocial and mental health services. To date, there is very little evidence on interventions or packages of interventions that have been proven as effective for improving both psychosocial and clinical mental health outcomes in former child soldiers. Interventions with evidence of potential effectiveness for assisting war-affected children should be evaluated with particular attention to subgroups of interest (former child soldiers, children with significant trauma histories, etc.).

2. RESEARCH RECOMMENDATIONS

- Longitudinal research is needed in order to truly unpack forces of risk and resilience contributing to social and emotional outcomes in war-affected youth in general and former child soldiers in particular.

- More research is needed to better understand the consequences of child soldiering from a comprehensive bio-psychosocial and developmental perspective.

- Further research is needed to broaden and deepen the understanding of the factors that help to protect child soldiers from the consequences of war and that foster resilience to violence. Attention to understanding pathways of recovery is critical.

- Future research may be improved by integrating qualitative and quantitative methods in order to improve the culturally valid measurement of mental health and related constructs.

- Operational research is important for understanding how services function in terms of providing viable, sustainable and effective systems of psychosocial and mental health care for war-affected youth and families. Again, qualitative and quantitative research with beneficiaries and providers from front line staff to higher level leadership can illuminate critical issues in the implementation of mental health care in low resource settings.

- Participatory methods such as participatory action research should be implemented to improve opportunities for local people to set research agendas and focus on problems of local priority. Young people themselves have an important role to play in helping to set research agendas and help to collaborate in studies on the situation of war-affected youth.

- Future research will be improved if it brings together the academic and the policy/practitioner worlds. A more directed collaboration in gathering data and providing analysis is critical to advance research and practice.

- Future research with child soldiers should utilize relevant comparison groups of war-affected youth who were not involved in the fighting forces. This will lead to better contextualizing of the effect of war and violence on psychosocial adjustment.

- Future intervention research should examine the efficacy of adapted evidence-based interventions for mental health problems such as mood and anxiety disorders and complex trauma in war-affected youth. Intervention research should also explore the impact of traditional health approaches and examine their potential to be integrated into treatment models. In this way, the identification of core components of treatment models will be better grounded in evidence of "essential ingredients" for addressing distress and impairment in war-affected youth in different settings.

- Ethical research on war-affected youth must involve close collaboration with local services providers both for ensuring that findings may be translated into improve care as well as for providing a referral network for research participants who may require immediate medial or psychological support.

- Cost effectiveness research is needed in order to bolster policy arguments about the importance of preventative investments in child and adolescent psychosocial and mental health care by local governments and international funders.

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APPENDIX I:
PUBLICATIONS AND REPORTS WITH SPECIFIC REFERENCE TO FORMER CHILD SOLDIERS

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
1	Acosta, Y.	2003	Face to face with former child soldiers - and hope	UN paper	n/a
2	Action for the Rights of Children	2001	Critical issues: Child soldiers	NGO report	n/a
3	Adok, N. et al.	2007	Trauma, resilience and cultural healing: How do we move forward?	Article published by the CSUCS	n/a
4	Ager, A. et al.	2001	Discussion paper 2: Programming and evaluation for psychosocial programmes	Discussion Paper	n/a
5	Alexander, J.	2006	Community based reintegration: Programme evaluation	UN/Governmental report	n/a
6	Alfredson, L.	2001	Sexual exploitation of child soldiers: An exploration and analysis of global dimensions and trends	Article published by the CSUCS	n/a
7	Allen, T. et al.	2006	A hard homecoming: Lessons learned from the reception center process in northern Uganda.	UN/Governmental report	Uganda
8	Amone-P'Olak, K.	2006	Mental states of adolescents exposed to war in Uganda: finding appropriate methods of rehabilitation	Peer reviewed article	Uganda
9	Annan, J. et al.	2006	The psychological resilience of youth in northern Uganda: Survey of War Affected Youth, Research Brief 2	UN/Governmental report	Uganda
10	Annan, J. et al.	2006	The state of youth and youth protection in northern Uganda	UN/Governmental report	Uganda
11	Annan, K.	2000	Report of the secretary general on the work of the organization	UN/Governmental report	n/a
12	Ashby, P.	2002	Child combatants: A soldier's perspective.	Peer reviewed article	n/a
13	Ayalon, O.	1998	Community healing for children traumatized by war.	Peer reviewed article	n/a
14	Barth, E. F.	2002	Peace as disappointment: The reintegration of female soldiers in post-conflict societies: A comparative study from Africa	Comparative report	Multi Country
15	Bayer, C. P. et al.	2007	Association of trauma and PTSD symptoms with openness to reconciliation and feelings of revenge among former Ugandan and Congolese child soldiers	Peer reviewed article	Uganda and Congo

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
16	Betancourt, T.S. et al.	in prep.	Sierra Leone's child soldiers: War traumas and post-conflict psychosocial adjustment by sex	Peer reviewed article	Sierra Leone
17	Betancourt, T.S. et al.	2003	Psychosocial adjustment and social reintegration of child ex-combatants: Wave I report, baseline analysis	NGO report	Sierra Leone
18	Betancourt, T.S. et al.	2005	Psycho-social adjustment and social reintegration of child ex-soldiers in Sierra Leone - follow-up analysis	UN/Governmental report	Sierra Leone
19	Betancourt, T.S. et al.	2004	Holding on to hope: Education, coping, and the struggles of children associated with fighting forces in Sierra Leone	NGO report	Sierra Leone
20	Betancourt, T.S. et al.	2007	Executive summary of research: Psychosocial adjustment and social reintegration of child ex-combatants in Sierra Leone	NGO report	Sierra Leone
21	Bichescu, D. et al.	2007	Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression	Peer reviewed article	n/a
22	Blattman, C. et al.	2007	On the nature and causes of LRA abduction: What the abductees say (Draft)	Book chapter	Uganda
23	Blattman, C. et al.	2007	The consequences of child soldiering	Working Paper	Uganda
24	Boothby, N.	1986	Children in armed conflicts: Rights, reality and future implications	Book	n/a
25	Boothby, N.	2006	When former child soldiers grow up: The keys to reintegration and reconciliation	Book chapter	Mozambique
26	Boothby, N. et al.	2006	A world turned upside down: Social ecological approaches to children in war zones	Book	Multi Country
27	Boothby, N. et al.	2006	Mozambique child solider life outcome study: Lessons learned in rehabilitation and reintegration efforts	Peer reviewed article	Mozambique
28	Brett, R.	2004	Child soldiers: Denial of rights and responsibilities	Peer reviewed article	n/a
29	Castelli, L. et al.	2005	Psycho-social support for war-affected children in Northern Uganda: Lessons learned	Article published by the CSUCS	Uganda
30	Christian Children's Fund	1998	Project of reintegration of child soldiers in Angola	UN/Governmental report	Angola
31	Christian Children's Fund	2006	Child soldiers	NGO report	n/a
32	Coalition to Stop the Use of Child Soldiers	2001	Child soldiers-global report	Global Report	Multi Country
33	Coalition to Stop the Use of Child Soldiers	2004	Sudan - Child soldier use 2003: A briefing for the 4th UN Security Council open debate on children and armed conflict	Article published by the CSUCS	Sudan

