



The Invisible Wounds: Mental Health Support for the War Injured Children

18

Evelyne Baroud and Leila Akoury Dirani

18.1 Background and Epidemiology

In the world of today, there has been a shift in the type of armed conflict and war, from well-defined battlefields to civilian and community targeting [1]; conflicts have also become more stretched out and prolonged with a tendency to wax and wane [2]. Over the last few decades, there has been a consistent and steady rise in the number of children living in conflict areas [3]. In 2017, an estimated 1.8 billion children live in areas or countries torn apart by armed conflict [3]. In terms of the total number of children living in such areas, Asia has the highest figures; yet this must be taken in the context of the overall population size [3]. It is in fact the Middle East—with an approximate 40%, or 2 out of 5 children living in conflict regions—which has the highest portion of children affected by conflict; relative to its overall population [3]. The numbers for Africa, Asia, the Americas, and Europe, are as follows: 26%, 16%, 11%, and 5%, respectively [3]. Quite alarmingly, more than 420 million children live less than 50 km away from actual fighting zones [3]. In 2017, approximately a third (33.7%) of the world's children in conflict areas were reported to live in “high intensity” conflict regions where the census for battle-associated deaths exceeds 1000 children in a year's time [3]. There is a wide array of harms that befall children and adolescents during the conflict, these include but are not limited to death, physical injury, disfigurement, disease [3, 4] the failure of structures that deliver preventive, curative, and ameliorative care [4], as well as the hindrance of proper humanitarian help such as medical care, which according to United Nation reports, has become more widespread in recent years [3]. Deeper wounds that involve the mental health and psychological well-being of these children have also been well-documented in the literature [5–7]. The aims of the present chapter are to (1) provide an overview of the impact of war on children's mental health; (2)

E. Baroud · L. A. Dirani (✉)

Department of Psychiatry, American University of Beirut, Beirut, Lebanon

e-mail: eb22@aub.edu.lb; la55@aub.edu.lb

© Springer Nature Switzerland AG 2023

G. S. Abu-Sittah, J. J. Hoballah (eds.), *The War Injured Child*,

https://doi.org/10.1007/978-3-031-28613-1_18

219

explore some of the moderating factors in this complex relationship; (3) provide an overview of the assessment of children and adolescents exposed to war trauma; and (4) briefly review the evidence-based interventions and treatments that may help this vulnerable population.

18.2 Impact of War on Children's Mental Health

18.2.1 Stressors and Resilience

Stressors that may lead to acute and chronic stress responses in children may be classified into primary and secondary [8]. Primary stressors relate to the direct experience of harm or danger of harm, while secondary stressors encompass the repercussions of the disaster (i.e., adversities such as loss of home and injury). In many cases, if given appropriate support, children recover from acute stress responses over the course of time [8]. The American Psychological Association defines resilience as “the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress” [9]. Though resilience is an intricate concept and has been defined in many different ways; it generally refers to the capacity of a dynamic system to effectively adjust to disruptions that pose a danger to its viability; and an individual's ability to achieve a stable course of healthy function following an adverse experience [10]. For children in particular; there is an added layer of complexity to the concept of resilience; as a number of factors including parents or caretakers, family, and community/social come into play and are necessary for resilience to develop in children [11]. In trying to understand what adds to the resilience of children who experience war, factors are conceptualized on three levels [12–14]. The first level pertains to the children themselves and their individual characteristics; this includes their coping styles whereby resilient children characteristically evaluate traumatic incidents as less devastating and are able not only to appreciate the existing social resources but also to use relevant cognitive-emotional means that are appropriate to the stresses of the particular traumatic incident [12, 15]. Family is at the second level, as it is the main contributor to the healthy development of a child, especially after exposure to trauma [16]. The existing literature documents the buffering effect that a protective family environment can have. A study by Barber in 2001 showed that better parental education, integration in the family, and good parenting safeguarded the mental health of Palestinian children exposed to military violence. Specifically, the development of antisocial behavior among adolescents was precluded if they had elevated levels of parental acceptance and support [17]. In another study among Palestinians, supportive parenting styles were related to creativity and cognitive capacity in children, which in turn, added to psychological adjustment despite heavy war trauma experiences [18]. What is more, constructive relationships with siblings and connectedness with peers can dampen the mental health effects of war trauma particularly when it comes to symptoms of anxiety and depression [19, 20]. Having explored this, it is worthwhile to be aware that there are a number of other

Table 18.1 Factors that moderate the detrimental effects of war on children [21]

Solid bond between the primary caregiver and the child
Maternal mental health
Presence of additional caregivers
Social support from persons in the community who have been exposed to the same suffering
Shared sense of values
Religious beliefs that find meaning in suffering
Assuming responsibility for the protection and well-being of others
Having an internal locus of control
Using humor and altruism as defense mechanisms

factors that moderate the detrimental effects of war on children [21]. Table 18.1 lists the factors that were found to moderate the negative repercussions of war on children in the literature.

18.2.2 War and Psychopathology in Children and Adolescents

According to some researchers, traumatic experiences represent a continuum and it is the magnitude of the stress or the effect of moderating factors rather than the nature of the stress itself that is more important in determining aftermaths. According to this perspective, traumatic events may result in a wide variety of and are a risk for a number of different psychopathologies; and the particular psychiatric outcome may be related to characteristics of the child him/herself rather than the traumatic exposure [22]. On the other hand, other research explores that different types of stress may be specifically associated with different types of psychopathologies. For example, dangerous experiences usually generate distinctive signs of fear in a child, while losing essential relationships (for example, death of a loved one) may result in dysphoria [23]. It is important to keep in mind that during war times, multiple traumatic exposures are the rule rather than the exception; and that cumulative experiences are associated with greater symptomatology [24, 25]. Exposure to war results in a myriad of behavioral, emotional, and mental problems in children and adolescents; and the number of conflict-related traumatic occurrences is positively correlated with the prevalence of these problems [7]. The severity of traumatic experience is also a robust predictor of outcome, but other factors such as children's individual characteristics as well as elements related to their environment are also involved [26]. This range of exposure- and child-related influences entails that there are a number of possible targets for interventions intended to promote resilience in children [27]. In general, the more common diagnoses encountered in children exposed to war trauma are Post-Traumatic Stress Disorder (PTSD), depressive disorders, and anxiety disorders; and these may be comorbid [28]. A 2009 systematic review by Attanayake et al. of 17 studies included approximately 8000 children between the ages of 5 and 17 years, who have been exposed to wars in several regions including Central America, Bosnia, Cambodia, Rwanda, and the Middle East indicates that PTSD is the main sequel,

with a prevalence of 47%, followed by depression (43%), and anxiety (27%) [6]. In the middle east, the prevalence of PTSD among children and adolescents in war zones is approximately 5–8% in Israel; it ranges between 23 and 70% in Palestine and between 10 and 30% in Iraq. As for Lebanon, little is known about the prevalence of PTSD, although the country faces major challenges. These numbers are similar to those in other war-burdened regions, namely 70% in Kuwait following the Iraqi invasion [29]; 52% in Bosnia-Herzegovina [30], and 50% among Cambodian children after war trauma [31]. Studies led after the War on Gaza (2008–2009) showed that more than half of children [32, 33], exhibited clinically significant post-traumatic stress symptoms, and a third endorsed symptoms of depression [33].

