International Review of the Red Cross (2019), **101** (911), 481–506.
Children and war
doi:10.1017/S181638312000017X

INTERNATIONAL REVIEW of the Red Cross

Living through war: Mental health of children and youth in conflict-affected areas

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Abstract

Children in armed conflict are frequently deprived of basic needs, psychologically supportive environments, educational and vocational opportunities, and other resources that promote positive psychosocial development and mental health. This article describes the mental health challenges faced by conflict-affected children and youth, the interventions designed to prevent or ameliorate the psychosocial impact of conflict-related experiences, and a case example of the challenges and opportunities related to addressing the mental health needs of Rohingya children and youth.

Keywords: children and youth, armed conflict, mental health, psychosocial, epidemiology, interventions, child soldiers, refugees, Rohingya, Cox's Bazar, social determinants of health.

Introduction

More than twenty years after Graça Machel's report to the United Nations (UN) on children and armed conflict,[1] one of the first documents to promote international awareness of the impact of war and conflict on children and youth, there are still an estimated billion children living in war zones and regions of terror.[2] Children continue to be disproportionately affected by armed conflict, and providing support for them should be a priority for the international community.[3] Conflict experiences, ranging from being denied access to psychologically supportive environments and resources to being forced into involvement with armed forces or armed groups, violate child rights as outlined in the Convention on the Rights of the Child.[4] The burden of mental disorders that results from conflict-related

1 Graça Machel, *Impact of Armed Conflict on Children: Report of the Expert of the Secretary-General, Submitted Pursuant to UN General Assembly Resolution 48/157*, UN, New York, 1996.
2 War Child UK, *War: The Next Generation – The Future of War and Its Impact on Children*, 2013.
3 Office of the Special Representative of the Secretary-General for Children and Armed Conflict (SRSG CAAC), *20 Years to Better Protect Children Affected by Conflict*, United Nations, New York, 2016.
4 Molly R. Wolf, Shraddha Prabhu and Janice Carello, "Children's Experiences of Trauma and Human Rights Violations around the World", in Lisa D. Butler, Filomena M. Critelli and Janice Carella (eds), *Trauma and Human Rights: Integrating Approaches to Address Human Suffering*, Palgrave Macmillan, Cham, 2019.

neglect, abuse and exploitation is particularly alarming. It is well documented that there are disparities between the mental health of war-affected children and youth and those in the general population.[5]

This article describes the epidemiology of psychosocial functioning of conflict-affected children and youth, interventions designed to prevent or ameliorate mental health problems, and a case example of current work to address the mental health needs of war-affected children and youth in Southeast Asia. We first present what is known about the prevalence of mental health problems of conflicted-affected children exposed to different facets of the phenomena of conflict experience, including child soldiers. Turning to interventions, we describe work conducted with different age groups in conflict-affected regions and refugee camps. The second part of the article focuses on Rohingya children and youth in Cox's Bazar, Bangladesh. After presenting a framework for understanding Rohingya mental health, we present information on child and youth interventions being carried out in camps in Bangladesh, as well as challenges and barriers to providing services. We discuss the importance and potential of broader socio-economic interventions, specifically those related to employment and livelihoods, to promote the psychosocial well-being of Rohingya youth. Finally, we reflect briefly on the generalizability of the Rohingya experience to war-affected youth in other contexts.

Epidemiology

The effects of war on children

Experiencing armed conflict during childhood and adolescence poses serious mental health risks and threats to a child's development. Exposure to different types of violence, the duration of the conflict, and the nature of experienced and witnessed traumatic events are all associated with the onset and severity of mental disorders among conflict-affected children.[6] Although the links between armed conflict exposure during childhood and subsequent mental health risks are well established, the reported prevalence of mental disorders varies widely. For example, studies among children affected by the Israeli–Palestinian conflict report post-traumatic stress disorder (PTSD) prevalence ranging from 18% to 68.9%.[7] In

5 Michelle Slone and Shiri Man, "Effects of War, Terrorism, and Armed Conflict on Young Children: A Systematic Review", *Child Psychiatry and Human Development*, Vol. 47, No 6, 2016; Vindya Attanayake, Rachel McKay, Michel Joffres, Sonal Singh, Frederick Burkle Jr. and Edward Mills, "Prevalence of Mental Disorders among Children Exposed to War: A Systematic Review of 7,920 Children", *Medicine, Conflict and Survival*, Vol. 25, No. 1, 2009.

6 Fiona Charlson, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford and Shekhar Saxena, "New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review", *The Lancet*, Vol. 394, No. 10194, 2019.

7 Daphna Canetti, Shaul Kimhi, Rasmiyah Hanoun, Gabriel Rocha, Sandro Galea and Charles Morgan, "How Personality Affects Vulnerability among Israelis and Palestinians following the 2009 Gaza Conflict", *PLoS One*, Vol. 11, No. 7, 2016; Abdelaziz Thabet, Sanaa Thabet and Panos Vostanis,

one study among children exposed to the ongoing Syrian Civil War, 60.5% meet the criteria for at least one psychological disorder.[8]

In addition to real differences due to variation in exposure to trauma, estimates of the percentage of war-affected youth with mental health problems (prevalence) are influenced by the use of an array of assessment tools for screening. Variance may also be attributed to cultural factors including differences in conceptualization of mental health, socio-environmental processes that influence psychological well-being, and expression of psychological distress.[9] Also of note is that prevalence surveys in humanitarian settings are often unable to distinguish between normal stress reactions and persistent clinical mental disorders, which may result in inflated estimates. These issues, in addition to the fact that administering prevalence surveys is resource-intensive, suggest caution in spending time and money identifying precise prevalence estimates in conflict settings.[10]

Overall, the most common mental disorders reported among children exposed to conflict are PTSD and depression.[11] Other reported disorders include acute stress reactions, attention deficit hyperactivity disorder (ADHD), panic disorder, anxiety disorders specific to childhood, and sleep disorders. In later childhood, children exposed to conflict-related trauma are predisposed to externalizing symptoms, including behavioural problems and conduct/oppositional defiant disorders.[12] In addition, children exposed to armed conflict often experience comorbid psychopathologies, and symptoms of disorder may increase in number with age, with school-age children being the most vulnerable.[13]

The effects of armed conflict reverberate through a child's social and developmental ecology.[14] Psychosocial manifestations of war trauma among children include proximal and distal effects on family interactions, peer relations,

"The Relationship between War Trauma, PTSD, Depression, and Anxiety among Palestinian Children in the Gaza Strip", *Health Science Journal*, Vol. 10, No. 5, 2016.

8 John D. Perkins, Maiss Ajeeb, Lina Fadel and Ghassan Saleh, "Mental Health in Syrian Children with a Focus on Post-Traumatic Stress: A Cross-Sectional Study from Syrian Schools", *Social Psychiatry and Psychiatric Epidemiology*, Vol. 53, No. 11, 2018.

9 Eva Heim, Iris Wegmann and Andreas Maercker, "Cultural Values and the Prevalence of Mental Disorders in 25 Countries: A Secondary Data Analysis", *Social Science and Medicine*, Vol. 189, 2017.

10 Inka Weissbecker, Fahmy Hanna, Mohamed El Shazly, James Gao and Peter Ventevogel, "Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings", in Thomas Wenzel and Boris Drozdek (eds), *An Uncertain Safety: Integrative Health Care for the 21st Century Refugees*, Springer International, Cham, 2019.

11 Claudia Catani, "Mental Health of Children Living in War Zones: A Risk and Protection Perspective", *World Psychiatry*, Vol. 17, No. 1, 2018.

12 Galit Halevi, Amir Djalovski, Adva Vengrober and Ruth Feldman, "Risk and Resilience Trajectories in War-Exposed Children across the First Decade of Life", *Journal of Child Psychology and Psychiatry*, Vol. 57, No. 10, 2016.

13 John A. Shaw, "Children Exposed to War/Terrorism", *Clinical Child and Family Psychology Review*, Vol. 6, No. 4, 2003.