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
34	Coalition to Stop the Use of Child Soldiers	2005	Child soldiers bibliography	Article published by the CSUCS	Multi Country
35	Cortes, L. et al.	2007	The experience of Colombian child soldiers from a resilience perspective	Peer reviewed article	Colombia
36	Creson, et al.	2001	A manual for psychosocial intervention: Psychological and social interventions in complex emergencies	NGO report	n/a
37	De Silva, D.	2001	Conscription of children in armed conflict: Clarifications	Peer reviewed article	n/a
38	Denov, M. S.	2006	Is the culture always right? The dangers of reproducing gender stereotypes and inequalities in psychosocial interventions for war-affected children	Article published by the CSUCS	n/a
39	Denov, M. S.	2006	Wartime sexual violence: Assessing a human security response to war-affected girls in Sierra Leone	Peer reviewed article	Sierra Leone
40	Derluyn, I. et al.	2004	Post-traumatic stress in former Ugandan child soldiers	Peer reviewed article	Uganda
41	Dodge, C.	1986	Child soldiers of Uganda — What does the future hold?	Peer reviewed article	Uganda
42	Druba, V.	2002	The problem of child soldiers	Peer reviewed article	n/a
43	Duncan, J. et al.	2003	Children in crisis: Good practices in evaluating psychosocial programming	NGO report	n/a
44	Economist, The	1999	Kalashnikov kids	Article	n/a
45	Goodwin-Gill, G. et al.	1994	Child soldiers, the role of children in armed conflicts	Book	Multi Country
46	Green, E. et al.	1999	Indigenous healing of war-affected children in Africa	UN/Governmental report	Multi Country (Africa)
47	Gupta, L. et al	2008	Psychosocial intervention for war-affected children in Sierra Leone	Peer reviewed article	Sierra Leone
48	Hauge, W.	2007	The demobilization and political participation of female fighters in Guatemala	UN/Governmental report	Guatemala
49	HealthNet TPO	2006	Child thematic psychosocial project: School-, and community based psychosocial care for children in areas of armed conflict in Sri Lanka, Sudan, Burundi and Indonesia	NGO report	Multi Country
50	HealthNet TPO	2007	Child thematic project: School and community based psychosocial care for children in areas of armed conflict in Burundi, Sri Lanka, Sudan and Indonesia	NGO report	Multi Country
51	Heeren, N.	2004	Sierra Leone and civil war: Neglected trauma and forgotten children	Article published by the CSUCS	Sierra Leone

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
52	Hoiskarh, A. H.	2001	Underage and under fire: An enquiry into the use of child soldiers 1994–8	Peer reviewed article	n/a
53	Honwana, A.	1998	Okusiakala ondalo yokalye: Let us light a new fire: Local knowledge in the post-war healing and reintegration of war-affected children in Angola	NGO report	Angola
54	Honwana, A.	2002	Negotiating postwar identities: Child soldiers in Mozambique and Angola	Book chapter	Mozambique and Angola
55	Honwana, A.	2006	Child soldiers in Africa	Book	Africa
56	Human Rights Watch	1994	Easy prey: Child soldiers in Liberia	NGO report	Liberia
57	Human Rights Watch	1997	The scars of death: Children abducted by the Lord's Resistance Army in Uganda	NGO report	Uganda
58	Human Rights Watch	1999	Forgotten children of war: Sierra Leonean refugee children in Guinea	NGO report	Sierra Leone
59	Human Rights Watch	2002	My gun was as tall as me: Child soldiers in Burma	NGO report	Burma
60	Human Rights Watch	2003	"We'll kill you if you cry": Sexual violence in the Sierra Leone Conflict.	NGO report	Sierra Leone
61	Human Rights Watch	2003	Abducted and abused: Renewed conflict in Northern Uganda	NGO report	Uganda
62	Human Rights Watch	2003	Forgotten fighters: Child soldiers in Angola	NGO report	Angola
63	Human Rights Watch	2003	Stolen children: Abduction and recruitment in northern Uganda	NGO report	Uganda
64	Human Rights Watch	2004	How to fight, how to kill: Child soldiers in Liberia	NGO report	Liberia
65	Human Rights Watch	2005	Youth, poverty and blood: the lethal legacy of West Africa's regional warriors	Article published by the CSUCS	Africa
66	Inter-Agency Reintegration Workshop	2006	Meeting the challenges: Inter-Agency Workshop on the reintegration of children affected by armed conflict in West and Central Africa	Working Paper	West Africa
67	Inter-Agency Standing Committee	2007	IASC guidelines on mental health and psychosocial support in emergency settings	International guidelines/law	n/a
68	International Labour Organization	2002	Investigating the worst forms of child labour no. 21. Philippines child soldiers in central and western Mindanao: a rapid assessment	NGO report	Philippines
69	Kalksma-van Lith, B.	2005	Psychosocial interventions with children in war-affected areas: the state of the art	Peer reviewed article	n/a

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
70	Kanagaratnam, P. et al.	2005	Ideological commitment and posttraumatic stress in former Tamil child soldiers	Peer reviewed article	Sri Lanka
71	Kays, L.	2005	Why we cannot find the hidden girl soldier: A study of professional attitudes towards gender analysis in international conflict and development work	Peer reviewed article	n/a
72	Keairns, Y.	2003	The voices of girl child soldiers: Sri Lanka	UN/Governmental report	Sri Lanka
73	Keairns, Y.	2003	The voices of girl child soldiers: Colombia	UN/Governmental report	Colombia
74	Kellah, A. T.	2007	Establishing services in post-conflict Sierra Leone	Peer reviewed article	Sierra Leone
75	Kerins, M. A. et al.	2005	A case study of the psychosocial program of AVSI in Uganda 1994-2005	NGO report	Uganda
76	Kimmel, C. E. et al.	2007	Institutionalized child abuse: The use of child soldiers	Peer reviewed article	n/a
77	Kline, P. et al.	2003	Coping with war: Three strategies employed by adolescent citizens of Sierra Leone	Peer reviewed article	Sierra Leone
78	Kohrt, B.	2007	Recommendations to promote psychosocial well-being of children associated with armed forces and armed groups (CAAFAG) in Nepal	UN/Governmental report	Nepal
79	Kona, S.	2007	IPCS special report: Child soldiers in Afghanistan	NGO report	Afghanistan
80	Lamberg, L.	2004	Reclaiming child soldiers' lost lives	Peer reviewed article	n/a
81	Lancet, The	2004	The hidden health trauma of child soldiers	Peer reviewed Editorial	n/a
82	Lorey, M.	2001	Child soldiers care & protection of children in emergencies: A field guide	NGO report	n/a
83	Lowicki, J. et al.	2000	Recognizing war-affected adolescents: Frameworks for action	Peer reviewed article	n/a
84	Lustig, S. L. et al.	2004	Review of child and adolescent refugee mental health	Peer reviewed article	n/a
85	MacMullin, C. et al.	2004	Investigating psychosocial adjustment of former child soldiers in Sierra Leone and Uganda	Peer reviewed article	Sierra Leone and Uganda
86	Maurin, J.	2006	Education initiatives for war-affected youth: An examination of programs in Sierra Leone and Liberia	Dissertation	Sierra Leone and Liberia
87	Maxted, J.	2003	Children and armed conflict in Africa	Peer reviewed article	Africa

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
88	Mazurana, D. et al.	2001	Child soldiers: Where are the girls?	Peer reviewed article	n/a
89	Mazurana, D. et al.	2003	Girls in fighting forces in northern Uganda, Sierra Leone, and Mozambique: Policy and program recommendations	UN/Governmental report	Uganda, Sierra Leone, and Mozambique
90	Mazurana, D. et al.	2004	From combat to community: Women and girls of Sierra Leone	NGO report	Sierra Leone
91	McConnan, I. et al.	2001	Children - not soldiers: Guidelines for working with child soldiers and children associated with fighting forces	NGO report	n/a
92	McKay, S. et al.	2004	Where are the girls? Girls in fighting forces in Northern Uganda, Sierra Leone, and Mozambique: Their lives during and after war	Conference paper	Uganda, Sierra Leone, and Mozambique
93	McKay, S. et al.	2006	Girls formerly associated with fighting forces and their children: Returned and neglected	Article published by the CSUCS	n/a
94	MDRP	2006	Elisabeth Schauer, Director of Vivo, Speaks about psycho-social support for ex-combatants	NGO report	n/a
95	Medeiros, E.	2007	Integrating mental health into post-conflict rehabilitation: The case of Sierra Leonean and Liberian 'child soldiers'	Peer reviewed article	Sierra Leone
96	Miller, V. W. et al.	2002	Helping children outgrow war	UN/Governmental report	n/a
97	Mitchell, J. A.	2006	Soldier girl? Not every Tamil teen wants to be a tiger	Peer reviewed article	Sri Lanka
98	Morales, F. J. A.	2005	The psycho-social care of demobilized child soldiers in Colombia: Conceptual and methodological aspects	Article published by the CSUCS	Colombia
99	National Child Traumatic Stress Network	2005	Mental health interventions for refugee children in resettlement: White paper II	White paper	n/a
100	Neuner, F. et al.	2002	A narrative exposure treatment as intervention in a refugee camp: A case report	Peer reviewed article	n/a
101	OCHA	2006	Child soldiers global report: United Nations Office for Coordination of Humanitarian Affairs	Global Report	n/a
102	Odeh, M. et al.	n.d.	Children in armed conflict: Recent developments in international rehabilitation of child soldiers	NGO report	n/a
103	Olness, K. et al.	2005	How to help the children in humanitarian disasters	NGO report	n/a
104	Onyut, L. P. et al.	2005	Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: two case reports and a pilot study in an African refugee settlement	Peer reviewed article	Uganda
105	Patel, V. et al.	2007	Mental health of young people: a global public-health challenge	Peer reviewed article	n/a

