



Child Development
A reference paper for War Child



Mathijs Euwema
Amsterdam, 2006



War Child Holland is an independent international non-governmental organization. The organization invests in a peaceful future of children affected by armed conflict. War Child Holland is part of War Child International, a network of independent organization.

War Child Holland programmes strengthen psychosocial development, contribute to peacebuilding processes and advocate for the rights of children and youth, applying the power of creative arts and sports.

War Child Holland has programmes in Afghanistan, Colombia, DR Congo, Georgia, Israel and Palestinian Territories, Kosovo, the Netherlands, Pakistan, Sierra Leone, Sudan and Uganda.

CHILD DEVELOPMENT

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Introduction

War Child Holland's Mission Statement reads: "War Child's goal is the empowerment of children in war-affected areas, through: psychosocial programmes applying the power of creative arts and sports to strengthen the children's psychological and social *development* and well-being."

The support to healthy child development of children in war-affected areas is the most important feature of WCH's work. Taking into account relevant aspects of child development when designing and implementing psychosocial programmes is essential if these programmes are to be effective. This reference paper aims to provide international and national War Child staff with a solid knowledge base with regard to child development.

It can be used, for example, when staff is:

- Working with, or observing a specific child or group of children;
- Organizing or developing a training for teachers or other caregivers;
- Assessing the situation of children in a country or community;
- Designing a programme or project.

This document describes and explains child development as briefly, yet comprehensively as possible. It should serve as an important resource and framework for all of WCH's programming. It is best used in combination with the training module on child development.

Chapter 1 Child Development: Definitions and important topics

1.1 Introduction

Childhood has been perceived differently throughout history and across cultures. This chapter describes the concepts of childhood and child development. What is childhood? What is child development? How do these relate to the Convention on the Rights of the Child and the wider context in which children are living? What is the impact of social circumstances and cultural traditions? What are important aspects of, and issues in, child development? There are many theoretical views on child development. We will explain the choice for the transactional, ecological approach.

1.2 Towards a definition of childhood¹

Although it is common to define children by reference to age and the level of their biological and psychological development, definitions of children and of childhood are much more complex than this. The CRC's (Convention on the Rights of the Child) Article 1 states that *"a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier"*. While this definition provides a point of common reference for international organizations, NGO's, and governments, operational definitions in the field may differ. Also, in many situations of conflict and displacement, the accuracy of children's ages may be doubtful. Lack of official birth records can combine with the fact that, in many societies, exact dates of birth are of little importance (in such places lots of people may simply be born on 1 January, at least according to their passports; that is if they have passports at all!). In others, children are considered to be aged one at birth. In the context of very high infant mortality, new-borns may not be formally named or even recognized until they have passed a full year, when it becomes more certain that they will survive. In many cultures there is a distinction between different stages of childhood - especially between stages of the "innocence" or "ignorance" of childhood and a later stage of "reason" and "responsibility". Many legal codes define the age at which children are legally deemed to be responsible for their actions.

In different cultural contexts, factors other than age may be important in determining who is a child or an adolescent. Factors such as, social roles, gender, marital status and the capacity to contribute economically may be more important than chronological age in shaping the expectations of children. Rituals of religion or custom may also confer social status, clearly marking points of transition in rights and obligations in the eyes of the wider community. These may be indirectly linked to age, notably the onset of puberty. For example, in Sudan girls are considered women from 13 years up, while boys become men around 15. And in Afghanistan girls are considered adults as soon as they are married, which can happen at 12 or 13 years of age. In many cultures, adolescents, both boys and girls, go through rites of passage that, once successfully completed, mean they have adult rights and responsibilities. For example, in Southern Sudan, with the Nuer tribe, you are only considered a man if you display certain cuts made on your head. Nuer boys receive these cuts after going through certain initiation rites. The ability to maintain such customs is often difficult in the context of displacement, where lack of income and access to important resources may delay or dilute these practices. In the context of displacement and other circumstances of severe adversity, children may find themselves assuming roles that have not been traditionally prescribed. This can include becoming the head of a household.

Childhood is neither timeless nor universal. It is not determined only by age, or by biological and psychological factors. Rather childhood is understood by reference to particular cultural and social contexts and to particular periods in history. Childhood in Kabul is not the same as childhood in

¹ This section is mostly derived from *Child and Adolescent Development*, by Actions for the Rights of Children (ARC), Save The Children 2001 (www.savethechildren.net/arc/).

Freetown. Childhood in Uganda in 2006 is not the same as it was two hundred years ago. In the countries of the north, for example, childhood is now seen as an extended period of economic dependency and protected innocence during which play and schooling are seen as central components. But this is far removed from childhood in many other cultures, where work, whether paid or within the household, must take precedence over both schooling and play. In many countries of the south, the child-rearing environment is characterised by large families and high infant mortality: a heavy emphasis on parents' efforts to ensure the physical survival of their children means that parents must devote much of their time to economic and domestic activity, with many "parenting" tasks delegated to others, often older children. Western notions of childhood often place an emphasis on children's vulnerability and innocence, but again in other contexts this may be much less appropriate.

It is important to avoid introducing expectations and norms of childhood derived from one situation into another, different cultural context. There are many examples of situations where it is essential to have a comprehensive grasp of the culture in order to understand and make sense of what children experience - whether in respect of separation from the family or other caregivers, exploitation, disability, and so on. Without an informed cultural lens, and the capacity to communicate with children, negotiations around different childrearing practices and norms are likely to produce conflicts that do not serve the best, long-term interests of the child.

War Child in general adheres to the definition of childhood as the period from 0 to 18 years of age (in line with the CRC). Exceptions to this can be seen in, for instance, Sierra Leone, where ex-child soldiers, now older than 20 are also part of the target group for program activities. These exceptions show the necessary flexibility that War Child practices when applying the definition of childhood in its programs.

1.3 Child Development: the transactional, ecological perspective

Development is best understood within a lifespan perspective, with growth and change beginning at conception and throughout the fetal stage, continuing throughout childhood and adolescence and, in some respects, during adulthood and old age. During the whole period of his or her development, the individual child will develop a mature body, brain, and nervous system and progressively acquire competence in a wide range of functions and skills which enable him or her to adapt and survive in many different types of environment (Save The Children/ARC, 2001).

Child Development is "the process of growth and maturation of the human individual from conception to adulthood".

The study of child development, like the definition of childhood, has been influenced by historical and cultural trends. Most work has been done by western developmental psychologists, studying children growing up in the richer countries (for the purpose of this paper it is not relevant to go into the detail of all of the different theoretical concepts and models that have been developed and applied by scientists). Most theories see children as going through different *stages* while they develop. To pass from one stage to another a child needs to master certain *developmental tasks* (e.g. a baby needs to be able to keep his neck up right, before he can start to crawl). The viewpoint that childhood consists of going through stages and mastering developmental tasks, remains one of the most important and useful notions in the field of child development.

Through time it is increasingly acknowledged by researchers and child practitioners, that child development is best explained by a transactional, ecological perspective, which recognises that the

path of development is influenced by a complex of interacting factors (Sameroff & Chandler, 1975; Bronfenbrenner, 1979).