18.2.3 A complex Interplay of Factors That Perpetuate Psychological Suffering

Children and adolescents in war-afflicted regions are at risk of physical injury, torture, and witnessing or participating themselves in combat; they are at subsequent risk for several forms of violence including abuse and neglect [34–38]. There are also exposures to community and school-level violence [39] as well as domestic violence [35, 36]. Caregivers who have themselves endured armed conflict are in fact more likely to engage in child neglect and abuse, and there are higher rates of both child- and caregiver-reported child abuse in caregivers who suffer mental health illness or stress associated with their experience of armed conflict [34–36]. Conflict also precludes children from attending school and lowers their overall educational achievement [40, 41]. Economic sequelae of war also influence psychopathology, as rates of anxiety, post-traumatic stress disorder and depression in children and adolescents are higher in families who have lower income [42–44], perhaps because those with higher income are able to provide basic necessities during times of war [42]. Children may also take on adult responsibilities and obligations prematurely; this involves becoming providers for their families and delivering care for ill or disabled parents [45–47]. During war conflicts children may experience, be a witness to, and perpetrate acts of sexual violence and sexual exploitation [48, 49]. The sequelae of sexual violence are broad and far-reaching. A recent systematic review has categorized them into physical aftermaths such as pregnancy, sexual dysfunction, sexually transmitted illnesses, and traumatic genital injuries; and mental health consequences which include post-traumatic stress disorder, depression, and anxiety; as well as social outcomes such as rejection [50]. Conflicts also drive children and families to abandon their homes and flee within national or across international borders [48]; a journey during which they are vulnerable to illness, psychological trauma as well as exploitation and during which they may be separated from their families [51, 52]. Even in cases of re-settlement in a foreign country; post-migration socioeconomic factors influence the risk of developing depression, post-traumatic stress disorder, and anxiety [53].

18.3 Special Considerations in the Assessment of Children and Adolescents Exposed to War Trauma.

The assessment of children exposed to war trauma is different from adults. A key point is that a child's clinical presentation depends on his or her developmental level [8], and the reactions to trauma can be most understood from the perspective of the children's social, emotional, and cognitive development [54]. For example, younger children may show regressive behaviors while school-aged children may struggle at school, and older children or adolescents may engage in substance misuse [55]. Depression may be more common among older children as well [56]. Specific features of the stressor and the exposure to it, as well as individual-level factors such as age, developmental level, gender, previous history of psychiatric illness, and other larger-scale factors such as family characteristics and social environment all, play a role in the response to trauma and influence the recovery trajectory of the child/adolescent [57]. The extent of exposure to acutely dangerous experiences appears to predict a greater risk for the development of subsequent psychiatric symptoms [22, 58]. A number of children will show non-specific behavioral and emotional symptoms, such as new-onset fears; clinging, and over-reliance on caregivers; they may also exhibit low frustration tolerance, aggressive behaviors, and changes in their eating patterns [1].

While assessing the sense of safety in children, one should consider the following. Infants and very young children rely on their parents or caregivers to estimate the actual degree of danger while preschoolers start to consciously incorporate the safety and protection of their parents as well as their own in their representations of danger [59]. By school age, children begin to grasp the complexity of dangerous situations and start to visualize self-efficacy as they become more and more involved in the safety and protection of themselves and others [59]. By mid-adolescence, they rely on themselves and on peers to evaluate threats and protection [59].

To assess the impact of the traumatic or stressful events, one should assess what is spoken by the child as much as the behavioral and somatic manifestations, particularly in young children and in children with limited cognitive and verbal abilities. Magical thinking, confusion, and self-accusation are developmentally related examples of early childhood thinking and emotional processing after a traumatic experience [54]. In the very young age group ranging from infancy to 6 years old, the following are some of the manifestations of distress: fear, increased startle, seeking attention from caregivers, temper tantrums, crying spells, and sleep interruptions along with trouble sleeping [1]. These young children are also more prone to experience somatic symptoms, such as gastrointestinal pains and changes in bowel movements [1]. They also show alterations in their play, which may change to more aggressive or on the contrary more inhibited [1]. Play is an important area of focus, as children tend to reflect on their traumatic experiences in the content of play; such as re-enacting the trauma, repetitive play, fantasy devoid play as well as macabre themes in the play. Their play is also less rich in social interactions and with a predominance of negative affect [60–62]. Young children may exhibit

sleep-related difficulties such as refusing to sleep alone, instance on sleeping with their parents; experiencing nightmares, and repeated awakenings[63–67]. On the other hand, while separation anxiety is a usual normative occurrence in younger children; it may become apparent in school-aged children as a manifestation of their distress[1]. In general, boys have more exposure to severe traumatic events than girls [42, 68]; and though both genders suffer from anxiety and depression symptoms; girls report considerably more symptoms of depression than boys [43]. After exposure to war trauma, adolescents experience elevated levels of intrusion, avoidance, and depression symptoms; with the female gender being a significant risk factor for depression[44]. What is more, adolescents who have increased exposure to war events and those who suffer from PTSD as a result, have greater rates of substance abuse and are more likely to be involved in violence within schools [69].

The following are some of the signs of distress in children exposed to war trauma across age groups: physical symptoms such as headaches and abdominal pain with no apparent physical origin; crying spells, sadness, or irritability; difficulties sustaining attention and focus; fear and anxiety; insomnia or hypersomnia; nightmares; recurrent thoughts about the traumatic event or avoiding discussion the event and avoiding reminders of the event; being distressed by reminders of the traumatic event; difficulties managing behavior or emotions; flashbacks; not engaging with others in play or in activities that were enjoyable and hopelessness [70].

As previously mentioned, signs of distress in children may vary according to age categories and developmental level. Below are some examples of distress stratified by age groups [70, 71]:

1. **Preschool Children:** Preschool children may experience a regression to younger behaviors which may include bed-wetting, thumb-sucking, and mutism. They may have unexplained physical symptoms as well as trouble separating from their parents or caregivers. They may also throw temper tantrums or have aggressive behaviors such as throwing kicking, biting, or hitting. They may be reluctant to engage in play or engage in a repetitive re-enactment of the traumatic event during their play.
2. **Elementary School Children:** These children may experience difficulties with concentration, memory, and attention, causing them to struggle in school. They may also have peer problems and aggression toward others. They may present with new-onset fears such as fear of separation from parents or caregivers and fear of something bad happening. They may isolate themselves from others; and may experience anger and irritability as well as feelings of sadness, self-blame, and guilt.
3. **Middle and High school children and Adolescents:** This category of children/adolescents may experience more complex emotions, such as a sense of guilt or responsibility for bad things that have happened; feelings of shame or embarrassment, and helplessness. They may have difficulties in interpersonal relationships with their parents, teachers, friends, and family. They may have changes in

their perception of the world or experience a loss of faith. Alternatively, they may have conduct problems or engage in substance use or misuse.