14 Urie Bronfenbrenner, *Ecological Systems Theory*, Jessica Kingsley, London, 1992; Wietse A. Tol, Corrado Barbui, Ananda Galappatti, Derrick Silove, Theresa S. Betancourt, Renato Souza, Anne Golaz and Mark Van Ommeren, "Mental Health and Psychosocial Support in Humanitarian Settings: Linking Practice and Research", *The Lancet*, Vol. 378, No. 9802, 2011.

educational outcomes and general life satisfaction.[15] Conflict-related stigma, for example, is widespread in many post-conflict settings and is understood to exacerbate mental health problems.[16] Psychosocial sequelae of armed conflict may affect children's ability to negotiate social support and resources, including basic needs, in the post-conflict environment – all with important consequences for mental health. Promisingly, though, longitudinal evidence suggests that although conflict experiences and the post-conflict environment can negatively affect mental health, the presence of protective factors including family and community acceptance may act to buffer the negative effects of war, thereby reducing the risk of mental disorders and promoting psychosocial functioning.[17]

Child soldiers

Recruitment and use of children as soldiers is a serious violation of children's rights[18] that persists despite coordinated, international efforts. The number of child soldiers is estimated to have increased nearly 160% from 2012 to 2017.[19] A little over 3,000 youth were recruited into armed forces in 2012, compared to over 8,000 in 2017.[20] Ongoing conflicts in the Middle East and persistent unrest in Somalia, South Sudan, the Democratic Republic of the Congo (DRC), the Central African Republic and elsewhere leave children at risk of recruitment.[21]

Child soldiers are exposed to high levels of violence, including coerced participation in warfare.[22] In a study comparing the mental health of former

15 Ruth V. Reed, Mina Fazel, Lynne Jones, Catherine Panter-Brick and Alan Stein, "Mental Health of Displaced and Refugee Children Resettled in Low-Income and Middle-Income Countries: Risk and Protective Factors", *The Lancet*, Vol. 379, No. 9812, 2012; Laila Farhood, Huda Zurayk, Monique Chaya, Fadia Saadeh, Garbis Meshefedjian and Thuraya Sidani, "The Impact of War on the Physical and Mental Health of the Family: The Lebanese Experience", *Social Science and Medicine*, Vol. 36, No. 12, 1993; Kirsi Peltonen, Samir Qouta, Marwan Diab and Raija-Leena Punamäki, "Resilience among Children in War: The Role of Multilevel Social Factors", *Traumatology*, Vol. 20, No. 4, 2014; Thomas Poirier, "The Effects of Armed Conflict on Schooling in Sub-Saharan Africa", *International Journal of Educational Development*, Vol. 32, No. 2, 2012; Guido Veronese, Marco Castiglioni, Marco Tombolani and Mahmud Said, "'My Happiness is the Refugee Camp, My Future Palestine': Optimism, Life Satisfaction and Perceived Happiness in a Group of Palestinian Children", *Scandinavian Journal of Caring Sciences*, Vol. 26, No. 3, 2012.

16 Kenneth E. Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks", *Social Science and Medicine*, Vol. 70, No. 1, 2012.

17 Theresa S. Betancourt, Dana L. Thomson, Robert T. Brennan, Cara M. Antonaccio, Stephen E. Gilman and Tyler J. VanderWeele, "Stigma and Acceptance of Sierra Leone's Child Soldiers: A Prospective Longitudinal Study of Adult Mental Health and Social Functioning", *Journal of the American Academy of Child & Adolescent Psychiatry*, 2019.

18 SRSG CAAC, *The Six Grave Violations against Children during Armed Conflict: The Legal Foundation*, UN, New York, 2013.

19 *Report of the Secretary-General on Children and Armed Conflict*, UN Doc. A/67/845, 15 May 2013; *Report of the Secretary-General on Children and Armed Conflict*, UN Doc. A/72/865, 16 May 2018.

20 *Report of the Secretary-General on Children and Armed Conflict*, UN Doc. A/67/845, 15 May 2013; *Report of the Secretary-General on Children and Armed Conflict*, UN Doc. A/72/865, 16 May 2018.

21 Child Soldiers Initiative, "Reports of Children Used in Hostilities", available at: https://childsoldiersworldindex.org/hostilities (all internet references were accessed in April 2020).

22 *Report of the Secretary-General on Children and Armed Conflict*, UN Doc. A/73/907, 20 June 2019.

child soldiers and children never conscripted by armed groups, former child soldiers in Nepal experienced a greater severity of mental health problems, with differences persisting after controlling for trauma exposure.[23] Many studies report high prevalence of mental health problems, such as PTSD and depression, among former child soldiers, and document risk and protective pathways associated with their mental health across their life span.[24] A longitudinal study of mental health among former child soldiers in Mozambique, for example, found that post-conflict experiences, including family support and economic opportunity, influenced the mental health outcomes of participants re-interviewed sixteen years after reintegration.[25] There are similar findings in northern Uganda.[26] In Sierra Leone, post-conflict discrimination was associated with the relationship between perpetrating violence during the war and subsequent externalizing symptoms.[27] In addition, stigma mediated the relationship between surviving rape during conscription and increases in depression in a two-year follow-up period.[28] These findings highlight that the experiences of child soldiers, in addition to post-conflict factors like economic and educational opportunities, community acceptance and stigma, and social support, are located along the continuum of mental health risk and protective factors.

Interventions

Early childhood

Early childhood interventions (ECIs) counter deficiencies and stressors faced by young children (up to age 5) and their families, and promote positive development during the critical first few years of life. ECIs target child physical, emotional, social and cognitive development outcomes (which facilitate school readiness), economic development of the parent/caregiver, parent education, parenting skills and prenatal well-being. ECIs aim to strengthen mental health

23 Brandon A. Kohrt, Mark J. D. Jordans, Wietse A. Tol, Rebecca A. Speckman, Sujen M. Maharjan, Carol M. Worthman and Ivan H. Komproe, "Comparison of Mental Health between Former Child Soldiers and Children Never Conscripted by Armed Groups in Nepal", *Journal of the American Medical Association*, Vol. 300, No. 6, 2008.

24 Ilse Derluyn, Eric Broekaert, Gilberte Schuyten and Els De Temmerman, "Post-Traumatic Stress in Former Ugandan Child Soldiers", *The Lancet*, Vol. 363, No. 9412, 2004.

25 Neil Boothby, "What Happens when Child Soldiers Grow Up? The Mozambique Case Study", *Intervention*, Vol. 4, No. 3, 2006.

26 Christopher Blattmann and Jeannie Annan, "The Consequences of Child Soldiering", *The Review of Economics and Statistics*, Vol. 92, No. 4, 2010.

27 Theresa S. Betancourt, Robert T. Brennan, Julia Rubin-Smith, Garrett M. Fitzmaurice and Stephen E. Gilman, "Sierra Leone's Former Child Soldiers: A Longitudinal Study of Risk, Protective Factors, and Mental Health", *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 49, No. 6, 2010.

28 Theresa S. Betancourt, Jessica Agnew-Blais, Stephen E. Gilman, David R. Williams and B. Heidi Ellis, "Past Horrors, Present Struggles: The Role of Stigma in the Association between War Experiences and Psychosocial Adjustment among Former Child Soldiers in Sierra Leone", *Social Science and Medicine*, Vol. 70, No. 1, 2010.

and well-being, prevent new problems from developing, and reduce symptoms or improve the functioning of children affected by war, by focusing on both children and their caregivers.[29] Guidelines call for the use of treatment techniques that are evidence-based, address a myriad of challenges and a range of mental health diagnoses,[30] and are scalable. Interventions should focus on modifiable risk factors, such as child cognitive and behavioural deficits or parental caregiving skills and mental health.[31] Special emphasis is warranted on the importance of preventing or reducing family separation, with parental presence being critical for the secure attachment and mental health of children.[32] Overall, effective ECIs benefit from timeliness (early in the life course), address multiple levels of socio-ecological influence, and use frameworks of child rights principles such as the SAFE model.[33] SAFE is an acronym that emphasizes the urgency of understanding the interrelatedness and interdependence of four elements of children's basic security needs and rights: *safety*/freedom from harm (S), *access* to basic physiologic needs and health care (A), *family* and connection to others (F), and *education* and economic security (E) for the children.

Intergenerational home visiting interventions address the needs of both children and caregivers; studies indicate that family-environment interventions promote protective elements of caregiver–child relationships,[34] increase access to hard-to-reach populations and can be tailored to the needs of each family.[35] In post-genocide Rwanda, family strengthening interventions have demonstrated improvements in parent–child relationships, child nutritional status and parenting behaviours related to violence. Such family-based preventive interventions have promise for work with war-affected populations, especially when integrated into social protection, health and education systems to ensure

29 Mark J. D. Jordans, Hugo Pigott and Wietse A. Tol, "Interventions for Children Affected by Armed Conflict: A Systematic Review of Mental Health and Psychosocial Support in Low- and Middle-Income Countries", *Current Psychiatry Reports*, Vol. 18, No. 9, 2016.

30 Gloria A. Pedersen, Eva Smallegange, April Coetzee, Kim Hartog, Jasmine Turner, Mark M. D. Jordans and Felicity L. Brown, "A Systematic Review of the Evidence for Family and Parenting Interventions in Low- and Middle-Income Countries: Child and Youth Mental Health Outcomes", *Journal of Child and Family Studies*, Vol. 28, No. 8, 2019.

31 Lynn A. Karoly, Rebecca Kilburn and Jill S. Cannon, "What Works in Early Childhood Intervention Programs", in Lynn A. Karoly, Rebecca Kilburn and Jill S. Cannon (eds), *Early Childhood Interventions: Proven Results, Future Promise*, RAND Corporation, Santa Monica, CA, 2005.

32 Alexander Miller, Julia Meredith Hess, Deborah Bybee and Jessica R. Goodkind, "Understanding the Mental Health Consequences of Family Separation for Refugees: Implications for Policy and Practice", *American Journal of Orthopsychiatry*, Vol. 88, No. 1, 2018.

33 Theresa S. Betancourt, Timothy P. Williams, Sarah E. Kellner, Joy Gebre-Medhin, Katrina Hann and Yvonne Kayiteshonga, "Interrelatedness of Child Health, Protection and Well-being: An Application of the SAFE Model in Rwanda", *Social Science and Medicine*, Vol. 74, No. 10, 2012.