Child development is the outcome of transactions between the child and his/her environment. This simple-sounding idea encompasses a complex and dynamic reality. The transactional, ecological model suggests that “the development of a child is a product of the continuous dynamic interactions between the child and the experience provided by his family and social context” (Sameroff & Fiese, 2000).

The ecological approach stresses the importance of understanding the relationships between the developing child and environmental systems such as the family, school, community, and culture. In this model, development involves the interplay between changing children and their changing relationships with different ecological (societal) systems. The children's subjective experience and understanding of the environment are important aspects of this perspective (Bronfenbrenner, 1979, 1988; Vygotsky, 1978).

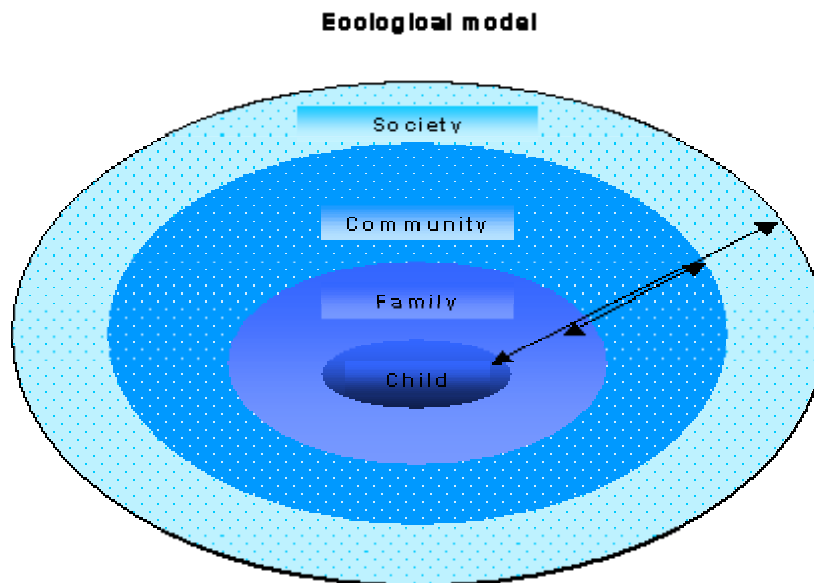
The transactional, ecological model of child development also recognizes that the child, from the beginning, works to organize his experience. Rather than being a passive container into which experience is poured, “the child actively creates his or her own environment, increasingly so with advancing development” (Sroufe, 1990).

The child's transactions with the environment create alternative paths along which development proceeds (*developmental pathways*). At critical points, determined by periods of developmental change or by external influences, such as, for example, experiencing conflict, junctions appear and the child may move off the path on which he was traveling and onto a different path. At these junctions a child may proceed in adaptive or maladaptive directions (Bowlby, 1973). For example: a 7-year old girl who transfers from a poorly equipped refugee camp, into a normal house and neighborhood, with a good school –at a developmental point where new thinking capacities increase her motivation to learn– may move to a more positive developmental pathway than she was on before. How and whether development may be affected by increased risk or opportunity depends on the timing of external factors in relation to current developmental tasks. Developmental capacities that are currently emerging or have recently been achieved are most vulnerable to disruption by stressors. Capacities that have long ago been consolidated are less susceptible to disruption, although under conditions of severe stress they may also be affected (Davies, 2004).

Although child development is to a great extent universal (all children acquire many of the same skills, such as speech), it is also culture specific. For example: Chinese children develop different self-concepts than American children do (Wang, 2000). Rabain-Jamin (1989) compared French and West African mothers in Paris. The French mothers spoke more because they expect their children to go on to formal education; the West Africans spoke less because they expect their children to take on practical everyday tasks at an early age. This will influence the way language develops in these children.

Development, learning and socialization are interwoven with the particular cultural contexts in which they take place (Bronfenbrenner, 1979). As children grow up, they learn from other people how to function in society. This involves an increasing awareness of how they are seen by others and how to control their own behaviour to make it more acceptable to others. Cognitive and learning processes based on input from others thus play a part in the development of the self, the appropriate gender role, the regulation of anti-social and promotion of pro-social behaviour, and the acquisition of morality. The environment influences the child, and the child influences its environment.

All this translates into the following transactional, ecological model of child development, that War Child adopts in its practice (based on Bronfenbrenner, 1979).



Transactional processes between the child and his environment take place on a continuous basis. In the early stages of development most of these are between the child and his parents and close family. As the child grows up, transactional processes with the wider environment like community and society become more important.

The transactional, ecological model closely links with the concept of psychosocial well-being, which also emphasizes the importance of transactional processes between the inner, psychological and the outer, social world.

One factor that facilitates optimal development of children in the face of adversity is superior psychosocial well-being (Leblanc, Talbot & Craig, 2005). It can be concluded that psychosocial well-being is necessary if healthy child development is to take place.

Psychosocial implies the close relationship between psychological and social processes. The one continually influences the other. Psychological are those experiences that affect emotions, behavior, thoughts, memory and learning ability. Social are those experiences that alter people's relationships to each other.

Psychosocial well-being is "healthy emotional, cognitive, social and spiritual development. It includes social integration, sense of economic and physical security, and a sense of identity". (Loughry, 1999)

Psychosocial well-being implies different things for different children at different stages in their lives. The psychosocial well-being of adolescents may be enhanced by other factors than would be the case for school-age children. For example, setting up a youth club, where adolescents can meet, have a good time and discuss their problems, might improve their psychosocial well-being more than simply organizing creative workshops for them.

1.4 Child Development and the Convention on the Rights of the Child (CRC)

The CRC is the most ratified human rights treaty in the world, although, sadly, this does not mean that children's rights are yet as well respected and upheld as they could be. But true implementation and promotion of the CRC offers great opportunities to ensure better chances for the healthy development of children living in difficult circumstances.

The concept of child development is central to the CRC. The Convention can be seen as a tool for promoting children's development, competence and emerging personal autonomy. As mentioned above, Article 1 defines the term 'child'. While it is clear that people develop throughout their lives – learning and growth do not cease at the age of 18 years – childhood offers a unique period of both opportunity and vulnerability and is, accordingly, offered special protection.

Article 6, the right to life, survival and development, is the platform for other developmental principles contained in the CRC. It asserts that State parties shall 'ensure to the maximum extent possible the survival and development of the child'. In imposing these obligations, it extends the mandate to the development of children's cognitive, social, emotional, physical and moral development throughout the text of other articles. This is affirmed in Article 27, which explicitly recognises the importance of an adequate standard of living for children's 'physical, mental, spiritual, moral and social development'. In addition Articles 28 and 29 spell out the role of education in developing the 'child's personality, talents, and mental and physical abilities to their fullest potential'. The right to play, embodied in Article 31, recognises the importance of opportunities to play in children's development. The CRC also extends the concept of development to State's obligations to children with disabilities: Article 23 stresses the right to opportunities conducive to the child 'achieving the fullest possible social integration and individual development including his or her cultural and spiritual development'.

Throughout the CRC it is acknowledged that providing children with adequate nutrition, intellectual stimulation, opportunities for play, a healthy environment, adequate rest, social interaction and emotional care and security are prerequisites for healthy development and realization of the child's potential capacities. Conversely, deprivation of these provisions will impede the growth and development of children.