Because children are embedded within families, and because it is the parents who usually are the closest and most impactful people in a child's development, particularly during the early years [72], it is crucial to incorporate parental mental health in the overall evaluation of a war-affected child. Indeed, children in families where a parent has suffered from war trauma may experience secondary traumatization and may suffer from the repeated use of ineffective coping skills by the distressed parent, generally the mother [73]. Furthermore, the psychological distress of parents mediates and moderates the connection between war trauma and developmental consequences in children including behavioral and emotional problems [72]. In particular, parental distress after exposure to war trauma may present a specific risk for depressive symptoms in the child [74]. In young children, the effect of the parents' responses may have an equal or bigger impact than that of the actual traumatic experience [75]. Not only is there a correlation between parental and children's psychopathology but the family environment and parental functioning moderate the relationship between exposure to trauma and outcome for children [1].

18.4 The Interplay Between Direct Physical Injuries, Pain, and Mental Health

There is a wide array of possible physical harms affecting all organ systems that may befall children as a result of penetrating injuries, burns, crush injuries, and blunt trauma [48]. Chronic physical illness places children at a higher risk of behavioral and emotional problems as well as at an increased risk of developing psychiatric disorders [76]. Between a quarter to a third of children who suffer from burns display some PTSD symptoms [77, 78], they may also suffer from anxiety and mood symptoms, sleep problems, as well as conduct, learning, and attention problems [79]. Interestingly, pathways leading to the development of PTSD in children with burns are mediated by separation anxiety and dissociative responses, with trauma magnitude being a mediator of both pathways, and pain having an influence on the development of PTSD indirectly through separation anxiety; thereby highlighting the complex and dynamic interaction between pain, family effects and the development of PTSD [80]. During the acute phase of burn injuries, for example, children experience a psychological reaction to the trauma of the burn injury itself and to its subsequent treatment [81]. Anxiety, fear, and pain frequently have comparable symptoms, particularly in younger children who may experience dread, tremulousness, restlessness, muscle tension, tachycardia, dizziness, sweating, dyspnea, cold hands and feet, excessive worries; nightmares as well as difficulties falling asleep [81]. Therefore, the child and adolescent psychiatrist, psychologist, or clinician assesses injury severity to plan interventions that can alleviate pain and reinforce coping strategies to manage the risk of death, disability, and effects on body image [82]. Later on, in the recovery process, children may show aggression, disruptive behaviors, mood symptoms, learned helplessness, enuresis and encopresis,

food refusal as well as sleep and attention difficulties [82]. Some suggested methods for the psychiatric care of the injured child include pain management, brief consultation, and crisis intervention followed by brief psychotherapeutic techniques [82]. As a first step, explaining and clarifying what is going on and what is going to happen, as well as giving the children reasonable choices about how a procedure can be performed boosts their sense of control, and can help diminish their sense of being a victim. For example, during dressing changes, a child may gain a sense of control by aiding in the removal of the dressing and will trust this will cause him or her less distress [83]. Particular attention should be paid to pain. While pharmacological interventions remain the core of pain treatment, it is important to be mindful of the large number of psychological factors that accompany pain and that may contribute to the sensation of pain [83]. These include emotional distress, stressful memories, anticipatory apprehension about both the treatment of the injury itself and the recovery period, as well as being restricted in a new and possibly frightening hospital environment. These factors are the target of psychotherapeutic interventions [83, 84]. Specific intervention approaches include cognitive behavioral therapy, hypnosis, relaxation training, guided imagery, art, music, and play therapies as well as biofeedback and distraction therapy [85–88]. In biofeedback, patients learn through self-regulation to voluntarily control body processes [89]. Common methods of distraction [81, 90] that help in alleviating pain in burned children are playing, reading a story, watching television, and listening to music [91]. Other techniques include biofeedback, massage [92], and even virtual reality [93]. The two principal psychotherapeutic methods used to treat an injured child are psychodynamic psychotherapy and cognitive behavioral therapy, and they are generally used together and explicitly oriented to the pain [94], the injury itself, coping with surgery, and other needed medical care, as well as addressing responses to disfigurement or disability and grieving losses [28]. Cognitive restructuring, management of anxiety, strategies to cope with anger, and exposure-based interventions are the main features of cognitive behavioral therapy in injured children who suffer from PTSD [95] and in those with facial deformities [96]. Table 18.2 lists some strategies to help children cope

Table 18.2 Techniques to help children coping with anger

<i>Immediate reaction to anger outbursts from the caregiver</i>	
Do not yell	Use a neutral tone of voice
Do not scold	Encourage the child, or take him to a quiet place (remove him or her from the heat of the situation)
<i>After the anger outburst</i>	
Do not blame	Partner with the child in defining the problem that led to anger
	Find several alternative solutions
Do not shame	Encourage emotional expression
	Encourage peaceful conflict resolution
<i>Continuous preventive measures and coping techniques to adopt with the child</i>	
Identifying the bodily sensations as signs of emergent anger outburst	
Use relaxation techniques (breathing, distraction, humor)	
Step out of the “circle of anger”	
Promise to get back to problem solving after the anger is tamed	

with anger. Further on in the recovery process, clinicians should be mindful that burn disfigurement impacts children's self-confidence, affects their social interactions, and marks their identity [97]. These children are more likely to be bullied [98]. In adolescents, predictors of positive body image and improved self-esteem are linked to perceived social support [99]. This applies to all other types of acquired disabilities.

18.5 Interventions for Recovery from War Trauma Among Children and Adolescents

Research in the field of the resilience of war-exposed children and their growth post-trauma has recognized potentially changeable protective processes that may become the focus of interventions [21, 100]. Once the armed conflict is over; essential needs such as primary health care, limiting the spread of infectious diseases, access to clean water, food, shelter, and sanitation must be met; and educational activities should be started or reinstated as soon as possible [100]. Indeed, a large number of children may improve when access to water, food, shelter, health care, and security is restored [71]. Other children and adolescents will need dedicated support, with particular consideration for the child, family, and group. This psychological first aid should be delivered by health workers [71]. Lastly, children who suffer from exceptionally stressful reactions may require focused support for months; this may encompass counseling by social workers, teachers, and health care workers as well as broader social and cultural activities with Non-Governmental Organizations or groups within the community [71]. In general, the principles of management in line with those of Psychological First Aid include the following: (1) Creating a sense of safety, (2) instilling calm and lessening physiologic arousal, (3) reinstating a sense of personal efficacy, (4) re-establishing a sense of connectedness to others, and (5) imparting hope [101]. For those who will be working on the front line with traumatized children, it is important to keep in mind that the goal of Psychological First Aid for children is to provide relief from distress, help their current needs, and to foster adaptive functioning, and does not aim to gather details of painful experiences and loss [71].