34 Sally Grantham-McGregor and Joanne A. Smith, "Extending the Jamaican Early Childhood Development Intervention", *Journal of Applied Research on Children*, Vol. 7, No. 2, 2016; Kimberly Josephson, Gabriela Guerrero and Catherine Coddington, *Supporting the Early Childhood Workforce at Scale: The Cuna Más Home Visiting Program in Peru*, Results for Development, 2017.

35 Shelley Peacock, Stephanie Konrad, Erin Watson, Darren Nickel and Nareem Muhajarine, "Effectiveness of Home Visiting Programs on Child Outcomes: A Systematic Review", *BMC Public Health*, Vol. 13 No. 1, 2013.

greater reach.[36] Studies have examined the effectiveness of child-friendly spaces interventions that promote the mental and psychosocial well-being of young children.[37] Alternatively, individual-level or group-based interventions may be warranted. Art therapy carried out by trained mental health practitioners shows promise in supporting children toward longer-term healing and enhancing community resilience.[38] Finally, schools, early education centres and clinics are indicated as a focal point for intervention delivery. In Zambia, a trauma-focused cognitive behavioural therapy (TF-CBT) intervention was delivered by trained and supervised lay counsellors to trauma-affected children as young as 5, with significant reductions in trauma symptoms and improvement in functioning.[39]

School-aged youth

The realities of work in often chaotic humanitarian settings, such as the overwhelming need to focus on the basic needs of vulnerable populations (i.e., food and shelter), make the development, implementation and evaluation of mental health interventions for war-affected youth extremely challenging. Despite this, there are promising treatment approaches for working with school-aged youth. Such interventions can broadly be categorized as having a socio-ecological orientation, delivered in individual or group-based formats, and/or situated in classroom or school settings.

Socio-ecological interventions

In one vein, interventions targeting this age group assume a socio-ecological orientation whereby the youth's family and community may be targeted within the treatment. In the northern DRC, a pilot study of a family-focused, community-based psychosocial intervention incorporated a life skills leadership programme, relaxation training drawn from TF-CBT, and mobile cinema screenings to address stigma and model community acceptance.[40] Each youth participant was encouraged to bring one caregiver to the sessions, with the overall

36 Theresa S. Betancourt, Emily Franchett, Catherine M. Kirk, Robert T. Brennan, Laura Rawlings, Briana Wilson, Aisha Yousafzai, Rose Wilder, Sylvere Mukunzi, Josee Mukandanga, Christian Ukundineza, Kalisa Godfrey and Vincent Sezibera, "Integrating Social Protection and Early Childhood Development: Open Trial of a Family Home-Visiting Intervention, Sugira Muryango", *Early Childhood Development and Care*, Vol. 190, No. 2, 2018.

37 Janna Metzler, Karin Diaconu, Sabrina Hermoilla, Robert Kaijuka, George Ebulu, Kevin Savage and Alastair Ager, "Short- and Longer-Term Impacts of Child Friendly Space Interventions in Rwamwanja Refugee Settlement, Uganda", *Journal of Child Psychology and Psychiatry and Allied Disciplines*, Vol. 60, No. 11, 2019.

38 Sinaria Jabbar and Amy Betawi, "Children Express: War and Peace Themes in the Drawings of Iraqi Refugee Children in Jordan", *International Journal of Adolescence and Youth*, Vol. 24, No.1, 2019.

39 Laura K. Murray, Stephanie Skavenski, Jeremy C. Kane, John Mayeya, Shannon Dorsey, Judy A. Cohen, Lynn T. M. Micalopoulos, Mwiya Imasiku and Paul A. Bolton, "Effectiveness of Trauma-Focused Cognitive Behavioral Therapy among Trauma-Affected Children in Lusaka, Zambia: A Randomized Clinical Trial", *JAMA Pediatrics*, Vol. 169, No. 8, 2015.

40 Paul O'Callaghan, Lindsay Branham, Ciaran Shannon, Theresa S. Betancourt, Martin Dempster and John McMullen, "A Pilot Study of a Family Focused, Psychosocial Intervention with War-Exposed Youth at

goals of the programme being to strengthen pro-social behaviour and decrease conduct problems. Compared to those not enrolled in the programme, youth who received services reported significant reduction in traumatic stress reactions; at three-month follow-up, there were reductions in internalizing symptoms and increases in pro-social behaviours, and caregivers also noted a decline in conduct problems. An innovative feature of this intervention is the use of community advisory boards comprised of community leaders and local youth to address challenges that arose during implementation. The community advisory board, led by a community pastor with a Master's in trauma interventions for youth, provided feedback on the appropriateness of interview questions and data collection; throughout the intervention, the lead researcher met weekly with four adults and four youth to assess intervention impact and propose changes to the programme to improve effectiveness, such as having a graduation ceremony.[41]

This strategy of incorporating community advisory boards into mental health interventions is well aligned with broader guidelines and best practices on working with war-affected populations, in which humanitarian workers and affected communities build equitable partnerships that serve to support and empower vulnerable communities.[42]

Individual and group-based treatment

Interventions have also prioritized an individual or group-based approach to treatment. For example, narrative exposure therapy (NET) was developed to be a brief treatment "for the psychological sequelae of torture and other forms of organized violence" that can be delivered by lay workers in low-resource settings.[43] The main intervention element of NET – which is known as KIDNET when used with children and adolescents – is the construction of a trauma narrative.[44] KIDNET has successfully been delivered as treatment for PTSD to former child soldiers in Uganda[45] and the DRC,[46] asylum-seekers resettled in

Risk of Attack and Abduction in North-Eastern Democratic Republic of Congo", *Child Abuse & Neglect*, Vol. 38, No. 7, 2014.

41 *Ibid.*

42 Office of the UN High Commissioner for Refugees (UNHCR), *A Community-Based Approach in UNHCR Operations*, Geneva, 2008, available at: www.refworld.org/pdfid/47da54722.pdf

43 Katy Robjant and Mina Fazel, "The Emerging Evidence for Narrative Exposure Therapy: A Review", *Clinical Psychology Review*, Vol. 30, No. 8, 2010.

44 Maggie Schauer, Frank Neuner and Thomas Elbert, "Narrative Exposure Therapy for Children and Adolescents (KIDNET)", in Markus A. Landolt, Marylene Cloitre and Ulrich Schnyder (eds), *Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents*, Springer International, Cham, 2017.

45 Verena Ertl, Anett Pfeiffer, Elisabeth Schauer, Thomas Elbert and Frank Neuner, "Community-Implemented Trauma Therapy for Former Child Soldiers in Northern Uganda", *Journal of the American Medical Association*, Vol. 306, No. 5, 2011.

46 Katharin Hermenau, Tobias Hecker, Susanne Schaal, Anna Maedl and Thomas Elbert, "Addressing Post-Traumatic Stress and Aggression by Means of Narrative Exposure: A Randomized Controlled Trial with Ex-Combatants in the Eastern DRC", *Journal of Aggression, Maltreatment, and Trauma*, Vol. 22, No. 8, 2013.

Germany,[47] Somali refugees living in a Ugandan refugee camp,[48] and youth orphaned from the Rwandan genocide.[49] In all studies, NET, compared against either a control group or another form of treatment, resulted in significant reductions in PTSD, which were often maintained or enhanced over time. TF-CBT has also been utilized to assist school-aged youth as they recover from trauma. TF-CBT is a phased evidence-based mental health intervention that consists of promoting youth coping skills, processing of trauma experiences, and consolidating and providing closure to the treatment experience.[50] In Palestine, trained counsellors delivered a TF-CBT programme called Teaching Recovery Techniques to groups of youth; post-test analyses demonstrated significant reductions in PTSD, depression, traumatic grief and mental health difficulties.[51] Several studies have demonstrated TF-CBT effectiveness in the DRC, targeting male children affected by armed conflict[52] and female youth who have experienced sexual violence.[53] The Youth Readiness Intervention (YRI) is a common-elements based transdiagnostic intervention which integrates elements of CBT and interpersonal psychotherapy and utilizes a group-based format to address emotion regulation and improve daily functioning in war-affected youth.[54] As tested in Sierra Leone, the YRI showed significant post-intervention effects on emotion regulation, pro-social attitudes, social support and reduced functional impairment. Additionally, youth receiving the YRI were rated by teachers as better behaved and better prepared for the classroom, as well as six times more likely to persist in school, compared to youth not receiving the intervention.[55]

47 Martina Ruf, Maggie Schauer, Frank Neuner, Claudia Catani, Elisabeth Schauer and Thomas Elbert, "Narrative Exposure Therapy for 7- to 16-Year-Olds: A Randomized Controlled Trial with Traumatized Refugee Children", *Journal of Traumatic Stress*, Vol. 23, No. 4, 2010.

48 Lamaro P. Onyut, Frank Neuner, Elisabeth Schauer, Verena Ertl, Michael Odenwald, Maggie Schauer and Thomas Elbert, "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*, Vol. 5, No. 1, 2005.