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
106	Peters, et al.	1998	Why we fight: Voices of youth combatants in Sierra Leone	Peer reviewed article	Sierra Leone
107	Pham, P. et al.	2007	Abducted: The Lord's Resistance Army and forced conscription in northern Uganda	NGO Report	Uganda
108	Psychosocial Working Group	2003	Case study: Child soldiers	Psychosocial Working Group.	Multi Country
109	Santacruz, M. L. et al.	2002	Experiences and psychosocial impact of the El Salvador civil war on child soldiers	Peer reviewed article	El Salvador
110	Save the Children	1996	Promoting psychosocial well-being among children affected by armed conflict and displacement: Principles and approaches	UN/Governmental report	n/a
111	Save the Children	2004	Classroom-based intervention (CBI) impact evaluation	NGO report	Palestine
112	Schauer, E. et al.	2004	Narrative Exposure Therapy in children: A case study	Peer reviewed article	n/a
113	Shepler, S.	2005	The rites of the child: Global discourses of youth and reintegrating child soldiers in Sierra Leone	Peer reviewed article	n/a
114	Somasundaram, D.	2002	Child soldiers: Understanding the context	Peer reviewed article	n/a
115	Sommers, M.	1997	The children's war: Towards peace in Sierra Leone. A field report assessing the protection and assistance needs of Sierra Leonean children and adolescents	UN/Governmental report	Sierra Leone
116	Sommers, M.	2002	Children, education and war: Reaching Education for All (EFA) objectives in countries affected by conflict	UN/Governmental report	n/a
117	Summerfield, D.	1996	The impact of war and atrocity on civilian populations: Basic principles for NGO interventions and a critique of psychosocial trauma projects	NGO report	n/a
118	SWAY	2007	Making reintegration work for youth in Northern Uganda: Findings from two phases of the Survey of War Affected Youth	UN/Governmental report	Uganda
119	The Coalition to Stop the Use of Child Soldiers	2002	Girls with guns: An agenda on child soldiers for 'Beijing plus five'	Article published by the CSUCS	China
120	The Coalition to Stop the Use of Child Soldiers	2004	Child soldiers. Global report 2004	Global Report	Multi Country
121	The Coalition to Stop the Use of Child Soldiers	2006	Call for action: Working with child soldiers in West Africa	Article published by the CSUCS	West Africa
122	The Coalition to Stop the Use of Child Soldiers	2006	Child soldiers and disarmament, demobilization, rehabilitation and reintegration in West Africa: A survey of programmatic work on child soldiers in Cote d'Ivoire, Guinea, Liberia and Sierra Leone	Article published by the CSUCS	Cote d'Ivoire, Guinea, Liberia and Sierra Leone

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
123	The Coalition to Stop the Use of Child Soldiers	2007	Democratic Republic of the Congo: Priorities for children associated with armed forces and groups	Article published by the CSUCS	Congo
124	Theidon, K.	2007	Transitional Subjects: The disarmament, demobilization and reintegration of former combatants in Colombia	Peer reviewed article	Colombia
125	UNHCR	2002	Action for the Rights of Children (ARC): Critical issues - child soldiers	UN/Governmental report	n/a
126	UNICEF	n.d.	Psychosocial intervention: CBI	UN/Governmental report	n/a
127	UNICEF	1997	Cape Town principles and best practices	International guidelines/law	n/a
128	UNICEF	2002	Adult wars, child soldiers: Voices of children involved in armed conflict in the East Asia and Pacific region	UN/Governmental report	East Asia and Pacific region
129	UNICEF	2003	Guide to the optional protocol on the involvement of children in armed conflict	International guidelines/law	n/a
130	UNICEF	2008	Course book for community psychosocial workers providing psychosocial support for children associated with armed forces and armed groups	UN/Governmental report	Nepal
131	United Nations	2006	Human rights abuses by the CPN-M: Summary of concerns	International guidelines/law	n/a
132	Uppard, S.	2003	Child soldiers and children associated with the fighting forces	Peer reviewed article	n/a
133	Uribe Velez, A.	2003	The children's stories	Peer reviewed article	n/a
134	Verhey, B.	n.d.	The demobilization and reintegration of child soldiers: El Salvador case study	UN/Governmental report	El Salvador
135	Verhey, B.	2001	Child soldiers: Preventing, demobilizing and reintegrating	UN/Governmental report	Multi Country
136	Verhey, B.	2002	Child soldiers: Lessons learned on prevention, demobilization and reintegration	UN/Governmental report	Multi Country
137	Verhey, B.	2003	Going home: Demobilising and reintegrating child soldiers in the Democratic Republic of the Congo	UN/Governmental report	Congo
138	Wessells, M.	n.d.	A living wage: The importance of livelihood in reintegrating former child soldiers	Book chapter	Multi Country
139	Wessells, M.	2005	Child soldiers, peace education, and postconflict reconstruction for peace	Peer reviewed article	Sierra Leone
140	Wessells, M.	2006	Child soldiering: Entry, reintegration, and breaking cycles of violence	Book Chapter	Multi Country

	AUTHOR	YEAR	TITLE	TYPE OF PUBLICATION	COUNTRY OF FOCUS (IF APPLICABLE)
141	Wessells, M.	2006	Child soldiers: From violence to protection	Book	Multi Country
142	Wessells, M.	2007	Trauma, culture and community: Getting beyond dichotomies	Article published by the CSUCS	Multi Country
143	Williamson, et al.	1999	Liberia's WAYS project assessment	UN/Governmental report	Liberia
144	Williamson, et al.	2005	Children's reintegration in Liberia	UN/Governmental report	Liberia
145	Williamson, J.	2005	Reintegration of child soldiers in Sierra Leone	UN/Governmental report	Sierra Leone
146	Williamson, J.	2006	The disarmament, demobilization and reintegration of child soldiers: social and psychological transformation in Sierra Leone	Peer reviewed article	Sierra Leone
147	Williamson, J. et al.	1999	Liberia's WAYS Project Assessment: July 1999	UN/Governmental report	n/a
148	Williamson, J. et al.	2002	Assessment of DCOF-supported child demobilization and reintegration activities in Sierra Leone	UN/Governmental report	Sierra Leone
149	Williamson, J., et al.	2005	Children's reintegration in Liberia	UN/Governmental report	Liberia
150	World Revolution, The	2001	Child soldiers: A global problem	UN/Governmental report	n/a
151	Zack-Williams, T. B.	2006	Child soldiers in Sierra Leone and the problems of demobilisation, rehabilitation and reintegration into society: Some lessons for social workers in war-torn societies	Peer reviewed article	Sierra Leone