18.5.1 Encounter with the Trauma-Affected Child or Adolescent

In general, the evaluation of the child begins with extracting the storyline of the trauma, preferably from the child himself or herself [28]. Children as young as ages 2–12 years can remember details of stressful incidents after injury [102]. Throughout the child's narrative, it is important to be mindful of his or her account of related memories, thoughts, and feelings, the occurrence of alterations, and potential recurrent themes [103]. Afterward, in addition to assessing existing symptoms, it is important to look into the child's developmental history and the presence of previous psychopathology [28]. This information may be obtained

from the parent or caretaker whenever possible. Before beginning the assessment of traumatized child or adolescent, patience is of the utmost importance. The interviewer should not take for granted that children or their parents/caregivers will respond positively straightaway [71]. The interviewer must remain sensible, sensitive, and attentive and must follow the pace of the child, all the while providing support for difficult emotions [71]. Accepting that the child may be experiencing difficult emotions such as anger, guilt and grief is paramount, and this involves avoiding telling the child or adolescent how he or she should feel, and rather mirroring the feelings of sadness; and acknowledging the overwhelming nature of these emotions [71]. Equally imperative is to offer hope to the child without dismissing or minimizing the reality of the situation [71]. Figure 18.1 provides general instructions when performing an interview with a child/adolescent following a traumatic experience. Specifically, the use of active listening helps to reinforce cooperation and nurtures understanding between the interviewer and the child/adolescent [71]. Active listening is a communication technique based on the work of psychologist Carl Rogers, which involves providing full attention to the speaker; and encompasses both verbal and non-verbal communication approaches [104]. There are five elements to active listening: (1)attentive focus, (2) paraphrasing, (3)

Fig. 18.1 General considerations in the interview of a child/adolescent following a traumatic experience



- Have the encounter take place in a discreet and private location, as much as possible.
- Questions should be simple and open-ended; to help the child/adolescent tell his or her story in their own way
- Speak in an unhurried and gentle manner
- Allow for the parents/caregivers to be present during the interview.
- Provide only truthful information.
- When in doubt, it is best to clarify that you are gathering additional information and that you will deliver it to the child as soon as you are able to

encouragement, (4) questioning/clarifying, and (5) summarizing [71]. In attentive focus, the emphasis is on listening while avoiding interruptions, regardless of what the child is saying; and on being aware of one's own body language [71]. In paraphrasing the interviewer may restate important words spoken by the child/adolescent, and may reprise what was heard in a descriptive rather than an interpretative way; for example, by using statements such as "I understand what you are saying"; "Did I understand correctly?"; and "It sounds like this experience made you feel scared; is that so? [71]. Depending on the context of the assessment, and the level of acuity of the situation, the interviewer may be faced with an emotionally overwhelmed and very distressed child or adolescent. Stabilization of this state of hypervigilance and hyperarousal may be achieved through the use of some relaxation and grounding techniques [71], examples of which are shown in Figure 18.2. As previously mentioned, it is imperative to involve the parents/caregivers in the evaluation of traumatized children and adolescents. Priority should be given to educating the parents/caregivers about the wide range of signs and symptoms and possible reactions of their child's distress depending on the child's age and development level [71], keeping in mind that parents are themselves traumatized or at least heavily affected by the situation which means that they are also in need of active listening and support.

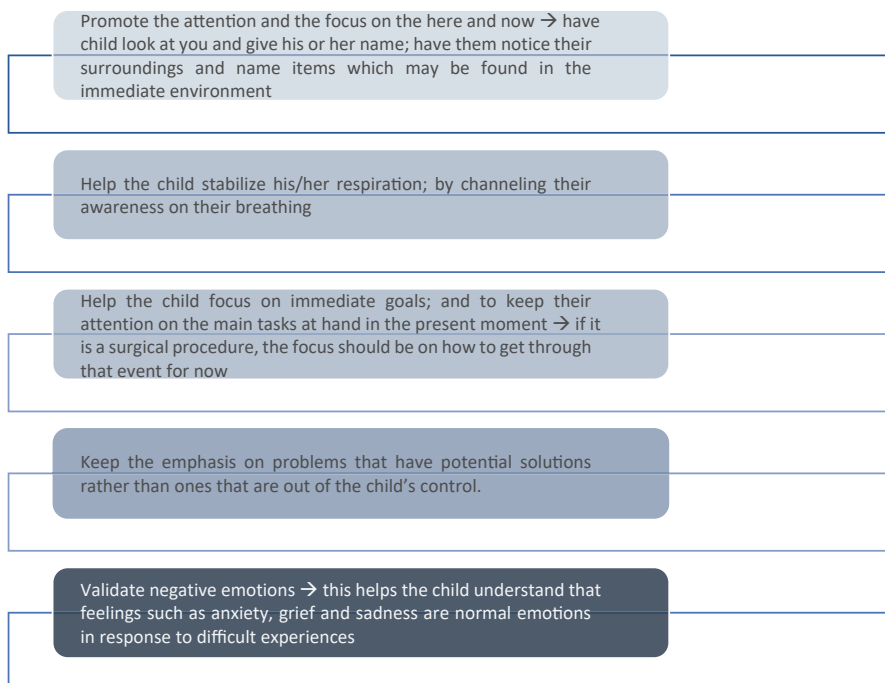


Fig. 18.2 Examples of relaxation and grounding techniques

18.5.2 Evidence-Based Approaches for Treating War-Affected Children and Adolescents

There is increasing awareness and emphasis on incorporating the mental health and psychosocial support needs of people who experience humanitarian crises into humanitarian aid responses [105]. Mental health and psychosocial support programs are defined as any local or external support that purposes to safeguard or promote psychosocial well-being [106] or to prevent or treat mental health problems [107]. This definition is used broadly in the area of humanitarian emergencies to describe strategies devised to tackle the mental health and psychosocial difficulties of people in disaster and conflict situations [108]. There are numerous challenges to implementing proper evidence-based interventions in low and middle-income countries following trauma. These include the paucity of mental health services, insufficiently qualified clinicians, and barriers to modifying established interventions to the needs of contexts that are specific to low and middle-income countries [109]. The more common mental health and psychosocial support interventions relate to community-based social support, structured social activities, providing information and counseling, psychoeducation, and fostering awareness [110].