49 Susanna Schaal, Thomas Elbert and Frank Neuner, "Narrative Exposure Therapy Versus Interpersonal Psychotherapy: A Pilot Randomized Controlled Trial with Rwandan Genocide Orphans", *Psychotherapy and Psychosomatics*, Vol. 78, No. 5, 2009.

50 Judith A. Cohen, Anthony P. Mannarino, Matthew Kliethermes and Laura A. Murray, "Trauma-Focused CBT for Youth with Complex Trauma", *Child Abuse & Neglect*, Vol. 36, No. 6, 2012.

51 Ian G. Barron, Ghassan Abdallah and Patrick Smith, "Randomized Control Trial of a CBT Trauma Recovery Program in Palestinian Schools", *Journal of Loss and Trauma*, Vol. 18, No. 4, 2013.

52 John McMullen, Paul O'Callaghan, Ciaran Shannon, Alastair Black and John Eakin, "Group Trauma Focused Cognitive Behavioural Therapy with Former Child Soldiers and other War-Affected Boys in the DR Congo: A Randomised Controlled Trial", *Journal of Child Psychology and Psychiatry*, Vol. 54, No. 11, 2013.

53 Paul O'Callaghan, John McMullen, Ciaran Shannon, Harry Rafferty and Alastair Black, "A Randomized Controlled Trial of Trauma-Focused Cognitive Behavioral Therapy for Sexually Exploited, War-Affected Congolese Girls", *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 52, No. 4, 2013.

54 Theresa S. Betancourt, Ryan McBain, Elizabeth A. Newnham, Adeyinka Akinsulure-Smith, Robert T. Brennan, John R. Weisz and Nate Hansen, "A Behavioral Intervention for War-Affected Youth in Sierra Leone: A Randomized Controlled Trial", *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 53, No. 12, 2014.

55 *Ibid.*

Classroom-based approaches

While access to education is often disrupted during war, when areas are stabilized or youth have been resettled into more secure environments, the classroom presents a useful setting for delivering interventions. In northern Uganda, the school-based Psychosocial Structured Activities programme utilized fifteen sessions to centre resilience as youth recovered from trauma.[56] Ethnographic approaches were used to identify culturally grounded concepts of youth well-being from the perspective of youth (e.g. social and happy), caregivers (e.g. unstressed and open) and teachers (e.g. cooperative and respectful). Pre- to post-intervention comparisons demonstrated that youth enrolled in the programme had significant increases in ratings of well-being via child and caregiver reports. Other school-based interventions have been implemented and assessed in Burundi,[57] Nepal[58] and Sri Lanka,[59] with varying levels of effectiveness. Across studies, factors such as the age and gender of the young people involved, as well as ongoing exposure of youth to daily stressors, influence intervention effectiveness. For instance, a mental health intervention among war-affected youth in Sri Lanka was more effective in reducing symptoms of conduct problems among younger participants.[60] While school-based interventions have shown promise in addressing youth well-being and mental health, and the classroom setting creates an accessible site from which to deliver such programming, researchers should consider whether classroom-based programming should be delivered to gender- or age-segregated groups. We suggest additional caution related to who delivers these interventions, as it is important to avoid over-tasking and over-burdening teachers; instead, a separate group of individuals should be identified and trained to deliver mental health services.

56 Alastair Ager, Bree Akesson, Lindsay Stark, Eirini Flouri, Braxton Okot, Faith McCollister and Neil Boothby, "The Impact of the School-Based Psychosocial Structured Activities (PSSA) Program on Conflict-Affected Children in Northern Uganda," *Journal of Child Psychology and Psychiatry*, Vol. 52, No. 11, 2011.

57 Wietse A. Tol, Ivan H. Komproe, Mark J. D. Jordans, Aline Ndayusaba, Prudence Ntamutumba, Heather Sipsma, Eva S. Smallegange, Robert D. Macy and Joop T. V. M. de Jong, "School-Based Mental Health Intervention for Children in War-Affected Burundi: A Cluster Randomized Trial", *BMC Medicine*, Vol. 12, No. 56, 2014.

58 Mark J. D. Jordans, Ivan H. Komproe, Wietse A. Tol, Brandon A. Kohrt, Nagendra P. Luitel, Robert D. Macy and Joop T. V. M. de Jong, "Evaluation of a Classroom-Based Psychosocial Intervention in Conflict-Affected Nepal: A Cluster Randomized Controlled Trial", *Journal of Child Psychology and Psychiatry*, Vol. 51, No. 7, 2016.

59 Wietse A. Tol, Ivan H. Komproe, Mark J. D. Jordans, Anavarathan Vallipuram, Heather Sipsma, Sambasivamoorthy Sivayokan, Robert D. Macy and Joop T. V. M. de Jong, "Outcomes and Moderators of a Preventive School-Based Mental Health Intervention for Children Affected by War in Sri Lanka: A Cluster Randomized Trial", *World Psychiatry*, Vol. 11, No. 2, 2012.

60 *Ibid.*

Mental health and psychosocial well-being in the Rohingya community in refugee camps in Bangladesh

Background and context

Myanmar, known historically as Burma, is bordered by Bangladesh, India, China, Laos and Thailand. The tensions between the government and the Rohingya people date to centuries of persecution;[61] Myanmar has a population of approximately 51 million and is ethnically and religiously diverse. Only a small number of ethnic minorities, of which the Rohingya are not one, are recognized officially as citizens, despite their historical presence in Myanmar.[62] The 1982 Citizenship Law[63] excluded the Rohingya from Myanmar's recognized ethnic groups, rendered them stateless and barred them from the rights and protections of national and international law.[64] In August 2017, the situation escalated to the level of a humanitarian emergency involving State-sponsored genocide, mass rape and sexual violence, ethnic cleansing and crimes against humanity.[65] More than 730,000 Rohingya, including over 400,000 children, fled violence in Myanmar and settled in Cox's Bazar District, Bangladesh. Of these 400,000, there are an inconclusive number of unaccompanied or orphaned children, with one report suggesting over 6,000 unaccompanied children[66] and another suggesting that one in four Rohingya children are orphaned.[67] In Myanmar, 600,000 Rohingya continue to face significant challenges, including lack of freedom of movement, discrimination and limited access to basic services.[68]

Politically, the government of Bangladesh and the international community have concentrated on immediate and transitory humanitarian relief. The repatriation of Rohingya refugees from Bangladesh to Myanmar has proved deeply problematic, with the Myanmar government denying the legitimacy of the Rohingya people's right to belong in Myanmar. Such complex political and

61 Jeff Crisp, *The Role of the UN Agencies in Rohingya Genocide since 1978*, Panel Discussion, International Conference on Protection and Accountability in Burma, New York, 2019; Alvin K. Tay, Rafiqul Islam, Andrew Riley, Courtney Welton-Mitchell, Benedicte Duchesne, Valerie Waters, Derrick Silove and Peter Ventevogel, *Culture, Context, and Mental Health of Rohingya Refugees: A Review for Staff in Mental Health and Psychosocial Support Programmes for Rohingya Refugees*, UNHCR, Geneva, 2018.

62 J. Crisp, above note 61; A. K. Tay *et al.*, above note 61.

63 Burma Citizenship Law, 15 October 1982.

64 Jobair Alam, "The Rohingya of Myanmar: Theoretical Significance of the Minority Status", *Asian Ethnicity*, Vol. 19, No. 2, 2018.

65 *Rohingya Crisis in Cox's Bazar District, Bangladesh*, Health Sector Bulletin No. 6, 6 September 2018, available at: www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/healthsectorcxbbanbulletinno6.pdf; Razia Sultana, *Rape by Command: Sexual Violence as a Weapon against the Rohingya*, Kalandan Press, Chittagong, 2018.; A. K. Tay *et al.*, above note 61.

66 Mohsin Habib, Christine Jubb, Salahuddin Ahmad, Masudur Rahman and Henri Pallard, "Forced Migration of Rohingya: An Untold Experience", *SSRN Electronic Journal*, 2018, available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3242696.

67 Save The Children, "Alarming Number of Rohingya Refugee Children Orphaned by Brutal Violence, New Save the Children Study Finds", available at: www.savethechildren.org.uk/news/media-centre/press-releases/alarming-number-of-rohingya-refugee-children-orphaned-by-brutal-.

68 UNICEF, *UNICEF Humanitarian Action for Children 2019: Overview*, New York, January 2019, available at: www.unicef.org/media/48796/file/Humanitarian-action-overview-cover-eng.pdf.

humanitarian contexts have profound long-term implications regarding the Rohingya community's social, physical and mental health, linked to a lack of belonging and certainty. The cumulative psychological impact of these experiences on child and adolescent mental health is apparent,[69] although robust psychological intervention outcome data is sparse.[70]

With a population of approximately 162.9 million, Bangladesh is one of the most densely populated countries in the world, with the ongoing refugee influx creating a further strain on the limited resources of the nation. Rising tensions between the Rohingya and local host communities, and within the camps regarding access to limited local resources and concomitant acculturation issues, add to the ongoing complexity.