APPENDIX II:
MAJOR NONGOVERNMENTAL AND INTERNATIONAL AGENCIES SERVING WAR-AFFECTED YOUTH

PROGRAM	AREAS OF PROGRAMMING WITH WAR-AFFECTED YOUTH (education, job skills, psychosocial care, etc.)	WORK WITH FORMER CHILD SOLDIERS / WAR-AFFECTED YOUTH?	COUNTRIES OF FOCUS
Amnesty International www.amnesty.org	Research Advocacy Policy	Child soldiers War-affected youth	Global
AVSI www.avsi-usa.org	Education Foster/host families & community daycare Psychosocial support Reintegration Vocational/skills training	Child soldiers War-affected youth	Active programs in 35 countries
CARE International www.care.org	Education Vocational/skills training Demobilization Reintegration Psychosocial support Child tracing Healthcare Nutrition Water & sanitation	Child soldiers War-affected youth	Active programs in 66 countries
Center for Victims of Torture www.cvt.org	Mental health services Psychosocial training for community health workers Community sensitization	War-affected youth No programs specifically target child soldiers	Sierra Leone Liberia DRC
Christian Children's Fund www.christianchildrensfund.org	Reunification Reintegration Primary Education Psychosocial support Economic reintegration	Child soldiers War-affected youth	Uganda Sierra Leone Liberia Angola Afghanistan
Coalition to Stop the use of Child Soldiers www.child-soldiers.org	Research & monitoring Advocacy Policy	Child soldiers War-affected youth	Global
HealthNetTPO www.healthnettpo.org	School and community based psychosocial care	Child soldiers War-affected youth	Indonesia Sri Lanka Burundi Sudan

PROGRAM	AREAS OF PROGRAMMING WITH WAR-AFFECTED YOUTH (education, job skills, psychosocial care, etc.)	WORK WITH FORMER CHILD SOLDIERS / WAR-AFFECTED YOUTH?	COUNTRIES OF FOCUS
Human Rights Watch www.hrw.org	Research Advocacy Policy	Child soldiers War-affected youth	Global
IRC www.theirc.org	Protection Health care Emotional support Demobilization Reintegration	Child soldiers War-affected youth	Burundi DR of Congo Côte d'Ivoire Liberia Uganda
Médecins Sans Frontières www.msf.org	Psychosocial support Reintegration Community sensitization Medical care	Child soldiers War-affected youth	Active programs in more than 70 countries
OXFAM www.oxfam.org	Psychosocial support Livelihoods assistance Policy Advocacy	Child soldiers War-affected youth	Active programs in more than 100 countries
Right to Play www.righttoplay.com	Facilitate normalization Rehabilitation Reintegration Psychosocial support & play programs	Child soldiers War-affected youth	Chad Ethiopia Indonesia Lebanon Liberia Mozambique Pakistan Palestinian Territories Rwanda Sierra Leone Sri Lanka Sudan Uganda and others
Save the Children www.savethechildren.org	Emergency education Reunification Demobilization Reintegration Prevention of recruitment Psychosocial support Raising awareness	Child soldiers War-affected youth	Active programs in more than 50 countries
Search for Common Ground www.sfcg.org	Policy Community outreach Peacebuilding through media outlets	Child soldiers War-affected youth	Angola Burundi Côte d'Ivoire DR of Congo Guinea Indonesia Liberia Macedonia Nepal Sierra Leone

PROGRAM	AREAS OF PROGRAMMING WITH WAR-AFFECTED YOUTH (education, job skills, psychosocial care, etc.)	WORK WITH FORMER CHILD SOLDIERS / WAR-AFFECTED YOUTH?	COUNTRIES OF FOCUS
UNHCR www.unhcr.org	Relocation & resettlement Repatriation Skills training Income generation Education Psychosocial support Legal assistance Nutrition Healthcare Water & sanitation Shelter	Child soldiers War-affected youth	Active programs in more than 110 countries
UNICEF www.unicef.org	Policy reform Advocacy Child protection Tracing Reunification Prevention of recruitment Demobilization Education Healthcare & sanitation Nutrition	Child soldiers War-affected youth	Active programs in 190 countries
United Nations Secretary General - Special Representative for Children in Armed Conflict www.un.org/children/conflict/english/index.html	Policy Advocacy Research Monitoring & reporting	Child soldiers War-affected youth	Global
USAID/DCOF www.usaid.gov/our_work/humanitarian_assistance/the_funds/dcof	Funds: Education & literacy Vocational training Water & sanitation Advocacy and Policy Child protection Community mobilization/sensitization Reunification Psychosocial support	Child soldiers War-affected youth	Afghanistan DR of Congo Sri Lanka Sudan Uganda and others
Vivo www.vivofoundation.net	Advocacy Research Evidence-based psychological interventions	Child soldiers War-affected youth	Global
War Child www.warchild.org	Reintegration Psychosocial support Prevention Reintegration Peace building Conflict resolution	War-affected youth No programs specifically target child soldiers	DR of Congo Sierra Leone N. Uganda Colombia Sudan

PROGRAM	AREAS OF PROGRAMMING WITH WAR-AFFECTED YOUTH (education, job skills, psychosocial care, etc.)	WORK WITH FORMER CHILD SOLDIERS / WAR-AFFECTED YOUTH?	COUNTRIES OF FOCUS
WHO www.who.int/mental_health/emergencies/en	Policy Technical advice/assistance to field-based programs Research	Child soldiers War-affected youth	Global
World Vision www.worldvision.org	Prevention Demobilization Reintegration Raise awareness Advocacy for US policy	Child soldiers War-affected youth	N. Uganda

APPENDIX III:
TRAINING MANUALS REVIEWED FOR ASSISTING WAR-AFFECTED CHILDREN, FAMILIES AND COMMUNITIES

ORGANIZATION	YEAR	TITLE/TOPIC	WHAT IS IT?	FOR WHOM?	FOCUS
ACT	2005	Community based psychosocial services in humanitarian assistance	Facilitator's guide to train people who will be responding to disasters	Community	Identifying and assisting people following disasters
Action for the Rights of Children (ARC)	2002	A child rights based training and capacity building initiative	A brochure for their resource packs	Children	Includes abstracts relating to children
ADEPT	2005	Disaster psychosocial response	Training community workers and volunteers to identify services people could need and offer support	Community	In the context of the tsunami in Tamil Nadu, India, pertinent for survivors of natural disasters
AVSI	2003	Handbook for teachers	A handbook for teachers used in Uganda for people displaced by Lord's Resistance Army (LRA)	Children	Psychosocial - teachers' role
AVSI	2003	Manual for teachers	Manual for training teachers, handbook followed manual	Children	Psychosocial - teachers' role
AVSI (Uganda)	2000	Training manual for community volunteer counselors	Manual for 5-day training of volunteer counselors	Community	Training volunteer counselors
Catholic Relief Services	2001	A manual for psychosocial intervention in complex emergencies	Step by step guide for people working in CRS to provide on-site care	Community	What counselors and program officers can do "in the moment"
Center for Health and Counseling Shantiam (Jaffna)	2001	Training counselors in areas of armed conflict within a community approach	Manual for counselors to use in training professional/lay counselors	Community	Training counselors--includes info on how to train, as well as content related to MH in armed conflict
Child in Need Network	1999	Trainer's manual for psycho-social counseling of children	Developed in Zambia for people providing services to children	Children	Family, gender, what children need, child abuse, communication, counseling, implementation

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ORGANIZATION	YEAR	TITLE/TOPIC	WHAT IS IT?	FOR WHOM?	FOCUS
Health Frontiers	2005	How to help children in humanitarian disasters	For people who are experts in own field but may not be familiar with issues around children	Children	Priorities in disasters
Hong Fook Mental Health Association	2006	Journey to promote mental health	Series of workshops that peers do with participants around mental health	Community	Mental health/illness in general
Hong Fook Mental Health Association	2007	Training mental health peer leaders	Training mental health peer leaders - adult education	Adult	How to engage adult learners
IMHPA	2005	A training manual for preventing illness: Managing emotional symptoms and problems in primary care	2 day training program for primary care health professionals with problem solving and symptom management	Community	Focuses on preventing mental illness in primary care settings
NCTSN	2006	Psychological first aid	Training first responders for use in the immediate aftermath of disasters and terrorism	Community	Mental triage care for both children and adults in specific types of trauma
Norwegian Refugee Council	n.d.	Psychosocial support/trauma healing	For teachers of children affected by the war in Sierra Leone	Children	Illustrations relating to stressors children may have experienced, to help teachers better understand what the children are going through
Office of Emergency Programmes	1997	Psychosocial care and protection of children in situations of armed conflict	5 day training course for program officers	Children	Descriptive
Pakistan	n.d.	Mental health module for psychosocial care givers	For health workers serving earthquake victims	Community	Understanding common responses to earthquakes, differences between distress and disorders