Randomized trials in conflict-affected areas propose that brief and structured intervention may improve outcomes in traumatized children and adolescents when carefully applied [111, 112]. A 2011 meta-analysis that comprised four randomized controlled trials in children and adolescents who experienced mass traumatic events showed that school-based interventions did not improve symptoms of post-traumatic stress disorder per se, but that psychosocial interventions (group interpersonal psychotherapy, group meetings with parents, and school-based interventions) were beneficial for internalizing symptoms (anxiety or depression) [110]. However, there is much heterogeneity in the literature, and the effects of various programs may depend on the initial intervention objectives [113], the characteristics of the program itself, as well as its quality and delivery [107, 114]. The specifics of the target population also play a role, including the type of trauma exposure, gender, level of social support, and context-related considerations such as degree of insecurity [115]. It is therefore important to identify common practice features of interventions that are successful at inducing targeted change [114]. It is equally important to describe different effects for dissimilar subgroups of participants [116] with regard to age, gender, socioeconomic level, geographic location, and trauma exposure [117]. A 2017 systematic review evaluated the effectiveness of mental health and psychosocial support programs in areas affected by humanitarian crises, though these were not limited to war-ridden areas [107]. The programs were likely to use cognitive behavioral techniques or other psychotherapy modalities including interpersonal grief-focused therapy and narrative exposure and were typically given in school-based environments, for the longest duration of 3 months [107]. The following evidence emerged:

1. Strong evidence is that the programs reduce functional impairment but have little impact on anxiety.

2. Moderate evidence that the programs marginally improve symptoms of post-traumatic stress disorder conduct problems, and psychological distress; and that they may have no effect on depression or prosocial behaviors.
3. Moderate evidence that Trauma-focused cognitive behavioral therapy is helpful in effectively ameliorating post-traumatic stress disorder symptoms as well as emotional and conduct problems.
4. Moderate evidence is that classroom and school-based interventions do not help reduce anxiety.
5. Moderate evidence that Narrative Exposure Therapy helps functional impairment but has little effect on post-traumatic stress symptoms.

18.6 Conclusion

War-related consequences are common worldwide and relate not only to the direct impact of war on the children themselves but also to major societal breakdowns, leading to consequential psychiatric morbidity [118–121]. War consequences such as death, injury, illness, disability, child soldiers, sexual violence as well as social and cultural losses [122] to name a few perpetuate psychological suffering in children exposed to war. Post-traumatic stress disorder, depression, and anxiety are among the most common disorders after traumatic events, including physical injuries; but other problems include sleep and elimination difficulties, conduct, learning, and attention problems as well as longer terms effects on body image and self-esteem may become apparent. The clinical presentation of distress in a child is developmentally dependent and must be grasped from the perspective of the child's social, emotional, and cognitive development. The elaboration of clear, consistent, and effective interventions for managing war-related traumatic experiences can only be done through a better understanding of conflicts and the multitude of mental health problems that result from them[123]. It is imperative to keep in mind the importance of social resources in trauma—particularly the role of family—and their potential to shield children from the detrimental effects of war, as well as their contribution to the resilience of children [124, 125]. Cognitive behavioral therapy and trauma-focused cognitive behavioral therapy, remain validated therapeutic approaches for children and adolescents who suffer from trauma-related symptoms. The potential for children to recover is inherently related to resilience, which in turn depends on broader systems of care. Residual symptoms in children who have experienced war may be considered normal reactions to very abnormal situations; therefore there is a need for longer-term follow-up of these children, to better understand which symptom dimensions remain as psychopathology; and which fade away when a normal life balance is restored. Lastly, when trauma exposure becomes chronic and danger is ongoing, strong reactions may become a mechanism for survival, rather than a manifestation of psychopathology. More research is needed into what strategies work best to foster resilience in war-exposed children and to help them overcome, step by step, the difficulties they may face in the long road to recovery.

These children without a childhood
 Without youth and without joy
 Who shivered helplessly
 With sorrow and cold
 Who defied suffering
 And silenced their turmoil
 But lived in hope
 Are like you and me
 Charles Aznavour

References

1. Slone M, Mann S. Effects of War, Terrorism and Armed Conflict on Young Children: A Systematic Review. *Child Psychiatry Hum Dev.* 2016;47:950–65.
2. Austin A, MRN FM. Trends and causes of armed conflict. In: *Transform.* New York: Ethnopolitical Confl. Berghof Handb. VS Verlag für Sozialwissenschaften; 2004. p. 111–27.
3. Østby G, Aas Rustad S, Forø Tollefsen A. *Children Affected by Armed Conflict, 1990–2017.* Oslo; 2018.
4. Devakumar D, Birch M, Osrin D, Sondorp E, Wells JC. The intergenerational effects of war on the health of children. *BMC Med.* 2014;12:57.
5. Shaar KH. Post-traumatic stress disorder in adolescents in Lebanon as wars gained in ferocity: a systematic review. *J Public Health Res.* 2013;2:e17.
6. Attanayake V, McKay R, Joffres M, Singh S, Burkle F, Mills E. Prevalence of mental disorders among children exposed to war: a systematic review of 7,920 children. *Med Confl Surviv.* 25:4–19.
7. Dimitry L. A systematic review on the mental health of children and adolescents in areas of armed conflict in the Middle East. *Child Care Health Dev.* 2012;38:153–61.
8. Chrisman AK, Dougherty JG. Mass Trauma. *Child Adolesc Psychiatr Clin N Am.* 2014;23:257–79.
9. American Psychological Association. *The Road to Resilience.* Washington DC: American Psychological Association. 2014. <http://www.apa.org/helpcenter/road-resilience.aspx>.
10. Southwick SM, Bonanno GA, Masten AS, Panter-Brick C, Yehuda R. Resilience definitions, theory, and challenges: interdisciplinary perspectives. *Eur J Psychotraumatol.* 2014;5:25338.
11. Pine DS, Cohen JA. Trauma in children and adolescents: risk and treatment of psychiatric sequelae. *Biol Psychiatry.* 2002;51:519–31.
12. Betancourt TS, Meyers-Ohki SE, Charrow AP, Tol WA. Interventions for Children Affected by War. *Harv Rev Psychiatry.* 2013;21:70–91.
13. Dubow EF, Huesmann LR, Boxer P. A social-cognitive-ecological framework for understanding the impact of exposure to persistent ethnic-political violence on children's psychosocial adjustment. *Clin Child Fam Psychol Rev.* 2009;12:113–26.
14. Ungar M. Resilience, Trauma, Context, and Culture. *Trauma, Violence, Abus.* 2013;14:255–66.
15. Tol WA, Song S, Jordans MJD. Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict - a systematic review of findings in low- and middle-income countries. *J Child Psychol Psychiatry.* 2013;54:445–60.
16. Bowlby J. Attachment and loss: Retrospect and prospect. *Am J Orthopsychiatry.* 1982;52:664–78.
17. Barber BK. Political violence, social integration, and youth functioning: Palestinian youth from the Intifada. *J Community Psychol.* 2001;29:259–80.
18. Punamaki R-L, Qouta S, El SE. Models of traumatic experiences and children's psychological adjustment: the roles of perceived parenting and the children's own resources and activity. *Child Dev.* 1997;68:718.