Understandings of mental health, culture and trauma

There is "no single universal or definitive way of being a healthy person, hence no psychological theory fits everywhere".[71] As such, conceptual and epistemological challenges prevail in understanding the influence of personal, relational, community and socio-political structures on individual mental health. Adult Rohingya camp residents report systematic discrimination in Myanmar, particularly in accessing health and education.[72] One can hypothesize that such experiences influence how health and mental health providers are viewed – e.g., as benign or persecutory – and thus have an impact on the community's help-seeking behaviour, their relationship to mental health provisions, and their acceptance of support. As such, recognizing the impact of historical oppression and persecution, and the acute traumatic experiences of torture, genocide, gender-based violence, and subsequent migration to and residence in the camps, is crucial to understanding mental distress and how services are accessed, accepted or even understood. Given that individual mental difficulties show strong correlations with social factors, distress is unlikely to be relieved through improved access to mental health treatments alone.[73]

69 World Vision, "Psychological Support for Refugee Children of Myanmar in Bangladesh", 22 January 2018, available at: https://reliefweb.int/report/bangladesh/psychological-support-refugee-children-myanmar-bangladesh.

70 Nargis Islam, Nishat F. Rahman and Naila Z. Khan, "Trauma and Mental Health in the Rohingya Camps: One Year On", in *BRAC Health Watch: Health Sector's Response to the Rohingya Crisis*, BRAC University, 2019.

71 Susan Llewelyn and Katie Aafjes-van Doorn (eds), *Clinical Psychology: A Very Short Introduction*, Oxford University Press, Oxford, 2018, p. xvi.

72 Moshin Habib, Christine A. Jubb, Salahuddin Ahmad and Masudur Rahman, *Forced Migration of Rohingya: The Untold Experience*, Ontario International Development Agency, Ottawa, 2018.

73 Crick Lund, Carrie Brooke-Sumner, Florence Baingana, Emily Claire Baron, Erica Breuer, Prabha Chandra, Johannes Haushofer, Helen Herman, Mark Jordans, Christian Kieling, Maria Elena Medina-Mora, Ellen Morgan, Olayinka Omigbodun, Wietse Tole, Vikram Patel and Shekhar Saxena, "Social Determinants of Mental Disorders and the Sustainable Development Goals: A Systematic Review of Reviews", *The Lancet Psychiatry*, Vol. 5, No. 4, 2018; World Health Organization (WHO), *Social Determinants of Mental Health*, Geneva, 2014; Erik Blas and Anand Sivasankara Kurup, *Equity, Social Determinants and Public Health Programmes*, WHO, Geneva, 2010.

Human rights and mental health

Human rights violations are inherently linked with humanitarian crises where issues of oppression, power and denied opportunities prevail, particularly in the context of support for mental health difficulties.[74] Human rights violations such as torture and displacement, denial of access to adequate resources, and coercive treatment practices infringe on people's rights to live healthy lives with opportunities to thrive, further impacting mental health.[75] In the Rohingya experience, human rights-related health issues have been found to present significant structural barriers such as poor living conditions, restricted mobility and lack of working rights, and collectively contribute to poor physical and mental health outcomes.[76]

Social determinants of mental health

It is increasingly recognized that the determinants of mental health and illness involve not just individual factors but also social and socio-political factors, and their interaction with each other,[77] with vulnerabilities linked to poverty, social inequality, persecution and discrimination.[78] Global mental health and global economy researchers are developing a growing body of evidence that associates social inequalities with increased risk of mental health difficulties.[79] Given the structural barriers to social and health support that the Rohingya people have faced in Myanmar and in post-migration displacement settings, their unique social determinants of mental distress are important. The barriers to accessing opportunities to live a fulfilled life and contribute to the well-being of society[80] are particularly salient for refugee populations, where many mental health difficulties

74 I. Weissbecker *et al.*, above note 10; Lisa D. Butler, Filomena M. Critelli and Janice Carella, *Trauma and Human Rights: Integrating Approaches to Address Human Suffering*, Palgrave Macmillan, Cham, 2019.

75 Sebastian Porsdam Mann, Valerie J. Bradley and Barbara J. Sahakian, "Human Rights-Based Approaches to Mental Health", *Health and Human Rights Journal*, Vol. 18, No. 1, 2016.

76 Nidhi Wali, Wen Chen, Lal B. Rawal, A. S. M. Amanullah and Andre M. N. Renzaho, "Integrating Human Rights Approaches into Public Health Practices and Policies to Address Health Needs amongst Rohingya Refugees in Bangladesh: A Systematic Review and Meta-ethnographic Analysis", *Archives of Public Health*, Vol. 76, No. 1, 2018.

77 Malin Eriksson, Mehdi Ghazinour and Anne Hammarstrom, "Different Uses of Bronfenbrenner's Ecological Theory in Public Mental Health Research: What Is Their Value for Guiding Public Mental Health Policy and Practice?", *Social Theory and Health*, Vol.16, No. 4, 2018.

78 *Ibid.*; Michael Marmot, "Social Determinants of Health Inequalities", *The Lancet*, Vol. 365, No. 9464, 2005; Jamie Pearce and Danny Dorling, "Tackling Global Health Inequalities: Closing the Health Gap in a Generation", *Environment and Planning A*: *Economy and Space*, Vol. 41, No. 1, 2009.

79 Vikram Patel, Crick Lund, Sean Hatherill, Sophie Plagerson, Joanne Corrigall, Michelle Funk and Alan J. Flisher, "Mental Disorders: Equity and Social Determinants", in Erik Blas and Anand Sivasankara Kurup (eds), *Equity, Social Determinants and Public Health Programmes*, WHO, Geneva, 2010; Vikram Patel, Jürgen Unützer *et al.*, "The Lancet Commission on Global Mental Health and Sustainable Development", *The Lancet*, Vol. 392, No. 10157, 2018; Catherine Panter-Brick and Mark Eggerman, "Anthropology and Global Mental Health: Depth, Breadth, and Relevance", in Ross G. White, Sumeet Jain, David M. R. Orr and Ursula M. Read (eds), *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*, Palgrave Macmillan, London, 2017; Ross G. White, Maria Grazia Imperiale and Em Perera, "The Capabilities Approach: Fostering Contexts for Enhancing Mental Health and Well-being Across the Globe", *Globalization and Health*, Vol.12, No. 1, 2016.

80 WHO, above note 73.

are shaped by social, economic and physical environments. For the Rohingya community, occupying a "stateless" status is likely to influence their sense of safety and security within legal frameworks. This has significant implications for an internal sense of belonging and safety, validation and recognition of injustices, and recognition of self-worth in addition to future opportunities to thrive.

Of relevance in the Rohingya context is the fact that, despite recognition that social structures can negatively impact mental health,[81] mental health interventions in humanitarian settings often face challenges to an authentic recognition of the cultural and social aspects and idioms of mental distress[82] beyond cultural adaptations to the current (Western-oriented) evidence base. Where the experience of psychological and emotional distress is intrinsically linked to the systemic influence of power, the influence of certain groups prevails on how narratives are constructed, "producing dominant social discourses, with particular consequences".[83] Therefore, while "individualizing the distress of refugee people and 'treating' them by focusing on symptom alleviation" has the potential to be of benefit for those in therapeutic engagement with a compassionate professional, the risk lies in services overlooking, being unaware of, or dismissing the social and material causation of refugee people's distress while holding to an individualistic trauma discourse.[84] Power to influence global narratives and paradigms exists in the economic and political interests of governments, funders, global corporations and international organizations, in addition to the ethos and politics of the psychological and psychiatric professions.[85] Personal motivations, beliefs and values, post-colonialism and patriarchal worldviews are subtle but influential in what are accepted explanations of individual mental functioning.[86] What is clear is that no one profession or organization can target all levels of influence and power; thus, shared individual and overarching goals, in addition to collaborative action, are seen as the most effective way forward.

Mental health research from the Rohingya camps

There is a lack of published studies on the mental health of the Rohingya following the August 2017 crisis,[87] possibly due to the focus on emergency delivery of public

81 Michaela Hynie, "The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review", *Canadian Journal of Psychiatry*, Vol. 63, No. 5, 2018; C. Lund *et al.*, above note 73; Andrew Riley, Andrea Varner, Peter Ventevogel, M. M. Taimur Hasan and Courney Welton-Mitchell, "Daily Stressors, Trauma Exposure, and Mental Health among Stateless Rohingya Refugees in Bangladesh", *Transcultural Psychiatry*, Vol. 54, No. 3, 2017.

82 A. K. Tay *et al.*, above note 61.

83 Nimisha Patel, "The Mantra of 'Do No Harm' in International Healthcare Responses to Refugee People", in Thomas Wenzel and Boris Drozdek (eds), *An Uncertain Safety: Integrative Health Care for the 21st Century Refugees*, Springer International, Cham, 2019, p. 160.

84 *Ibid.*

85 China Mills, "The Psychiatrization of Poverty: Rethinking the Mental Health–Poverty Nexus", *Social and Personality Psychology Compass*, Vol. 9, No. 5, 2015.