1.5 Important developmental domains

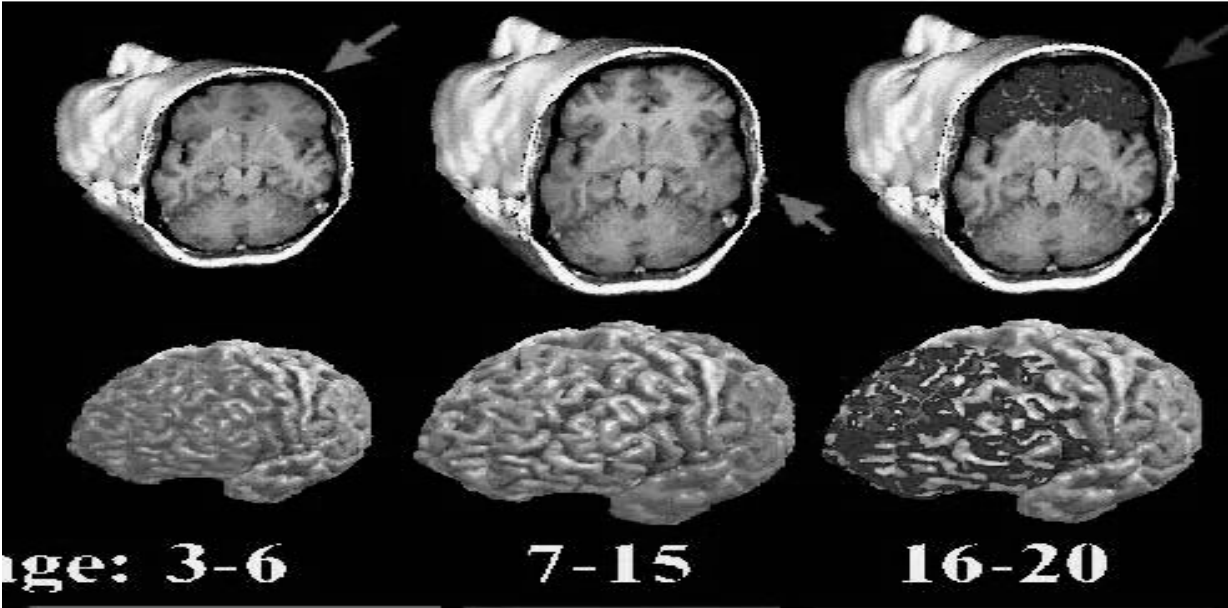
In this section we will describe some of the most important developmental domains. Knowledge of these domains is relevant when observing and analyzing the situation of a child, or a group of children, and when building up a relationship with children in the work setting. They will be referred to and described in more detail in chapters 2 and 3.

1.5.1 Cognitive development

Cognitive development is "the development of the ability to think and reason".

The development of good cognitive skills (or, as it more commonly called, intelligence) is closely linked to healthy brain development. The brain continues to develop throughout childhood, but the period between the 7th month of pregnancy and age 2 is a time of very fast brain growth. At birth the brain weighs 25% of its eventual size; by age 2 it has attained 75% of adult weight. Brain development continues well into adolescence. So while in some species brains are mature at birth, the human brain matures over many years. This means that as the brain develops it can be influenced in subtle and profound ways by the quality of the child's interactions with the environment (Nelson, 2000). During

the early years when growth is most rapid, the brain shows a great deal more plasticity than in later years. For example: children who suffer brain injury during the first 5 years of life often recover full function because the brain is able to reroute damaged circuits. Because of this plasticity, risk and protective factors during the early years have more influence on how the brain will ultimately function (Nowakowski & Hayes, 1999). During the early part of brain development, up to age 3-4, the brain is more reactive to environmental influences than in later development (Perry, 2002). Therefore, in early childhood especially, it is positive relationships with caregivers that offer the best environment for optimal brain development.



<p>3- 6 years: Rapid growth in frontal circuits: this leads to increased capacity for attention, vigilance and alertness.</p>	<p>7-15 years: Growth spurt in temporal/parietal lobes: this leads to increased capacity for language learning and mathematics.</p>	<p>16-20 years: Tissue loss in frontal circuits: this leads to increased capacity for self-control, planning and regulating of behavior.</p>
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(Image taken from UNICEF's "Adolescence, A Time That Matters", 2002)

Factors negatively influencing brain development are:

- Genetic disorders. The most common of these are based on chromosomal abnormalities, where there is an extra or missing chromosome or chromosomes are arranged abnormally. The most common chromosomal disorder is Down syndrome (see also chapter 3);
- Prenatal exposure to alcohol. Use of alcohol by the mother during pregnancy can be very damaging for the baby's brain and can lead to a serious birth defect called foetal alcohol syndrome. Foetal alcohol syndrome includes head and face anomalies, delays in development, attention problems and hyperactivity, and, in about half of the children born with this syndrome, mental handicaps;
- Malnutrition causes poor overall brain growth, resulting in lower intelligence. However, these effects can be reversed if adequate nutrition is provided during the early years (Nelson, 2000);
- Pre-maturity. A normal or full-term pregnancy lasts 38-40 weeks. Risks to brain development are associated with earlier age of birth and low birth weight;
- Stress and traumatic events. Children, especially young children, who have been exposed to severe deprivation, neglect, abuse, and trauma, can show many problems in brain development (Perry, 2002).

As mentioned above, brain development is closely linked to the development of cognitive skills (or, as it is commonly called, intelligence). Most people have an intuitive notion of what intelligence is, and many words in the English language distinguish between different levels of intellectual skill: bright, dull, smart, stupid, clever, slow, and so on. Yet no universally accepted definition of intelligence exists, and people continue to debate what, exactly, it is. Fundamental questions remain: Is intelligence one general ability or several independent systems of abilities? Is intelligence a property of the brain, a characteristic of behaviour, or a set of knowledge and skills?

Whenever scientists are asked to define intelligence in terms of what causes it or what it actually is, almost every scientist comes up with a different definition. Examples of definitions of intelligence are: general adaptability to new problems in life; ability to engage in abstract thinking; adjustment to the environment; capacity for knowledge and knowledge possessed; general capacity for independence, originality, and productiveness in thinking; apprehension of relevant relationships; ability to judge, to understand, and to reason; deduction of relationships.

People in the general population have somewhat different conceptions of intelligence than most experts. More popular notions of intelligence tend to emphasize cleverness, common sense, practical problem solving ability, verbal ability, and interest in learning. In addition, many people think social competence is an important component of intelligence.

Some scholars argue that intelligence is whatever abilities are valued by one's culture. According to this perspective, conceptions of intelligence vary from culture to culture. For example, North Americans often associate verbal and mathematical skills with intelligence, but some seafaring cultures in the islands of the South Pacific view spatial memory and navigational skills as markers of intelligence. Those who believe intelligence is culturally relative dispute the idea that any one test could fairly measure intelligence across different cultures. Others, however, view intelligence as a basic cognitive ability independent of culture (Microsoft Encarta Online Encyclopedia, 2003).