19. Peltonen K, Qouta S, El Sarraj E, Punamäki R-L. Military trauma and social development: The moderating and mediating roles of peer and sibling relations in mental health. *Int J Behav Dev.* 2010;34:554–63.
20. Betancourt TS, Salhi C, Buka S, Leaning J, Dunn G, Earls F. Connectedness, social support and internalising emotional and behavioural problems in adolescents displaced by the Chechen conflict. *Disasters.* 2012;36:635–55.
21. Werner EE. Children and war: Risk, resilience, and recovery. *Dev Psychopathol.* 2012;24:553–8.
22. Steinberg L, Avenevoli S. The role of context in the development of psychopathology: a conceptual framework and some speculative propositions. *Child Dev.* 71:66–74.
23. Eley TC, Stevenson J. Specific life events and chronic experiences differentially associated with depression and anxiety in young twins. *J Abnorm Child Psychol.* 2000;28:383–94.
24. Hubbard J, Realmuto GM, Northwood AK, Masten AS. Comorbidity of psychiatric diagnoses with posttraumatic stress disorder in survivors of childhood trauma. *J Am Acad Child Adolesc Psychiatry.* 1995;34:1167–73.
25. Wright MO, Master A, Northwood J, Hubbard J. The effects of trauma on the developmental process. In: Cicchetti D, Toth L, editors. *Rochester Symp. Dev. Psychopathol.* Rochester: University of Rochester Press; 1997. p. 181–225.
26. Masten AS, Coatsworth JD. The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *Am Psychol.* 1998;53:205–20.
27. Pine DS, Costello J, Masten A. Trauma, proximity, and developmental psychopathology: the effects of war and terrorism on children. *Neuropsychopharmacology.* 2005;30:1781–92.
28. Caffo E, Belaise C. Psychological aspects of traumatic injury in children and adolescents. *Child Adolesc Psychiatr Clin N Am.* 2003;12:493–535.
29. Nader KO, Pynoos RS, Fairbanks LA, Al-Ajeel M, Al-Asfour A. A preliminary study of PTSD and grief among the children of Kuwait following the Gulf crisis. *Br J Clin Psychol.* 1993;32:407–16.
30. Smith P, Perrin S, Yule W, Hacam B, Stuvland R. War exposure among children from Bosnia-Herzegovina: psychological adjustment in a community sample. *J Trauma Stress.* 2002;15:147–56.
31. Kinzie JD, Sack WH, Angell RH, Manson S, Rath B. The psychiatric effects of massive trauma on cambodian children: I. the children. *J Am Acad Child Psychiatry.* 1986;25:370–6.
32. Thabet AA, Ibraheem AN, Shivram R, Winter EA, Vostanis P. Parenting support and PTSD in children of a war zone. *Int J Soc Psychiatry.* 2009;55:226–37.
33. Qouta SR, Palosaari E, Diab M, Punamäki R-L. Intervention effectiveness among war-affected children: a cluster randomized controlled trial on improving mental health. *J Trauma Stress.* 2012;25:288–98.
34. Reese Masterson A, Usta J, Gupta J, Ettinger AS. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. *BMC Womens Health.* 2014;14:25.
35. Rees S, Silove D, Verdial T, et al. Intermittent explosive disorder amongst women in conflict affected Timor-Leste: associations with human rights trauma, ongoing violence, poverty, and injustice. *PLoS One.* 2013;8:e69207.
36. Saile R, Ertl V, Neuner F, Catani C. Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse Negl.* 2014;38:135–46.
37. Rabenhorst MM, McCarthy RJ, Thomsen CJ, Milner JS, Travis WJ, Colasanti MP. Child maltreatment among U.S. Air Force parents deployed in support of Operation Iraqi Freedom/Operation Enduring Freedom. *Child Maltreat.* 2015;20:61–71.
38. Rentz ED, Marshall SW, Loomis D, Casteel C, Martin SL, Gibbs DA. Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families. *Am J Epidemiol.* 2007;165:1199–206.

39. Sullivan K, Capp G, Gilreath TD, Benbenishty R, Roziner I, Astor RA. Substance abuse and other adverse outcomes for military-connected youth in California: results from a large-scale normative population survey. *JAMA Pediatr.* 2015;169:922–8.
40. Poirier T. The effects of armed conflict on schooling in Sub-Saharan Africa. *Int J Educ Dev.* 2012;32:341–51.
41. Di Maio M, Nandi TK. The effect of the Israeli–Palestinian conflict on child labor and school attendance in the West Bank. *J Dev Econ.* 2013;100:107–16.
42. Qeshta HA, AL Hawajri AM, Thabet AM (2019) The Relationship between War Trauma, PTSD, Anxiety and Depression among Adolescents in the Gaza Strip. *Heal Sci J.* <https://doi.org/10.21767/1791-809X.1000621>
43. Dawwas MK, Thabet AAM. The Relationship between Traumatic Experience, Posttraumatic Stress Disorder, Resilience and Posttraumatic Growth among Adolescents in Gaza Strip. *Glob J Intellect Dev Disabil.* 2017;3(3):73–82.
44. Kolltveit S, Lange-Nielsen II, Thabet AAM, Dyregrov A, Pallesen S, Johnsen TB, Laberg JC. Risk factors for PTSD, anxiety, and depression among adolescents in Gaza. *J Trauma Stress.* 2012;25:164–70.
45. Mann G. ‘Finding a Life’ Among Undocumented Congolese Refugee Children in Tanzania. *Child Soc.* 2010;24:261–70.
46. Erjavec K, Volčič Z. Living with the sins of their fathers: an analysis of self-representation of adolescents born of war rape. *J Adolesc Res.* 2010;25:359–86.
47. Dickson-Gomez J. Growing Up in Guerrilla Camp: the long-term impact of being a child soldier in El Salvador’s civil war. *Ethos J Soc Psychol Anthropol.* 2002;30:327–56.
48. Kadir A, Shenoda S, Goldhagen J. Effects of armed conflict on child health and development: a systematic review. *PLoS One.* 2019;14:e0210071.
49. Betancourt TS, Borisova II, de la Soudière M, Williamson J. Sierra Leone’s child soldiers: war exposures and mental health problems by gender. *J Adolesc Health.* 2011;49:21–8.
50. Ba I, Bhopal RS. Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review (1981–2014). *Public Health.* 2017;142:121–35.
51. ISSOP Migration Working Group. ISSOP position statement on migrant child health. *Child Care Health Dev.* 2018;44:161–70.
52. Marquardt L, Krämer A, Fischer F, Prüfer-Krämer L. Health status and disease burden of unaccompanied asylum-seeking adolescents in Bielefeld, Germany: cross-sectional pilot study. *Trop Med Int Health.* 2016;21:210–8.
53. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. *BMC Int Health Hum Rights.* 2015;15:29.
54. Joshi PT, O’Donnell DA. Consequences of child exposure to war and terrorism. *Clin Child Fam Psychol Rev.* 2003;6:275–92.
55. Dyregrov A, Salloum A, Kristensen P, Dyregrov K. Grief and traumatic grief in children in the context of mass trauma. *Curr Psychiatry Rep.* 2015;17:48.
56. Papageorgiou V, Frangou-Garunovic A, Iordanidou R, Yule W, Smith P, Vostanis P. War trauma and psychopathology in Bosnian refugee children. *Eur Child Adolesc Psychiatry.* 2000;9:84–90.
57. Pfefferbaum B. Posttraumatic stress disorder in children: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry.* 1997;36:1503–11.
58. Smith P, Perrin S, Yule W, Rabe-Hesketh S. War exposure and maternal reactions in the psychological adjustment of children from Bosnia-Herzegovina. *J Child Psychol Psychiatry.* 2001;42:395–404.
59. Pynoos RS, Steinberg AM, Piacentini JC. A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biol Psychiatry.* 1999;46:1542–54.
60. Almqvist K, Brandell-Forsberg M. Refugee children in Sweden: post-traumatic stress disorder in Iranian preschool children exposed to organized violence. *Child Abuse Negl.* 1997;21:351–66.