86 N. Patel, above note 83.

87 N. Islam *et al.*, above note 70.

health and social structure support systems, the ethical barriers to researching vulnerable populations, and the time and resources required to implement evaluation projects. However, there is evidence of trauma symptoms and environmental stressors associated with life in the camps (e.g., lack of food, restrictions on movement outside the camps and safety concerns), where symptoms of low mood were associated with daily stressors rather than prior experiences of trauma.[88] A report by the Office of the UN High Commissioner for Refugees (UNHCR) on the mental health and cultural needs of the Rohingya people established that the Rohingya people have limited familiarity with Western concepts of mental distress,[89] and their expressions of distress stem from cultural rather than global descriptors, including their beliefs in spirit possession for issues such as erratic behaviour, visual and auditory hallucinations and paranoid delusions. As such, psychological formulations need to incorporate cultural beliefs around spirit possession when working with psychotic experiences and epilepsy, and in neurodevelopmental disorders in infants, children and adolescents. Research in Bangladesh populations suggest that approximately 70% of attendees at a national epilepsy assessment unit visited indigenous medicine practitioners, exorcists and/or spiritualists before consulting the clinic; only 29% perceived epilepsy as a disease.[90] Cross-cultural studies also suggest that people can hold both neurological and metaphysical beliefs about epilepsy concurrently with regard to religiosity with positive outcomes,[91] with other discussions[92] noting that epilepsy interventions should incorporate both allopathic and faith-based responses to epilepsy. Similarly, clinical and research findings indicate that psychotic experiences are culturally determined; thus, adopting a pluralistic approach in treatment is effective. For instance, a study in India highlights how psychiatric professionals tend not to use diagnostic labels when discussing difficulties with patients, finding that the different meanings attached to unusual sensory experiences can enable a less pathological interpretation of their symptoms.[93]

Religiosity is an important source of finding meaning in the Rohingya experiences of trauma, both from research[94] and from field experiences. Religion as a protective factor and source of resilience has been identified in other refugee

88 A. Riley *et al.*, above note 81.
89 A. K. Tay *et al.*, above note 61.
90 Rajat Sanker Roy Biswas, Mohammad Gias Uddin and Mohammad Mostafa, "Pattern of Epilepsy Patients Visiting in a Psychiatry Outpatient Department", *Journal of the Scientific Society*, Vol. 45, No. 1, 2018.
91 Mina Gajjar, Esther Geva, Tom Humphries, Michele Peterson-Badali and Hiroshi Otsubo, "A New Scale to Assess Culture-Specific Beliefs and Attitudes about Epilepsy", *Epilepsy & Behavior*, Vol. 1, No. 4, 2000.
92 Penny Rhodes and Neil Small, "Crossing Continents: Meanings and Management of Epilepsy among People of Pakistani Origin Living in the UK", in Jaya Pinikahana and Christine Walker (eds), *Society, Behaviour and Epilepsy*, Nova Science Publishers, Hauppauge, NY, 2011.
93 Murphy Halliburton, "Finding a Fit: Psychiatric Pluralism in South India and Its Implications for WHO Studies of Mental Disorder", *Transcultural Psychiatry*, Vol. 41, No. 1, 2004.
94 A. K. Tay *et al.*, above note 61.

populations in adolescents,[95] and in adults in conflict situations.[96] It appears that initially, the Rohingya community were more likely to seek support for physical complaints or somatic symptoms of mental distress rather than seek formal support for mental health difficulties, as stigma and shame are associated with mental health problems in the Rohingya community.[97] Coping and health-related behaviours are important indicators of how comfortable children and young people feel in accessing mental health support.

In summary, while there is a dearth of evidence regarding prevalence and expression of mental distress in the Rohingya communities, what is clear is that the experience of forced migration is expressed through worry, fear, low mood and uncertainty about current security (or anxiety, depression and symptoms of PTSD). Factors to consider in a culturally authentic assessment of child and adolescent mental health include the individual experience and socio-political environment, the cultural descriptors and idioms of mental distress, cultural and social barriers to uptake of services, and culturally congruent coping and resilience variables.

Child- and adolescent-specific mental health activity

While in Myanmar, Rohingya children grew up not being legal citizens and experienced ongoing violence and persecution, forced displacement, and restrictions on movement and religious activity.[98] As the Rohingya community becomes more settled in the camps, they are helped by a wide range of Bangladeshi government, international NGO and humanitarian partners to gain access to public health and infrastructure services. However, these initiatives are of indeterminate duration, dependent on external aid, and in a context of congested and often hazardous living conditions (e.g., floods from monsoons and damage from cyclones). Holding a status of "forcibly displaced Myanmar nationals" means that the Rohingya community, like many refugees and stateless people, do not have access to formal education or employment that would enable them to gain practical skills and the self-worth they require to thrive.[99] Adolescents in particular suffer from a lack of opportunities to learn skills to earn a living, while young girls are vulnerable to trafficking and other forms of exploitation and oppression – i.e., sexual and other gender-based violence, including early and forced marriage.

95 B. Heidi Ellis, Alisa K. Lincoln, Meredith E. Charney, Rebecca Ford-Paz, Molly Benson and Lee Strunin, "Mental Health Service Utilization of Somali Adolescents: Religion, Community, and School as Gateways to Healing", *Transcultural Psychiatry*, Vol. 47, No. 5, 2010.
96 Amy L. Ai, Christopher Peterson and Bu Huang, "The Effect of Religious-Spiritual Coping on Positive Attitudes of Adult Muslim Refugees from Kosovo and Bosnia", *International Journal for the Psychology of Religion*, Vol. 13, No. 1, 2003.
97 A. K. Tay *et al.*, above note 61.
98 Ken MacLean, "The Rohingya Crisis and the Practices of Erasure", *Journal of Genocide Research*, Vol. 21, No. 1, 2019.
99 UNICEF, "Rohingya Crisis", 2019, available at: www.unicef.org/emergencies/rohingya-crisis.

Research specifically on child and adolescent mental health in the camps is scarce. One study examined neurodevelopmental difficulties in children presenting at a clinic in the Rohingya camps, assessing mental health as a component of their screening process;[100] it found that over half of the 622 assessed children were in the clinical range for emotional symptoms, and 25% for peer problems. Children's mental health difficulties were unsurprisingly significantly associated with being parentless in terms of emotional and peer problems. While parental mental health was not assessed in this study, strengths were noted in the caregiving of Rohingya mothers and kinship caregivers, and it was observed that caregiver mental health could affect children. This finding is supported by recent research conducted in a Western context which found that the neurodevelopmental effect of severe early life stress correlated with poor relational experiences and led to reduced emotion regulation and sensory integration skills.[101]

Mental health and psychosocial support interventions in the camps

The speed and scale of the influx of the Rohingya people's migration over the course of the three-month period from August 2017 placed an enormous strain on host communities and Bangladesh as a whole. The sheer volume of the humanitarian crisis required immediate responses with the available resource structure, with priority placed on addressing basic needs of food, shelter and public health management. The Bangladeshi army, with their experiences as the largest contributor to UN peacekeeping forces,[102] were able to rapidly establish infrastructural provisions for initial and basic needs, alongside first response teams from international and local humanitarian organizations.

With over 700,000 individuals joining the already resident 200,000 Rohingya refugees,[103] humanitarian and government agencies were suddenly required to provide immediate care to a population equivalent to that of Stockholm, Sweden (744,000). Adequate physical and mental health services for a population of these proportions are typically developed over long periods of time, with stable and established social, governmental and financial infrastructures. The emergency situation meant that aid agencies and the government of Bangladesh had to respond immediately, with limited information about the Rohingya's culture and unique needs. This, together with their immediate experiences of torture and genocide, meant that humanitarian and government agencies faced

100 Naila Z. Khan, Asma Begum Shilpi, Razia Sultana, Shaoli Sarker, Sultana Razia, Bipasha Roy, Abu Arif, Misbah Uddin Ahmed, Subas Chandra Saha and Helen McConachie, "Displaced Rohingya Children at High Risk for Mental Health Problems: Findings from Refugee Camps within Bangladesh", *Child: Care, Health and Development*, Vol. 45, No. 1, 2019.

101 Erin P. Hambrick, Thomas W. Brawner and Bruce D. Perry. "Timing of Early-Life Stress and the Development of Brain-Related Capacities", *Frontiers in Behavioral Neuroscience*, Vol. 13, 2019.

102 "Bangladesh: Three Decades of Service and Sacrifice in UN Peacekeeping", *UN News*, available at: https://news.un.org/en/gallery/520251.