What is clear is that cognitive skills develop as the child develops. The older the child gets the more abstract and complex his/her thinking becomes, so the more he or she will be able to understand and do. But cognitive skills differ not only per age group, but also per individual child. It's therefore always important to carefully assess what a child, or a group of children can and cannot understand, and adjust expectations, activities, and communication accordingly.

1.5.2 Identity development

Developing a clear sense of self ("Who am I?", "Why am I?", "Where do I want to go?", "What do I believe in?", "Where do I belong?" etc.) is probably one of the most important developmental tasks any person has to master.

"Identity is the feeling that someone is the same person in different circumstances and different times, that ones' past, present and future are experienced as an integrated whole, and that one feels recognized and appreciated by the social environment".

Identity basically has two components (Bosma, 1991):

1. That one experiences oneself as a unity in time and space, and...
2. That others (the social environment) recognize and appreciate that unity

Although this is flexible, most children won't reach a crystallized sense of identity until the end of adolescence (at about 18 to 20 years of age).

Erik Erikson, a leading psychologist in the field of human development, devoted considerable attention to the identity formation process. He described its evolution in childhood and the continuation of its developmental course throughout the life cycle. His description of the five different psychosocial stages that a child has to go through, gives an insightful picture on how identity may develop (Erikson, 1956):

Stage 1: 0 – 2 years	This first psychosocial crisis takes place in infancy. The child, well - handled, nurtured, and loved, develops trust and security and a basic optimism. Badly handled, he becomes insecure and mistrustful
Stage 2: 2 – 4 years	The second psychosocial crisis, Erikson believes, occurs during early childhood, probably between about 2 years and 4 years of age. The "well - parented" child emerges from this stage sure of himself, elated with his new found control, and proud rather than ashamed. Autonomy is not, however, entirely synonymous with assured self - possession, initiative, and independence but, at least for children in the early part of this psychosocial crisis, includes stormy self - will, tantrums, stubbornness, and negativism. For example, one may see 2 year olds resolutely folding their arms to prevent their mothers from holding their hands as they cross the street. Also, the sound of "NO!" rings through the house or the marketplace.
Stage 3: 3 – 6 years	Erikson believes that the third psychosocial crisis occurs during what he calls the "play age," or the preschool years. During it, the healthily developing child learns to use imagination and to broaden his skills through active play of all sorts, including fantasy, to cooperate with others and to lead as well as to follow. If the child is immobilized by guilt, he becomes fearful, hangs outside groups, continues to depend unduly on adults and is restricted both in the development of play skills and in imagination.
Stage 4: 6 – 12 years	Erikson believes that the fourth psychosocial crisis is handled, for better or worse, during the school age. Here the child learns to master the more formal skills of life: relating with peers according to rules, progressing from free play to play that may be elaborately structured by rules and may demand formal teamwork, such as football and mastering social studies, like reading and arithmetic. The need for self-discipline increases yearly. The child who, because of his successive and successful resolutions of earlier psychosocial crises, is trusting, autonomous, and full of initiative will learn easily enough to be industrious. However, the mistrusting child will doubt the future. The shame and guilt-filled child will experience defeat and inferiority.
Stage 5: 12 – 18 years	During the fifth psychosocial crisis the child, now an adolescent, learns how to answer satisfactorily and happily the question of "Who am I?". But even the best adjusted of adolescents experiences some role identity diffusion: most boys and probably most girls experiment with minor delinquency; rebellion flourishes; self-doubts flood the teenager. Erikson believes that during successful early adolescence the young person acquires self-certainty as opposed to self-consciousness and self-doubt. He comes to experiment with different - usually constructive - roles rather than adopting a "negative identity" (such as delinquency). He actually anticipates achievement, and achieves, rather than being "paralyzed" by feelings of inferiority. In later adolescence, clear sexual identity - manhood or womanhood - is established. The adolescent seeks leadership (someone to inspire him), and gradually develops a set of ideals (in line with social norms), in the case of the successful adolescent.

These five psychosocial stages in childhood are plausible and insightful descriptions of how identity may develop. Helping the child through the various stages and the positive learning that should accompany them is a complex and difficult task, as any parent or teacher knows.

When working with children it is important to realize how identity development of individual children or groups of children is taking shape. Problems in identity development may lead to, or be linked to psychosocial problems like: lack of self-esteem; insecure attachment; depression; and anti-social behaviour.

1.5.3 Moral development

Moral development, or the development of a conscience, the ability to judge what is right and what is wrong, is very important if children want to become socially adapted, responsible individuals. It can be seriously under threat in circumstances of family or social disruption, when role models may fall away (like for example for child soldiers in a conflict situation). Moral development (like any other aspect of development) is dependent on internal and external forces in the child's environment. Morality is closely related to the norms and rules in a particular cultural context, but many believe there are universal moral principles. The Convention on the Rights of the Child is based on this idea.

Kohlberg (1973) claims that there are six different stages in moral development:

LEVEL	STAGE	SOCIAL ORIENTATION
Pre-conventional	1	Obedience and Punishment
	2	Individualism, Instrumentalism, and Exchange
Conventional	3	"Good boy/girl"
	4	Law and Order
Post-conventional	5	Social Contract
	6	Principled Conscience

The first level of moral thinking is generally found in the infant, toddler, and pre-school child (0-6 years of age). In the first stage of this level, children behave according to socially acceptable norms because they are told to do so by some authority figure (e.g., parent or teacher). This obedience is compelled by the threat or application of punishment. The second stage of this level is characterized by a view that right behavior means acting in one's own best interests.

The second level of moral thinking is that generally found in society, hence the name "conventional." The first stage of this level (stage 3) is characterized by an attitude that seeks to do what will gain the approval of others. Most children in middle childhood and adolescence (6 – 18 years of age) think at this level. Only in adolescence (12-18 years of age) children may reach stage 4, which is oriented to abiding by the law and responding to the obligations of duty.

The third level of moral thinking is one that Kohlberg felt is not reached by the majority of adults. Its first stage (stage 5) is an understanding of social mutuality and a genuine interest in the welfare of others. The last stage (stage 6) is based on respect for universal principles (like: you shall not kill) and the demands of individual conscience.

Kohlberg believed that individuals can only progress through these stages one stage at a time. That is, they cannot "jump" stages. They cannot, for example, move from an orientation of selfishness to the law and order stage without passing through the good boy/girl stage. They can only come to a comprehension of certain moral principles one stage above their own.

Kohlberg also believed that these stages are universal and he managed to prove so with several studies. Although people in different cultures may reach different levels of moral thinking, the sequence of stages seems to be valid across cultures. But of course “moral thinking” does not necessarily mean “moral behaviour”. Many people know the difference between right and wrong, but fail to act accordingly.

When working with children it is important to realize what stage of moral development they are in. Is this adequate for their age and how does it relate to the norms and expectations prevalent in their family and culture?