61. Cohen E, Chazan S, Lerner M, Maimon E. Posttraumatic play in young children exposed to terrorism: an empirical study. *Infant Ment Health J.* 2010;31:159–81.
62. Smith E. The play behaviors of young children exposed to a traumatic event. Columbia University; 2011.
63. Zahr LK. Effects of war on the behavior of Lebanese preschool children: Influence of home environment and family functioning. *Am J Orthopsychiatry.* 1996;66:401–8.
64. Pat-Horenczyk R, Achituv M, Rubenstein AK, Khodabakhsh A, Brom D, Chemtob C. Growing up under fire: building resilience in young children and parents exposed to ongoing missile attacks. *J Child Adolesc Trauma.* 2012;5:303–14.
65. Thabet AAM, Karim K, Vostanis P. Trauma exposure in pre-school children in a war zone. *Br J Psychiatry.* 2006;188:154–8.
66. Klein TP, Devoe ER, Miranda-Julian C, Linas K. Young children's responses to September 11th: The New York City experience. *Infant Ment Health J.* 2009;30:1–22.
67. Chemtob CM, Nomura Y, Abramovitz RA. Impact of conjoined exposure to the World Trade Center attacks and to other traumatic events on the behavioral problems of preschool children. *Arch Pediatr Adolesc Med.* 2008;162:126–33.
68. Thabet AA, Abu Tawahina A, El Sarraj E, Vostanis P. Exposure to war trauma and PTSD among parents and children in the Gaza strip. *Eur Child Adolesc Psychiatry.* 2008;17:191–9.
69. Schiff M, Pat-Horenczyk R, Benbenishty R, Brom D, Baum N, Astor RA. High school students' posttraumatic symptoms, substance abuse and involvement in violence in the aftermath of war. *Soc Sci Med.* 2012;75:1321–8.
70. The National Child Traumatic Stress Network. <https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/effects>.
71. Save The Children (2017) Psychological First Aid for Children: Training manual.
72. Khamis V. Does parent's psychological distress mediate the relationship between war trauma and psychosocial adjustment in children? *J Health Psychol.* 2016;21:1361–70.
73. Khamis V. Long-term psychological effects of the last Israeli offensive on Gaza on Palestinian children and parents. In: Gaza strip: Gaza community mental health programme; 2013.
74. Lai BS, Hadi F, Llabre MM. Parent and child distress after war exposure. *Br J Clin Psychol.* 2014;53:333–47.
75. Green BL, Korol M, Grace MC, Vary MG, Leonard AC, Gleser GC, Smitson-Cohen S. Children and disaster: Age, gender, and parental effects on PTSD symptoms. *J Am Acad Child Adolesc Psychiatry.* 1991;30:945–51.
76. Hysing M, Elgen I, Gillberg C, Lie SA, Lundervold AJ. Chronic physical illness and mental health in children. Results from a large-scale population study. *J Child Psychol Psychiatry.* 2007;48:785–92.
77. Stoddard FJ, Norman DK, Murphy JM. A diagnostic outcome study of children and adolescents with severe burns. *J Trauma.* 1989;29:471–7.
78. Stoddard F. Care of infants, children and adolescents with burn injuries. In: Lewis M, editor. *Child Adolesc. psychiatry a Compr. Textb.* Williams & Wilkins; 1996. p. 1016–37.
79. Tarnowski K, Rasnake L. In: Tarnowski K, editor. *Behavioral aspects of pediatric burns.* New York; 1994. p. 81–118.
80. Saxe GN, Stoddard F, Hall E, Chawla N, Lopez C, Sheridan R, King D, King L, Yehuda R. Pathways to PTSD, part I: children with burns. *Am J Psychiatry.* 2005;162:1299–304.
81. Arceneaux LL, Meyer WJ. Treatments for common psychiatric conditions among children and adolescents during acute rehabilitation and reintegration phases of burn injury. *Int Rev Psychiatry.* 2009;21:549–58.
82. Stoddard FJ, Saxe G. Ten-year research review of physical injuries. *J Am Acad Child Adolesc Psychiatry.* 2001;40:1128–45.
83. Stoddard FJ, Sheridan RL, Saxe GN, King BS, King BH, Chedekel DS, Schnitzer JJ, Martyn JAJ. Treatment of pain in acutely burned children. *J Burn Care Rehabil.* 23:135–56.
84. Latarjet J, Choinère M. Pain in burn patients. *Burns.* 1995;21:344–8.
85. Henry DB, Foster RL. Burn pain management in children. *Pediatr Clin North Am.* 2000;47(681–98):ix–x.