103 Abhishek Bhatia, Ayesha Mahmud, Arlan Fuller, Rebecca Shin, Azad Rahman, Tanvir Shatil, Mahmuda Sultana, K. A. M. Morshed, Jennifer Leaning and Satchit Balsari, "The Rohingya in Cox's Bazar: When the Stateless Seek Refuge", *Health and Human Rights Journal*, Vol. 20, No. 2, 2018.

an exceptionally daunting task in prioritizing and addressing the Rohingya's multiple needs. Government, humanitarian and aid agencies such as BRAC, the UNHCR, UNICEF, the International Organization for Migration, Médecins Sans Frontières and the International Committee of the Red Cross all initiated interventions with regard to working with the Rohingya community in the camps and with the host communities, who, although not facing the particular difficulties experienced by the Rohingya, were nonetheless suffering from their own lack of personal and infrastructural resources.[104]

Child-friendly spaces (CFSs) are designated safe spaces within the camps where communities create nurturing environments in which children access free and structured play, recreation, leisure and learning activities.[105] CFSs are the recognized means by which psychosocial support activities for children in humanitarian settings are delivered,[106] and alongside temporary learning spaces, activities in these settings provide structure, normalizing activities, safety, socialization and adult supervision. They represent the only structured activities that can be offered to children and young people in the Rohingya refugee camps, and are considered to offer a protective function of providing a location from which to monitor and assess for child safeguarding and protection issues as well as a safe place to play. BRAC, one of the largest NGOs in the world, partnered with the LEGO Foundation, Sesame and UNICEF to implement mental health and psychosocial support (MHPSS) interventions and Humanitarian Play Labs (HPLs) in 308 CFSs across thirty-two camps in the Ukhiya and Teknaf areas of Cox's Bazar, as well as a number for host communities.[107] MHPSS and HPLs have been offered to over 60,000 children between the ages of 0 and 6 years and their families. Launched by BRAC in 2018, the HPL is an MHPSS model that integrates learning through play into the lives of young children. This model has trained paraprofessional play leaders who deliver a model of learning through play that integrates "playfulness" and psychosocial support in order to address the mental health needs of children. The HPL has received international attention and acclaim for its innovative approach to the psychological input and care of children in crisis and emergency settings.

Current challenges and gaps in provision

Despite the commitment and input of the aid and NGO agencies, there is currently no or very little reliable published data or literature on the efficacy of any

104 N. Islam, above note 70.

105 "Child Friendly Spaces (CFS) Minimum Standards: Cox's Bazar, Rohingya Emergency Response", available at: www.humanitarianlibrary.org/sites/default/files/2019/02/cfs_minimum_standard_-_cxb_cpss_2018.pdf.

106 *Ibid.*

107 Lego Foundation, "Play Labs, BRAC", available at: www.legofoundation.com/en/what-we-do/programmes-and-projects/play-labs-brac/; BRAC, "Humanitarian Play Labs: Helping Rohingya Children Heal and Learn through Play", available at: www.brac.net/latest-news/item/1213-humanitarian-play-labs-helping-rohingya-children-heal-and-learn-through-play.

intervention with regard to the psychological well-being of Rohingya children and adolescents; nor is there any evaluation of the clinicians and workers who deliver such interventions, or of whether the community feels that such interventions are useful and helpful. Anecdotally, we know that many children continue to attend the CFSs and are supported and encouraged by their families to do so. What is less clear is how many are not attending and what the reasons for this might be.

In addition to this, there is inconsistency in MHPSS and CFS provisions across the camps. Many organizations have psychosocial service centres and staff; however, given the stigma attached to mental health difficulties, uptake of services is challenging. One method of addressing the problem has been to adopt the Rohingya communities' term for the clinics as "peace centres" (*shanti khana*)[108] and MHPSS workers as "doctors of the heart" (*diller daktar*), thus bypassing the stigma of mental health labels and remaining culturally authentic.

Given the large geographical area involved, the distances from homes to health centres can be substantial, presenting a further challenge for MHPSS service provision. Here, outreach services have real potential for community engagement, although there continue to be concerns about the management and treatment of more severe mental health difficulties, confidentiality in client disclosure within the close confines of shelters that can be overheard by family members and neighbours, and safety of the outreach para-counsellors. What is apparent is that, anecdotally, over time the community has become more comfortable with the idea of a psychologically supportive space and has continued to use MHPSS services, suggesting that community members are less distrustful of such services.

Language is the key to ensuring effective MHPSS service. While there are some similarities between the Rohingya language and that of the host community (Chat Gaon), culturally and idiomatically there continue to be significant challenges in communication. While play-based interventions present more of a "universal language", communication with parents and caregivers with regard to supportive practices and strategies requires effective language communication. Currently, most organizations employ paraprofessionals from the host community due to the similarity in dialects. However, recent research suggests that almost 60% of the surveyed Rohingya people have difficulty in understanding the host community dialect; this is a particular concern for the Rohingya women, who hold the main care responsibilities yet have low literacy rates.[109]

Understanding Rohingya culture and the importance of religion in Rohingya narratives of well-being is of particular importance in the delivery of appropriate interventions that are accessible and non-stigmatizing.[110] MHPSS

108 Médecins Sans Frontières, "Shanti Khana: Bringing Peace to Rohingya Refugees", Project Update, 28 September 2018, available at: www.msf.org/shanti-khana-bringing-peace-rohingya-refugees.

109 Translators without Borders, "Translators without Borders Launches Language Tool for Rohingya Humanitarian Response", 19 June 2018, available at: https://reliefweb.int/report/bangladesh/translators-without-borders-launches-language-tool-rohingya-humanitarian-response.

110 A. K. Tay *et al.*, above note 61.

providers have an ongoing remit to draw on the indigenous narratives of mental health and coping strategies in order to introduce creative and non-traditional methods with regard to mental health support practices; it remains unclear how cultural awareness is informing MHPSS practices, however.

Incidences of polygamy across the host and Rohingya communities are rising. Recent unpublished data and reports[111] indicate that rising polygamy rates in both the host and Rohingya communities have a significant negative impact in terms of the psychological effect of abandonment and the lack of emotional and financial security that a stable marital union brings, in addition to increased risks and vulnerability to sexual and gender-based violence. There is also reason to believe that there is tension between the host and Rohingya communities regarding this incidence of polygamy, although this phenomenon is under-researched and therefore the specifics are unclear. It is therefore plausible to hypothesize that there will be uncertainties and difficulties, impacting on women and children predominantly, regarding emotional and economic resource allocation, with concomitant risks of sexual and gender-based violence. A key concern here is the appropriateness and ethicality of providing therapeutic coping strategies for women, children and adolescents in such contexts that implicitly condone uncertain, exploitative and violent living conditions. Conversely, encouraging the development of autonomy and a "zero-tolerance" approach to violence is problematic and risky without infrastructural support such as the provision of safe refuge spaces, which is particularly challenging in a refugee camp environment. Joint working with mental and social services and security and legal systems is the most effective method of addressing these structural challenges.

The current MHPSS provision is predominantly in the Rohingya communities, although government directives now ensure that any intervention must also be delivered in some form to the host community, where there continue to be pre-existing and ongoing mental health needs. These same host communities responded with great humanity and compassion to the arrival of the initial influx of traumatized Rohingya people, and subsequently sacrificed their lands and resources for the camp sites and provision of services. While some elements of the host communities are benefiting from paid employment in supporting the humanitarian effort, shortages of resources and work, high prices of commodities and intermarriages have created tensions between the host community and the Rohingya communities. Furthermore, such tensions hold significant risks for women and children in terms of psychological and economic impact. These issues of intermarriage, inflation of commodities and workforce problems require intervention on a public health, community development and economic policy level.[112]

111 M. R. Alam, "Polygamy in Rohingya Crisis and Aftermath", International Conference on Rohingya Crisis in Bangladesh: Challenges and Sustainable Solutions, North South University, Dhaka, 27–28 July 2019; Maliha Khan, "Polygamy in the Camps", *Daily Star*, 2 August 2019.

112 N. Islam, above note 70.

While there are numerous MHPSS interventions across the camps and host communities, there is very little to no information publicly available on quality assurance processes in the training and development of MHPSS professionals. Therapeutic practitioners have a professional and ethical obligation to provide care that is embedded in a structure of accountability and transparency, usually through case note auditing and clinical outcome measures and some type of regular supervision.[113] Such accountability should, in reality, extend to all who have a role in delivering MHPSS in a support or research capacity in the camps. Lack of accurate quality assurance information is of concern in terms of safeguarding the pre-existing vulnerabilities of the Rohingya people, and from a human rights and ethical practice perspective.[114]

Interconnections of agency, mental well-being and livelihood opportunities among Rohingya refugee youth in Cox's Bazar

The World Health Organization (WHO) recognizes that psychological well-being and many mental disorders are shaped by the social, economic, geopolitical and physical environments in which people exist.[115] Access and use of social institutions in host countries, such as education and health and social care, as well as employment, have a significant impact on how mental distress is reduced and psychological well-being is achieved, e.g. through meaningful activities such as education and employment. Engagement in such activity benefits individuals, particularly children and adolescents, through increased self-efficacy and sense of self-worth, and the potential to be valued contributors to their community and society. Addressing structural and psychological barriers to such engagement therefore has the potential to affect positive individual and community well-being.

Life skills and livelihood generation among Rohingya refugees is a vital issue as most refugee situations, and many situations involving internally displaced persons, are not resolved quickly; instead they become protracted and often without any clear end in sight. Life skills are usually associated with managing and living a better quality of life, and livelihood programmes generally seek to increase the capacity of households and individuals to enhance their income, skills and assets. In order to address these issues, life skills education activities have been started in Rohingya camps on a small scale. Schooling in camps was approved in 1996 and started in Nayapara camp in 2000. A joint assessment by the UNHCR and the International Labour Organization (ILO) found that Rohingya children are provided with informal education facilities in the camp up to grade five in the primary level (age 6 to 11), after which they cannot officially pursue further education either in the camps or outside due to restrictions placed upon them. As the existing facilities inside camps allow the

113 *Ibid.*
114 I. Weissbecker *et al.*, above note 10.
115 WHO and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health*, Geneva, 2014.

children to study up to grade five only, they have to look for outside schools or institutions and will encounter challenges obtaining admission without a valid address. A few children from vulnerable families are not enrolled in the camp schools for lack of awareness of the guardian.[116] These education services inside the camps have continued until now, and Rohingya children who have arrived in Bangladesh after the latest influx of 2017 are getting informal education in the camp schools, where the language of instruction is either English or Burmese but not Bengali.