1.5.4 Play and creative development



(Children playing with instruments, Georgia)

Play is beneficial for the development of coping mechanisms that enhance resilience and psychosocial well-being in children:

- Play offers a young child a means to relive and assimilate stressful aspects of reality, at a distance, through fantasy that is under a child’s control (Piaget, 1951);
- Through play a child can learn about the self (for example gender identity) in relation to others;
- Play stimulates cognitive development (especially in pre-school children) (Davies, 2005);
- The process of imagining and carrying out play scenarios supports the development of cognitive skills, such as planning and problem solving, as well as providing the child with opportunities to exercise autonomy and initiative (Piaget, 1962);
- Play can be a way to express aggressive and other negative impulses in a safe, positive way (Paley, 1988);
- Structured activities such as hobbies and sports are the most development enhancing ways for children to spend their time (Mc Hale et al., 2001);
- Participation in structured extracurricular pursuits and hobbies promotes resiliency by helping children feel proud (Werner, 1993).

The way children play changes through time:

Play in infancy (0-12 months of age) is primarily exploratory and interactive.

For toddlers (1 to 3 years of age) play is often a non-verbal means for coping with confusion and stress. At this age dramatic pretend play is beginning to develop.

Preschool (3 to 6 years of age) children love to play. Their play is more complex and imaginative than a toddler’s, but it is less constrained by rules and adherence to reality than the play of a school-age

child. Preschoolers' play takes two primary directions, which in practice are often combined. The first involves exploration of reality and especially social roles. For instance, by dressing up like others, preschoolers are exploring in fantasy what they may become. The second direction of preschool play involves using play for the mastery of stress and anxiety, as well as for the expression of wishes and fears.

For the school age child (6 to 12 years of age), a work orientation emphasizing intellectual mastery and physical competence gradually supplants play as a compelling interest (Erikson, 1963). Play remains important to the school-age child, but fantasy play is gradually supplanted by the organized and ritualized play of games and sports (Rubin, et al., 1998). Organized playground games like soccer, basketball implicitly socialize children to take turns, improve their skills, focus on planning and goals, exert sufficient control over emotions to allow the game to proceed, and to follow the rules (Piaget & Inhelder, 1969). In this period often hobbies like collecting things become important for children. The movement from social dramatic play to organized games tells only part of the evolution of play. In middle childhood, a kind of mental play, internal fantasy, increases as play with peers becomes more ritualized. Fantasy continues to fulfill the functions that dramatic play did for the preschooler: pleasure, imagined fulfillment of wishes, exploration of reality, imagining oneself in more advanced roles and understanding the emotions and perspectives of others through role-playing (Seja & Russ, 1999). These fantasy activities contribute to children's abilities in creative thinking and positive coping (Russ, Robins, & Christinano, 1999).

Adolescents (12-18 years of age) play is even more organized. It becomes a tool for interacting with peers, through for example sports or drama activities. It can also be a clear expression of the adolescent's emerging, separate identity. Ritualized play is also definitely a means for the adolescent to release energy and stress. At the same time play loses some of its importance, as work and study become more and more significant. Fantasy remains important; the adolescent can drift away in daydreams about a big love or a glorified future.

It is important for people who work with children to realize that play and creative expression, like other child behaviour, is often a representation of psychosocial processes, and the observation of such behaviour provides us with a window on the experiences and feelings that children have but may not be able to represent in language. In other words: if we observe carefully *how* children play, we can learn a lot about their feelings, problems, wishes, needs, and (developmental) situation.

1.6 Important transactional, ecological processes and concepts in child development

This section describes some of the most important issues in child development. These are examples of transactional, ecological processes that play a role in the mastering of tasks in the different developmental domains as described in 1.4 and chapters 2 and 3.

1.6.1 Attachment

Attachment is the deep emotional bond formed between a child and one or more adults, usually a parent or caregiver. Attachment is a fundamental need that has a biological basis (Bowlby, 1969). Attachment provides a sense of security for children and allows them to explore their environment, returning to the adult during periods of distress. Development of this emotional bond or attachment involves parents providing love, nurturing, trust, safety, and respect to their children, and sensitively responding to their children's needs. Although the behavioural expression of attachment varies across cultures, attachment is a universal phenomenon in humans (Bowlby, 1969; LeVine & Miller, 1990). In most cultures, infants' attachments have an order of preference, usually to mother, then father, and then siblings. The effects of early attachment have been shown to last a lifetime. Early parent-child

relationship mediates and influences the course of development. Although parenting is not the only influence on development, it is a critically important one (Davies, 2004).

- Attachment is a deep and lasting connection that develops between a child and specific caregiver (mother, family member, or community member) in the early years of life, particularly between the ages of 0 and 3 years;
- Attachment is a mutual relationship between a child and caregiver. Children instinctively reach out to a caregiver for security and protection; caregivers instinctively protect and nurture children;
- The mutual responsiveness of the attachment relationship, where caregivers respond to children's needs, and children respond to caregivers' care, creates the secure base for early development;
- Attachment influences early brain development, which has an impact on a child's lifelong abilities to regulate thinking, feelings and behaviour;
- Attachment behaviours are those behaviours that children use to seek response and maintain closeness to their caregivers. They include crying, grasping, clinging, reaching, crawling, smiling, and vocalizing. These behaviours promote the physical safety and survival of children;
- Lack of a secure attachment relationship seriously endangers healthy child development.

Ainsworth (1978) recognized three different patterns of attachment. A fourth pattern was added later on (Main & Solomon, 1990). These four patterns are classified as follows:

1. Group A: Insecure-avoidant
2. Group B: Secure
3. Group C: Insecure - Ambivalent/Resistant
4. Group D: Insecure – Disorganized/Disoriented

Children rated as having a **secure attachment** (B) show confidence in the attachment relationship. Secure children: want to be close to their caregiver; keep in physical contact with their caregiver; continue to interact with their caregiver; may try to engage their caregiver from a distance if they do not seek closeness and physical contact; settle down quickly when the caregiver is present and are able to go back to playing and exploring. Secure attachments have a positive impact on later development. Children with a history of secure attachment are more confident about exploring their environment and more open to learning. Good attachment relationships tend to be generalized to later relationships. Children with the benefit of secure attachment throughout childhood have the best developmental outcomes. Security in infancy (when the child is still very small) gets development off to a good start, but it should not be considered a complete protection against future disruptions of development, which can occur in response to changes in quality of attachment (for instance when a child gets orphaned or separated from a parent) (Davies, 2005).

Insecure attachment occurs when caregivers are not available, are not in tune with the needs of their child, are not affectionate, are unable to demonstrate pleasure in their interaction with their children, or are unable to comfort their stressed children. Insecure attachment takes on different forms depending on the extent to which primary caregivers neglect to respond to their children.

Insecure-avoidant attachments (A) occur when caregivers are rejecting and unavailable. They do not respond to their child's needs at all or respond in indifferent and hostile ways. This results in children

who deny their own needs and avoid interaction with their caregivers. The children may seem independent but this is based on the belief that they have to be because they cannot depend on their caregivers. These children are often ignored and actively rejected by their mothers. They have higher levels of hostility and unprovoked aggression and negative interactions with other children. Instead of expressing distress and asking for help with disappointment, they are likely to sulk or withdraw. Because they are emotionally distant and often behave in negative ways, children with insecure-avoidant attachment tend to be viewed more negatively and subjected to more discipline by their teachers, thus reinforcing and confirming the child's untrusting assumptions about attachment (Sroufe, 1989).