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ORGANIZATION	YEAR	TITLE/TOPIC	WHAT IS IT?	FOR WHOM?	FOCUS
Plan International	2001	Understanding trauma	Training teachers working with former child soldiers in Sierra Leone	Children	Children suffering loss or grief due to separation from loved ones, death and violence
SAMHSA	2000	Training manual for mental health and human service workers in major disasters	Training mental health professionals as they plan their crisis counseling disaster response	Community	Tailoring program to individual community event
Save the Children	2004	Good practices in evaluating psychosocial programming	Best practices for evaluating	Community	n/a
Save the Children	n.d.	Guidelines for early childhood development programs in conflicts and emergencies in the Balkans	Field guide/quick reference for field workers	Children	Minimum standards, drawing more attention to importance of mental health awareness in early childhood development
Save the Children	2004	Psychosocial care and protection of children in emergencies	Part of war capacity building initiative series	Children	Education, gender-based violence, youth, separated children, child soldiers, psychosocial care and support
Save the Children, Sweden	n.d.	Restoring playfulness: Different approaches to assisting children who are psychologically affected by war or displacement	A book and an introduction to the topic, guidelines for program planners	Children	Key themes and issues in restoring playfulness, with many global case studies
TPO (Uganda, S. Sudan)	2002	Training manual for volunteer community psychosocial assistants	Manual for training volunteer community assistants	Community	n/a
TPO Cambodia	n.d.	Community mental health in Cambodia	Cambodia specific for WHO's mental health interventions	Community	Community mental health, not necessarily individual
TPO Jaffna	2000	Mental health in the Tamil community	Overview of mental health (stress, helping, common disorders) for CHW, NOGS workers, etc	Community	Mental health of community

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ORGANIZATION	YEAR	TITLE/TOPIC	WHAT IS IT?	FOR WHOM?	FOCUS
UNICEF	2002	Working with children in unstable situations	For UNICEF and partners, humanitarian workers, principles, interventions	Children	Broad themes under four headings: unstable situations and psychosocial interventions, children and their needs, policies and programming principles, addressing needs
UNICEF	2000	Helping children cope with the stressors of war - A manual for parents and teachers	Specific incidents and how to respond to children who are coping	Children	Experiences that cause stress and common reactions in children - advice for teachers and parents
University of Manchester, UPE	2003	Helping people with mental illness: A mental health training program for community health workers	Training trainers/community health workers to go to South Africa and train more community health workers	Adult	Understanding and identifying people with mental illness, treatment and recovery, tracing people who default
University of Natal, South Africa	n.d.	A structured group therapy program to assist vulnerable children affected by HIV/AIDS, poverty, and violence	Structuring the way community health workers interact with children	Children	For children in South Africa
USHHS	1999	Disaster mental health: Crisis counseling programs for the rural community	For rural health outreach workers in the USA, mainly responding to floods and tornadoes	Community	Protecting rural communities and establishing support systems quickly
WHO	2005	Basic counselling guidelines for ARV programmes	Module 2 in series "Mental Health and HIV/AIDS"	Community	Counseling techniques, environment; ARV specific
WHO	2005	Human resources and training in mental health	How to manage human resources in mental health, integrate into primary care, etc.	Community	HR in program planning
WHO	1996	Mental health of refugees	Manual for health care professionals working with people who have fled disaster	Community	How to be a listener, what to expect from refugees

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ORGANIZATION	YEAR	TITLE/TOPIC	WHAT IS IT?	FOR WHOM?	FOCUS
WHO	1998	Mental disorders in primary care	For primary health care providers who could recognize the first signs of mental disorders in primary care	Adult	Assessment tools for identifying patients with mental illness
WHO	1990	An introduction of a mental health component into primary health care	Identifying need for more flexible methods of delivery	Community	Giving mental health more attention in the primary care phase of health delivery
WHO, MOH Ghana	n.d.	Psychiatric notes for volunteer community workers	For community health workers	Community	Identifying psychiatric patients

APPENDIX IV:
EVIDENCE-BASED MENTAL HEALTH INTERVENTIONS USED WITH CHILDREN IN CONFLICT-AFFECTED SETTINGS

SOMALI REFUGEES			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Onyut, L.P., Neuner, F., Schauer, E.S., Ertl, V., Odenwald, M., Schauer, M. & Elbert, T. (2005). Narrative Exposure Therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BMC Psychiatry, 5(7)*	Exposure Reconstructing Trauma Narrative Short-term treatment Intervention delivered by "expert clinicians experienced in the use of NET"	6 Somali refugees in Uganda Ages 13-17 4-6 individual sessions of KIDNET Pilot study: Symptoms assessed pre-treatment, post-treatment, and at 9 months follow up	Extensive training to properly apply instruments Need for interpreters Treatment cost: Highly trained professionals	Allocate more sessions particularly where traumatic events were severe or numerous Need to conduct RCT Eventually train non-professional paramedics to acquire adequate therapy skills through rigorous short-term training and supervision	1 – PTSD: Posttraumatic Diagnostic Scale 2 - Depression: Hopkins Symptom Checklist-25	Children had multiple and severe war events but showed a clear benefit from treatment Significant reduction in PTSD symptoms in post-test 2 of 6 patients still fulfilled PTSD criteria at 9-mo follow up Pilot study suggests KIDNET may be effective "short-term treatment with child patients even in the unsafe conditions of a refugee camp in an African country"

BOSNIA AND HERZEGOVINA			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Dybdahl, R. (2001). Children and mothers in war: An outcome study of a psychosocial intervention program. *Child Development,* 72(4), 1214-1230.	Maternal mental health improving child outcomes Improve mother-child interaction Psychosocial support Physical health Trauma exposure	Randomized control trial carried out in Tuzla, Bosnia N=87 internally displaced mother-(young) child dyads Assigned to treatment group (medical care and weekly psychosocial support) or control group (medical care) Treatment lasted five months Psychosocial intervention drew from (1) therapy discussion groups w/women and (2) International Child Development Program	Facilitators included free health care to all participants Assessment relied on accepted guidelines provided by UNICEF related to treatment in former Yugoslavia Nature of intervention in war/refugee camps is physical crowdedness and possible contamination of intervention between the groups	Involve fathers in intervention Author described intervention as "simple and inexpensive" psychosocial program Increase study size Cooperation with local professionals and paraprofessionals, as well as foreign experts who know the conditions well Collaboration between colleagues to influence policy and scale up similar interventions	1- Cognitive: Raven's Coloured Progressive Matrices 2 - Psychological: War Trauma Questionnaire; Impact of Event Scale; Qualitative interviews/ observations w/child and mother (both 1+2) 3 - Physical health	Baseline: dyads had been exposed to massive traumatic events; children were below average cognitive and physical health for region Intervention had a positive effect on mothers' mental health, children's weight gain, and several measures of children's psychosocial functioning and mental health. Mothers and (blind) interviewers both reported positive effects of intervention on children's problems, weight gain, reduced trauma symptoms in mother and increased life satisfaction. Some changes not statistically significant; author suggests this may be due to small sample size Most positive results came from "objective" measures such as child's weight gain, professional's blind assessments, and child's cognitive performance