86. Miller AC, Hickman LC, Lemasters GK. A distraction technique for control of burn pain. *J Burn Care Rehabil.* 13:576–80.
87. Pal SK, Cortiella J, Herndon D. Adjunctive methods of pain control in burns. *Burns.* 1997;23:404–12.
88. Patterson DR. Practical applications of psychological techniques in controlling burn pain. *J Burn Care Rehabil.* 13:13–8.
89. Frank DL, Khorshid L, Kiffer JF, Moravec CS, McKee MG. Biofeedback in medicine: who, when, why and how? *Ment Health Fam Med.* 2010;7:85–91.
90. Stoddard FJ. Psychiatric management of the burned patient. In: Martyn J, editor. *Acute Manag. Burn. patient*; 1990. p. 256–72.
91. Prensner JD, Yowler CJ, Smith LF, Steele AL, Fratianne RB. Music therapy for assistance with pain and anxiety management in burn treatment. *J Burn Care Rehabil.* 22:83–8. discussion 82-3
92. Hernandez-Reif M, Field T, Largie S, Hart S, Redzepi M, Nierenberg B, Peck TM Childrens' distress during burn treatment is reduced by massage therapy. *J Burn Care Rehabil* 22:191–5.; discussion 190
93. Hoffman HG, Doctor JN, Patterson DR, Carrougher GJ, Furness TA. Virtual reality as an adjunctive pain control during burn wound care in adolescent patients. *Pain.* 2000;85:305–9.
94. Berde C, B M (1999) Pain in children. In: Wall P, Melzack R (eds) *Textb. pain*, 4th ed. London, pp 1463–1478
95. March JS, Amaya-Jackson L, Murray MC, Schulte A. Cognitive-behavioral psychotherapy for children and adolescents with posttraumatic stress disorder after a single-incident stressor. *J Am Acad Child Adolesc Psychiatry.* 1998;37:585–93.
96. Robinson E, Rumsey N, Partridge J. An evaluation of the impact of social interaction skills training for facially disfigured people. *Br J Plast Surg.* 1996;49:281–9.
97. Tarnowski K, Brown R. Pediatric Burns. In: Roberts M, editor. *Handb. Pediatr. Psychol*; 2003. p. 451–61.
98. Rimmer RB, Foster KN, Bay CR, Floros J, Rutter C, Bosch J, Wadsworth MM, Caruso DM. The reported effects of bullying on burn-surviving children. *J Burn Care Res.* 28:484–9.
99. Fauerbach JA, Heinberg LJ, Lawrence JW, Bryant AG, Richter L, Spence RJ. Coping with body image changes following a disfiguring burn injury. *Health Psychol.* 2002;21:115–21.
100. Barenbaum J, Ruchkin V, Schwab-Stone M. The psychosocial aspects of children exposed to war: practice and policy initiatives. *J Child Psychol Psychiatry.* 2004;45:41–62.
101. Hobfoll SE, Watson P, Bell CC, et al. Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry.* 2007;70:283–315. discussion 316-69
102. Peterson C, Bell M. Children's memory for traumatic injury. *Child Dev.* 1996;67:3045–70.
103. Terr LC. Childhood traumas: an outline and overview. *Am J Psychiatry.* 1991;148:10–20.
104. Robertson K. Active listening: more than just paying attention. *Aust Fam Physician.* 2005;34:1053–5.
105. Sarah M, Mary-Beth M. Mental health and psychosocial support in humanitarian settings: reflections on a review of UNHCR's approach and activities. *Intervention.* 2013;13:235–47.
106. IASC Guidelines for mental health and psychosocial support in emergency settings- WHO 7 February 2007.
107. Bangpan M, Dickson K, Felix L (2017) The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies: A systematic review.
108. Mayer S. UNHCR's Mental Health and Psychosocial Support in Emergency Settings. Geneva; 2013.
109. Morina N, Rushiti F, Salihu M, Ford JD. Psychopathology and well-being in civilian survivors of war seeking treatment: a follow-up study. *Clin Psychol Psychother.* 17:79–86.
110. Tol WA, Barbui C, Galappatti A, Silove D, Betancourt TS, Souza R, Golaz A, van Ommeren M. Mental health and psychosocial support in humanitarian settings: linking practice and research. *Lancet (London, England).* 2011;378:1581–91.
111. Betancourt TS, McBain R, Newnham EA, Akinsulure-Smith AM, Brennan RT, Weisz JR, Hansen NB. A behavioral intervention for war-affected youth in Sierra Leone: a randomized controlled trial. *J Am Acad Child Adolesc Psychiatry.* 2014;53:1288–97.

112. Jordans MJD, Komproe IH, Tol WA, Kohrt BA, Luitel NP, Macy RD, de Jong JTVM. Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: a cluster randomized controlled trial. *J Child Psychol Psychiatry*. 2010;51:818–26.
113. Bolton P, Bass J, Betancourt T, Speelman L, Onyango G, Clougherty KF, Neugebauer R, Murray L, Verdelli H. Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: a randomized controlled trial. *JAMA*. 2007;298:519–27.
114. Brown FL, de Graaff AM, Annan J, Betancourt TS. Annual Research Review: Breaking cycles of violence - a systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. *J Child Psychol Psychiatry*. 2017;58:507–24.
115. Ziadni M, Hammoudeh W, Rmeileh NMEA, Hogan D, Shannon H, Giacaman R. Sources of human insecurity in post-war situations: the case of gaza. *J Hum Secur*. 2011; <https://doi.org/10.3316/JHS0703023>.
116. Das JK, Salam RA, Lassi ZS, Khan MN, Mahmood W, Patel V, Bhutta ZA. Interventions for adolescent mental health: an overview of systematic reviews. *J Adolesc Health*. 2016;59:S49–60.
117. Panter-Brick C, Dajani R, Eggerman M, Hermsilla S, Sancilio A, Ager A. Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis. *J Child Psychol Psychiatry*. 2018;59:523–41.
118. Toole MJ, Galson S, Brady W. Are war and public health compatible? *Lancet* (London, England). 1993;341:1193–6.
119. Ladd GW, Cairns E. Children: ethnic and political violence. *Child Dev*. 1996;67:14–8.
120. Laor N, Wolmer L, Cohen DJ. Mothers' Functioning and Children's Symptoms 5 Years After a SCUD Missile Attack. *Am J Psychiatry*. 2001;158:1020–6.
121. Aboutanos MB, Baker SP. Wartime civilian injuries: epidemiology and intervention strategies. *J Trauma*. 1997;43:719–26.
122. Santa Barbara J. Impact of war on children and imperative to end war. *Croat Med J*. 2006;47:891–4.
123. Murthy RS, Lakshminarayana R. Mental health consequences of war: a brief review of research findings. *World Psychiatry*. 2006;5:25–30.
124. Cohen E, Dekel R, Solomon Z. Long-term adjustment and the role of attachment among Holocaust child survivors. *Pers Individ Dif*. 2002;33:299–310.
125. Mikulincer M, Shaver PR, Horesh N. Attachment Bases of Emotion Regulation and Posttraumatic Adjustment. In: *Emot. Regul. couples Fam. Pathways to Dysfunct. Heal*. Washington: American Psychological Association. p. 77–99.