Anxious/ambivalent attachments (C) occur when primary caregivers are inconsistent and unpredictable. They are responsive to their infant's needs sometimes and non-responsive at other times. This results in children who long for closeness but do not trust that their caregiver will be available. As a result, the children become extremely distressed when separated from their attachment figures but are not easily comforted when their attachment figures return. The children are anxious about leaving their attachment figure to explore their environment, and thus do not develop independence. Mothers of these children are found to be inconsistently responsive to their infants' attachment-seeking behaviour: one time they may respond adequately, another time they don't. This type of attachment pattern predicts later disturbances in the infant's capacity for autonomous behaviour. Studies have linked this attachment pattern with social withdrawal and poor social interaction skills in early school age children (Renken, Egeland, Marvinney, Mangelsdorf, & Sroufe, 1989).

Disorganized/disoriented attachments (D) occur when caregivers are abusive or severely neglecting. This results in children who display both avoidant and ambivalent attachment styles. They are hyper-vigilant to abuse at times, while freezing and becoming disoriented at other times. They either reject their attachment figures or try to please them, sometimes alternating between the two behaviours. Two patterns contributing to the development of this type of attachment have been identified: a history of unresolved trauma in the parent and direct maltreatment by the parent. A high percentage of parents with disorganized/disoriented infants have themselves histories of unresolved childhood trauma, such as the early loss of a parent, abuse, or witnessing of parental violence (Main & Hesse, 1990; Lyons-Ruth, 1996). This type of attachment predicts high rates of aggression towards peers in pre-school and school age children (Lyons-Ruth & Jacobvitz, 1999). In school age children a history of disorganized/disoriented attachment may predict poor self-confidence and lower academic ability (Moss, Rousseau, Parent, St Lauerent, & Saintong, 1998).

Although there are variations in the forms that attachment behaviour takes, as well as differences in approaches to care giving and expectations of infants, the universality of attachment is not in question (Posada et al., 2002). Which factors seem to be universal? A baby needs to have an attachment to a primary caregiver (or, in many cultures, to a set of primary caregivers). Consistency, sensitivity, and responsiveness on the part of the primary caregivers are essential to the baby's psychological development. Across cultures, secure-base behaviour - the child's ability to use the caregiver for relief of distress and support for exploration (as defined by each culture) - has been identified as a marker of secure attachment (Waters & Cummings, 2000). When a caregiver is unresponsive, inconsistent, insensitive, or rejects the baby, the child's psychological development is seriously at risk.

Many studies have investigated the relationship between early attachment and development later on. Overall they have found impressive links between quality of attachment in infancy and later development (Matas, Aren, & Sroufe, 1978; Lyons-Ruth, 1996). Secure attachment in infancy and toddlerhood (0-3 years of age) predicts social competence, good problem-solving abilities, and other

personality qualities associated with successful adaptation in later childhood (Sroufe, 1989). Insecure attachment has been similarly linked to problematic behaviour and social difficulties in school-age children. Although other factors such as infant temperament and environmental risk factors influence outcomes, the overwhelming evidence of empirical studies makes clear that quality of attachment is a fundamental mediator of development (Davies, 2004).

1.6.2 Resilience

Resilience is a concept that has become increasingly important in the study of child development. From various studies it became clear that many children, even those growing up in very difficult and risky circumstances, grow up to be healthy, stable adults (e.g. Felsman & Vaillant, 1987; Werner, 1989; Masten, Best, & Garmezy, 1990). This ability, to develop healthily and overcome problems, is known as 'resilience'.

Resilience is "a universal capacity, which allows a person, a group or community to prevent, minimize or overcome the damaging effects of adversity". (Grotberg, 1995)

Even in the face of extremely stressful circumstances, such as violence, loss of family members, and displacement, resilient children are able to draw on internal resources and external support to help them deal with the situation and adapt (Arntson & Knudsen, 2004). The term resilience refers to both a child's state of well-being (as in he or she is resilient) and to the characteristics and processes by which that well-being is achieved and sustained (as in he or she shows resilience to a particular risk) (Gilgun, 1999).

Resilience is a relatively recent concept in the arena of human development and social services, having evolved from an earlier focus on social problems. This evolution had three major influences:

1. An increase in understanding that a variety of social problems appeared to be determined by a set of multiple risk and protective factors (e.g., Dryfoos, 1990; Hawkins, Catalano, & Miller, 1992);
2. The recognition that many individuals appear to do well despite sharing many of the same characteristics and conditions of those who have serious psychosocial problems (e.g., Anthony, 1987; Rutter, 1985; Werner & Smith, 2001)
3. An increase in the use of the "strengths perspective" in psychosocial work (e.g., Saleebey, 1997). This encourages professionals to build on beneficiaries' strengths or assets rather than focusing exclusively on problems or deficits.

Children can become resilient through the presence of *protective factors*, which enable them to deal with problems. Protective factors can include capacities within the child (for example an above average intelligence, good social skills and self-esteem), or capacities in the environment of the child (for example loving, caring parents and social services available in the community). We will discuss this in more detail in the next section. It is important to understand that resilience, risk and protective factors, psychosocial well-being, attachment, coping mechanisms, and all other aspects important in children's development, are inter-related and mutually influence each other in many (and not always completely understood) ways.

Research on childhood resilience suggests that a preventative approach to child development is more useful than a problem focussed approach. The studies suggest that if multiple risk factors accumulate and are not set off by compensating protective factors, healthy development is compromised. The

family, school, peers, and community play a key role in the attempt to instil resilience in children (Kosteck, 2005).

Prevention in this context means two things (Rispen & Van Tuijl, 1994):

1. Prevention of the development of psychosocial problems, and...
2. Support to healthy development of children.

All War Child programs are primarily preventative in nature. We seek to prevent psychosocial problems that can develop as a consequence of growing up in a war-affected area. Furthermore, by strengthening protective factors in children and their environment, we aim to increase the chances for healthy development of children in war-affected areas.

1.6.3 Risk and protective factors

The presence of risk and protective factors plays an important role in child development. Risk factors are those factors that endanger child development, whilst protective factors² promote chances for healthy development. Protective factors are individual or environmental safeguards that enhance children's ability to resist stressful life events and promote adaptation and competence (Garmezy, 1983; Werner, 1990). Both risk and protective factors can be found at child level, as well as at parental/family and community/society level. All of these factors are often inter-related and influence each other.

Protective factors are sometimes merely the opposite of risk factors; one major difference, however, is that risk factors lead directly to disorder while protective factors operate only when a risk is present (Rutter, 1987). This means that a protective factor:

1. Modifies the relationship between risks and expected problems in development (buffering or diminishing these risks)
2. Does not work in the absence of the risk factor. This implies that the presence of a certain protective factor will not have a significant influence on the occurrence of problematic behaviour for no-risk groups, but only has influence for at-risk groups.

To summarize: something can only be considered as a protective factor if the effect of an existing risk seems to be lessened by it (Groenendaal & Van Yperen, 1994).