BOSNIA AND HERZEGOVINA			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Layne C.M., Pynoos R.S., Saltzman W.S., Arslanagic B., Black M., Savjak N., Popovic T., Durakovic E., Campara N., Djapo N., Ryan H., & Music, M. (2001). Trauma/grief-focused psychotherapy: School based post-war intervention with traumatized Bosnian adolescents. *Group Dynamics: Theory, Research, and Practice, 5*(4): 277-290.	5 therapeutic foci: Traumatic experiences Trauma/loss reminders Postwar adversities Bereavement and the interplay of trauma and grief Developmental impact Psychosocial adaptation	School-based intervention including 55 pre-screened participants (age 15-19; mean=16.8) from Bosnian schools Utilized a "manualized" trauma/grief-focused psychotherapy to address the 5 foci – approximately 20 sessions with 4 modules covered Pre/posttest self-report measures of PTSD, depression, and grief Posttest measure also included psychosocial adaptation and group satisfaction	Logistical problems and delayed formal commencement resulted in many schools not fully implementing the 4 modules; this study was subsequently adapted to explore "full vs. partial modes of program implementation." These were not random assignment, however but no pre-test differences were found between groups Real world setting lacks strict methodology to safeguard internal validity: cannot rule out maturation, regression to the mean, selection, and history as explanations for findings No RCT Only self-reports used	Efficacy of post war programs need to be evaluated within the social, economic, and political contexts in which they are implemented Authors suggest asking, "Is this the best program for this population at this point in time, given the resources available?"	1-Posttraumatic stress 2 - Grief 3 - Depression 4 - Psychosocial Adjustment 5 -Group satisfaction Likert scale (not identified) for [1-3] Reaction Index – Revised [1] Grief Screening Scale [2] Depression Self-Rating Scale [3] Child self-rating scale Self-Satisfaction Survey	Preliminary results included reduced psychological distress (posttraumatic stress, depression and grief) and positive associations between distress reduction and psychosocial adaptation 50% showed reliable improvements in primary outcomes measures of posttraumatic stress and grief symptoms 35% showed reliable improvement in depressive symptoms No significant effects of group membership (full vs. partial treatment) were found for any of the distress measures

KOSOVO			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Gordon, J. S., Staples, J. K., Blyta, A., & Bytyqi, M. (2004). Treatment of posttraumatic stress disorder in postwar Kosovo high school students using mind-body skills groups: A pilot study. *Journal of Traumatic Stress, 17*(2), 143-147.	Mind-body techniques including: Mediation Biofeedback Drawings Autogenic training Guided imagery Genograms Movement Breathing techniques Posttraumatic stress	139 high school students in Kosovo (12-19 y/o) 6 week program (3 hrs/wk) A total of 3 groups participated in program over the course of 9 months; follow up PTSD measure after several months Sessions included didactic and small groups No control group	Relied on training non-specialist teachers (i.e., cost effective) Training to staff responsible for mind-body intervention was presented in English and translated into Albanian No triangulation of data or RCT	This study used no inclusion criteria Collected only one self-report measure	1- PTSD: Posttraumatic Stress Reaction Index	All 3 groups had similar baseline scores, despite the fact the intervention was stagger-started; author suggests that the passage of time therefore does not decrease PTSD symptoms Significant decreases in PTSD were measured in all three groups after participation in the program (p<.001) Follow up data collected from only one of the 3 groups (due to graduation or other factors) – this follow up group PTSD scores were significantly lower (p<.001) than in pretest or posttest

GAZA STRIP			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Thabet A A, Karim, K., &Vostanis, P. (2005). Group crisis intervention for children during ongoing war conflict. *European Child and Adolescent Psychiatry, 14,*: 262-269	Short-term impact Group crisis intervention during ongoing conflict: Drawing Free play Storytelling Expression of feelings Exposure	Children aged 9-15 in refugee camps who reported moderate to severe posttraumatic stress reactions assigned to one of three groups: 1 – Group intervention (7 weekly sessions) (N=47) 2 – Education (4 sessions) (N=22) 3 – No intervention (N=42) Groups assigned by school and refugee camp (not random) Assessed before treatment and after 3 months	Authors report intervention included relatively "non-active techniques" Could not used RCT due to nature of study and characteristics of participants Not measuring exposure to violence during the intervention period	Parental involvement during interventions Increase sample size Measure exposure to violence during intervention	1-Posttraumatic: Child Post Traumatic Stress Reaction Index 2- Depression: Children's Depression Inventory (validated in Arabic)	No significant impact of the group intervention was established on children's posttraumatic stress or depressive symptoms with the exception of decrease in intrusion scores in the intervention group (p=.06)

CROATIA			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Woodside, D., Barbara, J. S., & Benner, D. G. (1999). Psychosocial trauma and social healing in Croatia. *Medicine, Conflict and Survival, 15,* 355-367.	Ethnic attitudes Conflict resolution Manualized school based intervention Posttraumatic stress	RCT school-based intervention including 250 fourth and fifth grade Croatian students (mean age =11.9 yrs) Teachers received 3-day training to administer a "manualized" trauma/grief-focused psychotherapy Intervention: weekly 2 hour sessions for 4 months Two controls; one intervention One year follow up Pre/posttest self-report measures	Effect of time and media coverage related to ethnic bias Trainers were all women Political climate and its support (or lack) for reconciliation Parents were aware of the program but it was unclear as to what extent reconciliation received their support Authors ask: should reconciliation first begin in the classroom or wait until community is all on board?	Deliver curriculum to older students as well Include measures on parental attitudes and response Authors suggested biggest impact may have been the changing of relationship between teachers and students Program adopted by UNICEF and CARE and delivered to 1,200 children	1 – Posttraumatic stress: RTSI; PTSR 2 - Self-worth: Rosenberg's Self-Esteem Scale; Perceived Self Concept Indicators 3 - Conflict Resolution: Conflict Resolution Practices Scale; Attitudes and Beliefs Towards Conflict Resolution 4 - Social skills: Social Skills self report; teacher evaluation 5 – Psychosocial : Psychosocial Climate; Child Depression Inventory 6 - Ethnic Bias: Social Distance Scale 7 - Academic: Grades	Baseline: Boys recorded more trauma exposure than girls. Small but significant reduction in ethnic bias and a reduction of stress symptoms in the intervention group Self esteem: Intervention had more positive effects on girls than boys Increased positive attitude toward the Serbs No change in depression and authors noted it was low at time of pre-test Increased grades at the end of project for control and intervention groups No significant correlations between trauma exposure, trauma symptoms, and social distance (ethnic bias)

SUDANESE REFUGEES			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Paardekooper, B. P. (2002). *Children of the forgotten war: A comparison of two intervention programs for promotion of well-being of Sudanese refugee children.* Amsterdam: Vrije Universiteit, Academic Proefscrift.	Low-cost short term theory-driven psychosocial intervention Relationship between war trauma and psychopathology Effectiveness of short term programs on psychosocial wellbeing of war-affected refugee children in low resource country Community (center-based) mental health program	207 children (mean age=10.6 years) randomly assigned to 3 study groups: 1- Psychodynamic (N=68); 2- Contextual (N=69); or 3- Control (N=70) Inclusion criterion: score of more than 50 points on CBCL and Chuol/ Nyachuol together. Intervention (groups 1/2) are short term (7 session) center-based group (15 children) programs with creative activities *1- Psychodynamic* aimed at dealing with factors in the past *2- Contextual* aimed at the context in which children live by helping children to deal with daily stressors in a refugee camp Pre & post psychological questionnaires used for evaluation	Due to acts of war and organized violence, the project was transferred from N. Uganda to Addis Ababa No mention of use of a consent procedure for children and their parents High level of attrition of participants in between random allocation and use of data in analysis. The 3 groups were similar at pre-assessment. However to take this study's findings at face value we have to assume that those who dropped out of the study in each group were the same across the groups	Authors argue that results can be generalized and found the children in the study groups were similar to those in a wider census that they took. Authors note that the study is specific to Sudanese refugee children living in a host country – however the data may indicate ways in which other refugee children in similar circumstances may be helped Interesting to see effects of a long-lasting program	1 – PTSD : Chuol /Nyachuol questionnaire; Trauma Events Scale 2 - Coping: *KidCope* 3 - Social support: Interview 4 - Daily Stressors Inventory 5 - Child Behavior Checklist	Contextual program (2) most efficacious compared to compared to pre-assessment as well as comparison with a control group. The psychodynamic program (1), - which only differed in content from the successful contextual program in four out of 8 sessions - did not perform better than the control group Contextual program: significantly better effects on: 1) obsessive-compulsiveness and somatization (as measured through CBCL sub-scales); 2) behavioral problems related to fear and concentration problems (from modified subscales of the CBCL); 3) post-traumatic memories and post-traumatic depression (from Chuol-Nyachuol questionnaire); and 4) coping, social support network, daily stressors. Psychodynamic program showed no significant effects for the above aspects of their lives, other than following, which they do show significantly better effects on: 1) social support network; 2) daily stressors These findings imply that within the circumstances prevailing in many developing countries, programs should focus on dealing with the everyday stressors of being a refugee instead of program focusing on the consequences of traumatic stress