Restrictions on freedom of movement and lack of education and formal employment in Bangladesh limit not only refugees' current resilience opportunities, but also their prospects of accessing livelihoods in the future in their home country, Myanmar, and/or in any other country. Several studies have highlighted the importance of providing education and employment opportunities to Rohingya youth as livelihood enhancement has the potential to improve social capital, enabling refugees to contribute to local economies and to their future (re)integration within their former country of residence or any other country.[117] The UNHCR considers livelihood interventions such as microfinance an attractive option to address these challenges, since refugees in long-term displacement do not face an imminent prospect of return or resettlement.[118] This indicates a possible avenue through which Rohingya youth can be provided with formal opportunities to develop vocational skills, which can be tied with microfinance.

A recent Population Council assessment found a strong desire among Rohingya youth, regarding their involvement in income-generation activities (IGAs), to improve their living conditions. The study mainly inquired about the sexual and reproductive health and marriage practices of Rohingya in two time frames, pre-arrival in Bangladesh and post-arrival in Bangladesh, in order to understand how and to what extent their life realities have changed. The study also captured social dynamics and the voices of surrounding host communities to understand how they perceive the changes in their lives after the Rohingya's arrival in the camps, and related implications.[119]

In refugee situations in other countries where displacement is protracted, there is little support for livelihoods and self-reliance. To sustain themselves and their families, refugees rely on a wide range of support and *ad hoc* help from family, friends, neighbours, employers and others in the host community, while

116 UNHCR and ILO, *Rapid Appraisal of the Livelihood Capability of the Refugees: Kutupalong and Nayapara Refugee Camps*, Dhaka, 2009.

117 Food Security Sector, *Support to Livelihoods of Host Communities and Resilience Opportunities for the Rohingya Refugees*, Livelihood Working Group, Cox's Bazar, 2018, available at: https://fscluster.org/sites/default/files/documents/advocating_for_livelihoods_of_host_communities_and_resilience_opportunities_for_rohingya_refugees_0.pdf.

118 Michelle Azorbo, *Microfinance and Refugees: Lessons Learned from UNHCR's Experience*, Research Paper No. 199, Policy Development and Evaluation Service, UNHCR, Geneva, 2011.

119 Sigma Ainul, Iqbal Ehsan, Eashita Haque, Sajeda Amin, Ubaidur Rob, Andrea J. Melnikas and Joseph Falcone, *Marriage and Sexual and Reproductive Health of Rohingya Adolescents and Youth in Bangladesh: A Qualitative Study*, Population Council, Dhaka, 2018.

also benefiting from more formal support from State or aid actors. They adopt a range of strategies to sustain themselves over the course of their displacement, including working illegally and informally, working long hours in low-status and low-paying jobs, using their networks to find and increase the quality of their jobs, partnering with locals to start businesses, and maximizing access to formal humanitarian aid.[120]

Engaging Rohingya in the construction and manufacturing sector seems to be a feasible option. Recently, the Bangladeshi government has begun implementing large infrastructural and industrial (economic zone) projects in Chittagong and Cox's Bazar which require a large labour force. This opens a window of opportunity to engage young Rohingya populations in the construction and manufacturing sector. In addition, Rohingya can be trained and financed to start home-based enterprises or engage in petty trade.

In Bangladesh, there are few life skills and income-generation activities available at the camps where registered Rohingya have been living for years.[121] Little is known about the needs of the newly arrived refugees with regard to IGAs. Moreover, it is not known whether interventions designed to build skills among Rohingya are assumed to have effects in the community. Research is needed that will generate evidence on the extent to which livelihood training and IGA opportunities are available to Rohingya youth, what type of skills and training they need (including technical and vocational education and training), the impact of the interventions in the community, where the gaps are, and how to address their livelihood needs. There is uncertainty around how long the refugees will remain in Bangladesh, and in this context an interim strategy of support is needed to ensure an economically secure future for Rohingya youth and to promote their dignity and sense of self-worth. In this regard, policies that increase the Rohingya refugees' ability to prepare for an economically secure future should be put in place.

Conclusion

A review of the research and reports of clinical practices in the Rohingya camps highlights the culturally determined and individualized aspects of the mental health experience while also noting the challenges of understanding such cultural manifestations of distress within a predominantly Western mental health paradigm. In the Rohingya camps, as in most contexts, infants, children, young people and women are most vulnerable to psychological, social and economic difficulties, with determinants located in unhealthy, unsupportive or conflict-ridden environments. The Rohingya people have experienced significant historical and ongoing persecution, oppression and genocide. Being rendered stateless

120 Agenda for Humanity, "Supporting the Livelihoods of Refugees in Long-Term Displacement", available at: www.agendaforhumanity.org/news-details/6640.

121 UNHCR and ILO, above note 116.

disallows the protection and support of State nationality and presents an additional structural barrier to Rohingya community well-being. Without the freedom or ability to make choices about lifestyle, movement and employment, and with limited recourse for justice for the atrocities they have endured, the Rohingya occupy a place of disempowerment and subjugation despite concerted international efforts to remediate their plight. At the centre of these experiences reside a people like any other. They want to live in a place of safety where they have access to opportunities to work and for personal fulfilment, to be able to follow their religion in peace, and to be able to nurture and support their children so that they can lead safe and fulfilled lives. What is clear is that no one profession, service or organization can address all levels of influence and power, and as such, it will require collaborative interagency and intergovernmental work to move forward.

One of the main challenges identified from the research highlights the need for a culturally authentic conceptualization of mental health, distress and intervention. Community and outreach services, as well as a reconceptualization of para-counsellors and mental health professionals as *diller daktar* (doctors of the heart) and clinics as *shanti khana* (peace centres), appear to have greater relevance to the Rohingya people's acceptance of mental health services than counsellors and mental health clinics. Much can be learned from such examples in terms of introducing flexible and creative methods of describing and delivering accessible services that are culturally sensitive and appropriate. The Humanitarian Play Labs and other MHPSS interventions delivered in the CFSs are another example of delivering age-appropriate interventions that recognize the importance of family involvement in the process of healing. Such learning with regard to the importance of cultural context in how distress is experienced and described is relevant to any non-Western humanitarian and development setting. Similarly, recognition that there are commonalities (e.g. play) that are transcultural can enable a basis from which to develop effective and culturally authentic interventions, with the recognition that not all evidence-based interventions can comfortably translate to different communities and cultures.

As this paper has highlighted, critical MHPSS research and innovative intervention work is being conducted and will need to continue in the Cox's Bazar camps, including education, livelihood and work-related opportunities for children and young people. In the coming months and years, Bangladeshi government policies and practices to support the needs and aspirations of the young Rohingya population will need to evolve. As a protracted crisis and with a massive influx of Rohingyas, the senior policy-makers in the government of Bangladesh will need to understand that attention needs to be given not only to their most immediate needs, including accommodation, safe water, food, sanitation and other basic services, but also to the various coping strategies and livelihoods they adopt to survive in the camps in Bangladesh. Bangladeshi government senior policy-makers are historically open to change and innovations that will support improving broad-based social and economic justice outcomes. These policy-makers must be provided with evidence, clear arguments and policy

options. Based on the evidence of the research in Cox's Bazar and global best practice, a set of recommendations will be developed to help in-country policy-makers and programme managers develop better mental health and livelihood policies and interventions for Rohingya populations living in the camps. Targeted policy advocacy will also need to be in place to create an enabling environment for developing and implementing better mental health interventions as well as market-based skills development programmes for young Rohingya populations.

One crucial aspect to keep in mind while moving forward in the coming months and the next few years will be how the Rohingya context in Bangladesh can inform work in other refugee settings and how policy and practical innovations in MHPSS, livelihoods and work permit policy in other contexts (such as Jordan, Uganda, Kenya and Malaysia) can inform policy-makers in Bangladesh and the wider region. The important work of sharing global good practices is already under way, through the forums and policy advocacy of Bangladeshi, Rohingya and international researchers and practitioners in Cox's Bazar and Dhaka, who are conducting research, delivering interventions and formulating policy options for the central government to consider. Livelihood-related global experience on creating livelihood and employment opportunities for refugees will continue.

Children and youth exposed to armed conflict are at risk for mental health problems that may persist far into adulthood. In this article, we have highlighted the needs of conflict-affected youth and have discussed some promising mental health interventions aimed at ameliorating or preventing the negative psychosocial consequences of living and growing up in conflict-affected areas of the world. Our case example of Rohingya refugee children and youth highlights the important historical and cultural contexts that must be taken into consideration when working with conflict-affected youth, as well as the challenges and opportunities faced in implementing and monitoring psychosocial interventions in Cox's Bazar.