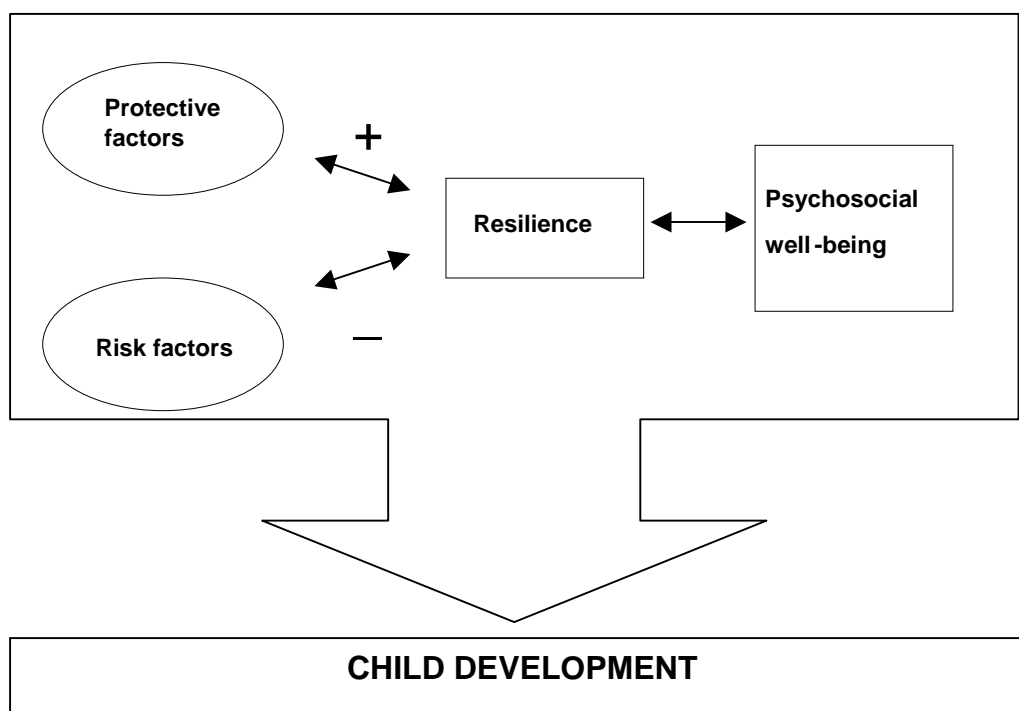
<p>Possible child <i>risk</i> factors include:</p> <ul style="list-style-type: none"> • Pre-maturity, birth anomalies • Chronic or serious illness • Temperament (difficult or slow to warm up) • Mental handicap/low intelligence • (Early) Childhood trauma • Insecure attachment • Antisocial peer group 	<p>Possible parental/family <i>risk</i> factors include:</p> <ul style="list-style-type: none"> • Single parenthood (with lack of support) • Harsh parenting, maltreatment • Family disorganization; low parental monitoring • Homelessness • Social isolation, lack of community support • Parental substance abuse • Parental psychopathology • Death of a parent or sibling 	<p>Possible community/societal <i>risk</i> factors include:</p> <ul style="list-style-type: none"> • Poverty • Lack of access to community support services (medical care, social services, etc.) • Exposure to community violence, discrimination • Poor schools • Exposure to environmental toxins • Exposure to media violence • Community disintegration and lack of social cohesion
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² Also sometimes referred to as *protective processes*; processes implies that for these factors to have an effect, they usually need to exert their influence for a longer period of time.

<p>Possible child <i>protective</i> factors include:</p> <ul style="list-style-type: none"> • Good health • Personality factors: easy temperament; active coping style, positive self-esteem; good social skills • Above-average intelligence • History of adequate development • Hobbies and interests • Good peer relationships 	<p>Possible parental/family <i>protective</i> factors include:</p> <ul style="list-style-type: none"> • Secure attachment; positive and warm parent-child relationship • Parents support child in times of stress • Household rules and structure; parental monitoring of child • Support/involvement of extended family • Stable relationship between parents • Parents model competence and good coping skills • Family expectations of pro-social behaviour 	<p>Possible community/societal <i>protective</i> factors include:</p> <ul style="list-style-type: none"> • Good Socioeconomic status • Access to health care and services • Adequate housing • Religious faith and participation • Good schools • Supportive adults outside family
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The effect of risk factors on children’s development is cumulative (Pollard, Hawkins & Arthur, 1999). This means that if there is one risk factor in place, the child is likely to be more susceptible to other risk factors too. For example: a child with insecure attachment (one risk factor) is more susceptible to becoming a victim of abuse (another risk factor). However, the presence of risk factors does not guarantee a negative developmental outcome, but rather increases the probability that problem behaviors will occur (Werner, 1990).

The whole process affecting psychosocial development can be conceptualized as follows. The two-way arrows emphasize that all aspects influence each other:



More on risk and protective factors can be found in Chapter 4.

1.6.4 Coping mechanisms

Coping mechanisms are those psychosocial skills or abilities that a child possesses and develops through life, that help him/her deal with situations.

A division can be made between negative coping mechanisms (which are eventually harmful to the child) and constructive coping mechanisms (which support healthy development and psychosocial well-being).

Examples of negative coping mechanisms include:

- Aggressive, anti-social behaviour. This kind of behaviour may help a child or a group of children to overcome low self-esteem and a feeling of neglect, and could create a certain social standing and safety. But in time it may also result in isolation, criminal behaviour and loss of future possibilities;
- Alcohol and drug abuse. Although the use of these substances may help to relief stress, they will eventually produce negative outcomes for the child, such as social isolation and possible brain damage;
- Closing off to the outside world. Again, turning inward may initially be helpful for a child in overcoming a stressful situation, but eventually this attitude can lead to isolation and social deprivation;
- Creating separate identities. This is a well known, albeit very rare phenomenon that can happen to children who are abused. Some of these children create different personalities, separate identities, in which they can escape as a way of trying to avoid further harm. This can lead to serious psychological problems later on in life.

Examples of constructive coping mechanisms include:

- The ability to share thoughts and feelings with others (communication skills). This can help a child to feel less lonely and can give the comforting realization that it does not have to go through an experience alone;
- Effective problem solving. Being able to analyze a situation and define steps that might resolve a problem, is extremely helpful. This is often linked to adequate cognitive skills;
- Self-expression. Being able to express one self through speech, play, art, music, and other activities, gives a child a sense of control. Self-expression also helps to connect with emotions and to relief possible stress associated with those emotions;
- Empathy. Empathy is the ability to put oneself in the position of another person and imagine how they feel. Having this skill is very important in our daily lives, because we are dealing with other people all the time. Having an understanding of peoples thoughts, emotions, wishes, etc, can help children to react in an appropriate way to others and to overcome difficult situations;
- The ability to have trusting relationships. This ability (which is very much based on having developed adequate attachment early in life) is of vital importance. Children need the ability to trust others to survive and to develop healthily.

Chapter 2 Child Development: Course and outcomes of normal development

2.1 Introduction

This chapter gives an overview of the normal developmental stages a child goes through. It is by no means exhaustive, but it should give the reader a fair idea of what to expect from children at different ages. It is again important to keep in mind that these are general descriptions; each child may differ in timing and expression of certain behaviours, emotions or cognitive skills. The circumstances of the family, community and society, as well as cultural customs, may influence how and if particular developmental tasks are acquired by children. But the information in this chapter does give War Child field staff clear, general reference points when observing children and analyzing their situation.