SIERRA LEONEAN / LIBERIAN REFUGEES			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Program Center for Victims of Torture (CVT) , Minneapolis, MN Source Stepakoff, S. et al. (2006). Trauma healing in refugee camps in Guinea: a psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *American Psychologist, 61(*8), 921-932	Relationship-based supportive group counseling using 3-stage model of trauma recovery: safety, mourning, and reconnection Psychological and psychosocial supports to survivors of torture and war trauma Enhance community capacity to meet mental health needs of torture survivors Provision of training and supervision for local refugee counselors Raise awareness about mental health and trauma training community leaders and sensitization campaigns	Sierra Leonean and Liberian trauma and torture survivors in Guinean refugee camp Sierra Leonean and Liberian trauma and torture survivors in Guinean refugee camp Weekly therapeutic groups comprised approx. 10 participants, lasted approx. two hours; and group met about 10 times. Groups led by two psychosocial agents (PSAs), one of which served as an interpreter for a clinical supervisor.	Were able to reach many refugees: 6 expatriates trained 80 refugees to carry out the role of community based local refugee counselors Reaching a large, traumatized population in an inherently unstable setting	Clinical interventions were able to be catered to the realities facing refugees in this setting without compromising quality of care Many psychosocial facilitators from Sierra Leone and Liberia are still working in the field of mental health	Demographic information and trauma history were recorded during the intake assessment Symptoms of depression, anxiety, posttraumatic stress, and somatic complaints; measures of social support, interpersonal relationships, and ability to engage in important daily activities recorded at intake and measured at specific intervals over the course of 12 months post-intake Specific assessment tools were not reported in study	4,000 refugees received counseling; 15,000 received other supportive services over 6 year intervention Reported significant reductions in trauma symptoms and increases in measures of daily functioning and social support during and after participation in groups while also finding meaningful reductions in trauma symptoms following participation CVT trainees: many developed level of competence to run their own counseling groups w/limited supervision; some conducted trainings; continue to work with CVT since repatriation; many obtained a diploma in counseling Figures or numerical references associated with these results were not published by the authors, and multiple attempts to access this information have been unsuccessful.

PALESTINIAN REFUGEES			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Program The Classroom Based Intervention Program (CBI) developed by the Boston Center for Trauma Psychology Source Save the Children USA (2004). *Classroom-Based Intervention (CBI) Impact Evaluation.* see also: www.unicef.org /turkey/lf/ep1i.html	Stabilizing mental health intervention for children in the context of ongoing violence and chronic political instability Drawing from the literature on PTSD, depression, and anxiety disorders; based on theory of classical conditioning CBI aims to identify and strengthen existing coping resources and strategies among these youth in order to improve psychosocial outcomes over time Highly structured expressive-behavioral activities to reduce traumatic stress reactions, anxiety, fear and depressed mood through playing, learning, and creative problem-solving	School- or camp-based group psychosocial intervention for trauma-exposed children and adolescents Delivered in 15 sessions over a 5-week period. Save the Children evaluation of West Bank and Gaza included over 600 children and adolescents 6 to 16 years old	Received multi-lateral support Integrated and implemented into multiple avenues: community organizations, summer camps schools, etc. Socio-cultural and emotional developmental stage of the 15 year old Palestinian male was not accounted for in this model, leading to negative outcomes for this demographic	Successfully implemented in other low resource contexts CBI received endorsement and support from the Ministry of Education; United Nations Relief and Works Agency for Palestinian refugees (UNRWA) also introduced it in its schools Countries for CBI scale up include: Indonesia, Sudan, Burundi, Sri Lanka	1- Demographic and Political Stress Factors 2 - Pro-Social Strengths: Child and Adolescent Strengths Assessment 3 - Coping Style/Utilization of Social and Spiritual Supports: Youth Coping Inventory; Adolescent Coping for Problem Experience 4 - Sense of Hope, Future/Goal Orientation: Children's Hope Scale Children's Hope Scale 5 - Mental Health: Strengths and Difficulties Questionnaire (SDQ) Child Form; PENN State Worry Questionnaire for Children; Impact of Event Scale (IES) 6 - Causal Attribution of Events: Children's Attributional Style Questionnaire (CASQ) 7 - Perception of One Self and Attribution of Meaning to Events: Children's Attribution and Perceptions Scale Self-Esteem Rosenberg's Self-Esteem Scale	A Save the Children USA randomized controlled trial involving over 600 children in the West Bank and Gaza found a significant positive impact of CBI on male and female war-affected children ages 6-12, and female adolescents ages 12-16; no significant positive impact was found on boys ages 12-16 Implemented successfully in Sudan, Burundi, Sri Lanka, Indonesia, Afghanistan, and the Palestinian Territories, among others Over 1,400 school counselors and social workers trained in CBI techniques; over 100,000 children completed the full 15-session program, making CBI in the West Bank and Gaza the largest scale psychosocial support program known to date in development assistance

SIERRA LEONEAN FORMER CHILD SOLDIERS			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Program UNICEF: Community-Based Reintegration Program (CBR) in Sierra Leone	Provide educational and psychosocial support to demobilized children Establish and support community based child protection systems in all districts Create systems of support to look after children Children's clubs offer recreational and educational opportunities to all children within the community	Over 7000 former child soldiers Establish and/or support: *1- Child Welfare Committees (CWCs)* - groups (leaders, teachers, women and youth representatives to follow-up with children in their homes, schools and children's clubs, promote sensitization on child rights issues within the community, intervene in cases of child abuse and exploitation *2- Children's Clubs (CCs)* to offer recreational and educational opportunities to all children within the community; based in one village/town per chiefdom, Train: *3- CWCs and CCs* – on human and child rights principles. *4- CPA Follow-Up at Home and in School* – from social workers to report on wellbeing of children 5- *Community Education Investment Program (CEIP) Schools* – Through this element of the program, school fees were waived for demobilized children and they were provided with a uniform, bag and other school supplies. In addition, materials such as notebooks, pencils, paper were provided to the school for all children in attendance. *6- Complimentary Rapid Education Primary School (CREPS*) – compressed primary school program for older children *7- Skills Training and/or Apprenticeship*	UNICEF coordinated with key local partners and international partners to deliver services to children Children's Clubs functioned well but were not inclusive of girls and children that do not attend school. Child Welfare Committees are trying to remain active in their communities, but lack guidance from the local partners and input from the Ministry.	Undetermined	Unspecified survey	7,204 separated child ex-combatants and non-combatants entered the CBR Program over 5 years *Established* 163 *CWCs*; 105 *CCs* Surveyed respondents satisfied with help of social workers provided during home and school visits, but visits deemed too irregular and inconsistent to address some of the children's most pressing concerns Children's awareness of and involvement with these committees is limited. CEIP schools greatly helped children return to the classroom after demobilization. Since the end of the program, though, many are struggling to remain in school The survey indicates that CBR beneficiaries are more optimistic about the future than children who did not go through the program. Beneficiaries also show greater self-efficacy and are more involved in school groups. The two groups were not statistically different in terms of school attendance, substance abuse, and involvement in paid work

SIERRA LEONEAN FORMER CHILD SOLDIERS			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Program Christian Children's Fund DDR program, Sierra Leone Source Wessells, M. (2005). Child soldiers, peace education, and postconflict reconstruction for peace. *Theory Into Practice, 44*(4), 363-369.	'Peace education' Disarmament, demobilization, and reintegration Community empowerment Traditional reconciliation processes Skills training	Three phase project: Phase 1 Facilitate discussions and meetings about children's wellbeing; child soldiers 'woven' into discussion; CCF staff led dialogues about child soldiers Phase 2 Facilitate reconstruction for children's wellbeing (i.e., schools, health posts); involve former child soldiers and village youth to transform attitudes; encourage open dialogue for traditional reconciliation Phase 3 Training in carpentry, tailoring, and other relevant professional skills; work with mentor and 'moral guide'; create conflict resolution committees	Stigma prior to intervention: girls perceived as 'damaged goods'; boys as 'rebels'	Project has expanded to other provinces in SL	Tools not specified Qualitative interviews	Villagers receptive to intervention because they were 'tired of war' Intervention served as catalyst for community members to utilize traditional forms on resolution, such as proverbs and dance to evoke themes of unity and forgiveness Physical structures were created (schools, health posts) that served as tangible reminders of reconciliation and forgiveness Children received trade skills to use for income generating Researcher noted 90% of former child soldiers have gone home to say they now have a civilian identity and hope of a positive life as civilians Communities perceive youth in a positive light

SIERRA LEONEAN REFUGEES			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Source Gupta, L., & Zimmer, C. (2008). Psychosocial intervention for war-affected children in Sierra Leone. *British Journal of Psychiatry, 192*, 212-216.	Normalization Education Trauma healing Recreation activities Short-term intervention	4 week pilot study with one treatment group and no control Including 315 children ages 8-18 years who were displaced by war Used adapted version of Rapid-Ed curriculum which also included a Trauma Healing Module and recreation Trauma healing included eight 60-minute structured healing activities Symptoms assessed at baseline and follow-up	Collaboration between Plan International, Ministry of Youth, Educations and Sports, and UNESCO Pilot testing questionnaire Child soldiers not discussed	Intervention occurred in late 1999 No control or comparison group; need to conduct RCT to strengthen findings Camp teachers were trained on how to implement Trauma Healing Module	1 - Impact of Events Scale (revised from Horowitz) 2 -'exposure to war' items 3 - 'Pilot items' including children's world view and future perspectives 4 – 'Subjective' items about feelings before-after intervention	Children had average of 25 war-related exposures; 80% experienced a death in the family; 50% witnessed a killing of a loved one (significant difference between males and females) High levels of intrusion, arousal and avoidance symptoms at pretest Posttest reported significant decrease in intrusion and arousal symptoms; slight increase in avoidance reactions; and greater optimism about future Significant reduction in concentration problems, sleep problems, nightmares and intrusive images Since there is no control group, unclear whether findings can be attributed to intervention or another factor such as time

LIBERIA			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Program Community Youth Peace Education Program (CYPEP), Liberia; Funded by USAID's Office of Transition Initiatives and implemented by Creative Associates International, Inc. Additional info Maurin, J. (2006). *Education Initiatives for War-Affected Youth: An Examination of Programs in Sierra Leone and Liberia* [dissertation]	Non-formal education program focusing on human rights, peace/conflict resolution, and a positive view of self Units of the program include topics such as "Who Am I?" and "Conflict Management" Address the evolution of youths and their communities from wartime into peace Discuss how the youth of Liberia can help rebuild the country Psychosocial components of CYPEP focused on improving the youth's daily lives including how to manage day-to-day issues and regulate emotions.	Six week, program based Integrates participatory learning. Peer educators elected by village elders, who nominate successive youth educators.	Described as, 'fast, flexible and targeted short-term assistance throughout Liberia'	Being implemented in Sierra Leone	N/A	CYPEP did not focus on literacy, numeracy, or vocational training to the extent that some youths and facilitators thought might be helpful in increasing the long-term, practical success of the program. Some of the psychosocial units included 'Western' notions of mental illness, such as posttraumatic stress disorder, and did not necessarily take traditional beliefs about psychological healing into account. No quantitative data on efficacy of CYPEP; case studies suggest that CYPEP youth had higher self-confidence and self-esteem. Reports from members of the community pointed to lower rates of violence from CYPEP youth. Youth stated that CYPEP helped them to "control their tempers" and improved interaction with the community

NORTHERN UGANDAN WAR-AFFECTED YOUTH			STRATEGIES		OUTCOMES	
PROGRAM / SOURCE	**CORE COMPONENTS**	**POPULATION / DESIGN**	**BARRIERS & FACILITATORS TO DELIVERY**	**SCALE UP**	**ASSESSED / TOOLS**	**RESULTS**
Program Conducted with World Vision Sources Bolton, et al. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: A randomized controlled trial. *Journal of the American Medical Association, 298*(5), 519-27.Betancourt, et al. (in press). A qualitative study of psychosocial problems of war-affected youth in northern Uganda. *Transcultural Psychiatry*	Depression intervention for war-affected youths Qualitative-derived assessment tools Psychotherapy-based intervention Activity-based intervention	314 adolescents (aged 14-17 years) in 2 camps for internally displaced persons in northern Uganda. Randomized into one of three groups: 1) Psychotherapy-based intervention (group interpersonal psychotherapy [IPT-G]; N=105) 2) Activity-based intervention (creative play; N=105) 3) Wait-control group (N=104) Intervention groups met weekly for 16 weeks; sessions lasted for approx. 2 hrs each Groups consisted of 6-8 youth of same sex	Authors noted that IPT-G's focus on interpersonal triggers and group relationship building seemed compatible with local culture Creative Play intervention used previously with war-affected youth	Authors noted this is the first randomized controlled trial of mental health interventions among African adolescents affected by war, and one of only a few RCTs of psychological treatments for depression symptoms conducted in a developing country Study demonstrated feasibility of mental health interventions in poor, rural, war-affected and illiterate communities, as are formal intervention trials	Acholi Psychosocial Assessment Instrument: a locally derived screening tool from qualitative data to assess effects of intervention on: symptoms of depression, anxiety, conduct problems, and functioning	Both interventions deemed locally feasible by research team Difference in change in adjusted mean score for depression symptoms between group interpersonal psychotherapy and control groups was 9.79 points (95% confidence interval) IPT-G showed significant improvement in depression symptoms compared with controls in girls; improvement among boys was not statistically significant Creative play showed no effect on depression severity; no statistically different improvements in anxiety symptoms in either intervention group; neither intervention improved conduct problem or function scores Group interpersonal psychotherapy demonstrated efficacy for depression symptoms among adolescent girls affected by war and displacement

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Theresa Stichick Betancourt is Director of the Research Program on Children and Global Adversity (RPCGA) and Assistant Professor of Child Health and Human Rights at the Harvard School of Public Health (HSPH). Her central research interests are the developmental and psychosocial consequences of concentrated adversity on children and families; resilience and protective processes in child development; child health and human rights; and applied cross-cultural mental health research. She is the Principal Investigator of an ongoing longitudinal study of former child soldiers in Sierra Leone and is currently collaborating with Partners in Health Rwanda to launch a mixed-methods study of mental health needs among HIV/AIDS-affected youth. Recently she served as the Co-PI of a randomized-controlled trial of interventions for the treatment of depression symptoms in youth displaced by war in northern Uganda. Her prior research includes a study of the psychosocial dimensions of an emergency education program serving internally-displaced Chechen youth, an investigation of the relationship between connectedness, social support and emotional problems in Chechen IDP youth and a study of the relationship between caregiver and child mental health among Eritrean Kunama refugees living on the Ethiopia-Eritrea border. She is also collaborating with local child protection NGOs in Sierra Leone to develop a policy initiative designed to improve child welfare and social services for war-affected youth in that country. Dr. Betancourt graduated summa cum laude in psychology from Linfield College. She holds a Masters degree in Art Therapy from the University of Louisville and completed her doctoral work in Maternal and Child Health with concentrations in Psychiatric Epidemiology and Health and Human Rights at the Harvard School of Public Health.

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