*Build up of this chapter*³

For each age period we will describe the main developmental tasks a child needs to achieve, and what progress is made in different developmental domains such as social development, cognitive development, language and communication, expressive development (including play and fantasy), regulation of emotions and behaviour (including coping mechanisms), moral development, and identity development.

2.2 Infant development (Birth – 12 Months of Age)⁴



(Baby boy, Sudan)

The first year of a child's life is one of extreme vulnerability and complete dependency, as well as of high-speed physical growth. One only has to think of a baby of a friend or a relative to realize the latter: if you haven't seen the child for a couple of weeks, he or she seems to have grown beyond recognition! The baby needs to develop secure attachments with his primary caregiver(s), to gradually gain control over motor skills and needs to begin to develop the ability to regulate (*have control over*) arousal and emotions.

In the **first 0-4 weeks** this includes abilities such as:

- Orientation to sounds and sights;
- Orientation to human voices and faces;
- Recognition of primary caregiver;

³ Information in this chapter is, if not otherwise noted, based on chapters 5 –12 from *Child Development: a practitioner's guide*, by Douglas Davies, Guilford Press, New York, 2004.

⁴ Although 0-4 years is usually not an age group War Child focuses on, we will give attention to this period of childhood as well. It is appropriate that War Child staff should have at least basic knowledge of this period, since it will influence child development later on. Also parents and caregivers may want to draw on the expertise of field staff in this domain.

- Differentiation between new and familiar stimuli.

In the first **3 months** this includes abilities such as:

- Developing the capacity to control body rhythms (with help of caregiver):
 - Sleep/wake and feeding cycles.
- Interactions with caregivers:
 - Focusing attention on primary caregiver for longer periods;
 - Social smiling.

In the period of **3 to 6 months** this includes abilities such as:

- Development of attachment:
 - Consistent recognition of primary caregivers;
 - Clear preference for interacting with primary caregivers;
 - Responsive to caregivers' playful behaviour.
- Development of play:
 - Interactive play and baby games with primary caregivers;
 - Exploratory play with primary caregivers;
 - Using his/her senses.
- Development of physical skills – control over upper body functions:
 - Head and neck control;
 - Reaching for and grasping objects;
 - Eye-hand coordination;
 - Coordination of hand movements.
- Development of memory:
 - Child can indicate a preference for certain types of interactions and play.

And in the period of **6 to 12 months** this includes abilities such as:

- More intense interest in relationships, own body, and the physical world;
- Development of play:
 - Child initiates play interactions rather than depending on caregiver to initiate them.
- Development of physical skills:
 - Creeping, crawling, cruising, and walking.
- Development of memory:
 - Child can keep an object (s)he has seen in mind, even though it is no longer in sight.
- Learning:
 - Following simple directions: responding to parents' words and gestures;
 - Imitative learning: watching caregivers to learn how to do things.
- Development of language and communication:
 - First: vocalizing and babbling;
 - Followed by: gestured communication (looking and pointing);
 - Followed by: understanding and speaking first words.
- Development of Identity:
 - Sense of feeling control over action and communication with caregivers;
 - Sense of self-esteem, when the child feels successful at accomplishing a goal;
 - Development of a positive sense of identity is strongly related to responsive care giving.

Some facts about infants worldwide:

- Every year more than 20 million low-birth weight babies are born in developing countries; these babies risk dying in infancy (WHO, 2005);
- Infant mortality has dropped by 2/3 worldwide since 1950 (www.ppionline.org);
- Over 300 million women in the developing world suffer from short-term or long-term illness brought about by pregnancy and childbirth; 529 000 die each year (WHO, 2005);
- More than 50% of all child deaths occur in just six countries: China, DR Congo, Ethiopia, India, Nigeria and Pakistan (WHO, 2005);
- Globally the average number of children per woman stands at 2.69, compared with 4.97 in the early 1960's (WHO, 2005).

2.3 Toddler⁵ Development (1-3 Years of Age)

(Toddler, Bosnia)

In this period we see that the child is increasingly capable of doing things on his/her own and with gradually improving skill. The upright position presents the toddler with a new and wider view of the world. Increasingly effective motor skills make possible all sorts of new actions. Cognitive advances combined with curiosity and will, intensify the child's desire to experience and understand everything it sees. But toddlers have a dual orientation: toward maintaining attachment and toward exploring the world and the self (Bowlby, 1969). Important developmental tasks in this period include: balancing attachment and exploration, with increasing movement toward autonomy and individuation; internalization of parental values and standards; and developing the ability to symbolize, through mental representation, play and communication.

Attachment

- Secure attachment with primary caregivers forms the basis for:
 - Continuing development of sense of identity (*see below*);
 - Development of self-comforting behaviour to cope with separation (like the toy bear in the picture above);
 - A role model for behaviour;
 - Helping the child to cope with stressful situations;
 - Helping the child understand the world;
 - Encouraging language and communication;

⁵ Comes from the verb "toddle", which means to walk with short and wobbly steps.

- Developing autonomous (independent) behaviour.

Social development

- Limited ability to share or acknowledge intentions and feelings of others, because of:
 - An egocentric (self centred) view of the world;
 - The need to feel autonomous and in control.
- Child begins to understand social relations through play with peers;
- Child begins to understand about social norms through imitation of caregivers' behavior.

Cognitive development

- Ability to observe and imitate others;
- Interest in understanding and learning about the world;
- Development of conscious expectations, based on:
 - memory of prior experiences;
 - awareness that not all expectations are being met.
- Development of conscious goals and plans:
 - child can formulate plans;
 - child can consciously remember them;
 - child can persist in trying to realize them.

Language and communication

- Gradual growth in vocabulary;
- Clear wish to communicate experiences:
 - limitations in language ability are a source of frustration and angry behaviour;
 - rapid growth in language development.
- Two- and three- words sentences are used;
- Use of language to understand the world:
 - asking questions;
 - telling about experiences;
 - talking to oneself.

Play and symbolic communication

- Exploration of materials and functions of objects;
- Pretend play:
 - Imitation of daily activities (i.e. pretending to eat);
 - Imitation of care giving behaviour.
- Symbolic play:
 - Replacing one object with another (i.e. pretending a broom is a horse);
 - Play is used to comment on and tell about experiences;
 - Play is used to represent reactions to stressful situations;
 - Play is used as an emotional release to stressful situations. Children are often better able to express themselves through play than with words.

Development of coping mechanisms

- Child has limited internal means of coping with stressful and difficult situations, so they continue to rely on help from their caregivers;
- Coping mechanisms include the following:
 - controlling emotions through relationship with caregivers;
 - play as a way to master / deal with stress;
 - language as a means for communicating distress;

- imitating and internalizing caregivers' ways to control anxiety.

Moral Development

- Child begins to experience a difference between his wishes and the limits caregivers impose:
 - Because of the strong motivation of the child to explore, the caregivers need to limit its behaviour, often to protect the child from dangers.
- Internalization of caregivers' rules start to develop:
 - Especially when (dis)approval of child's behaviour by caregivers goes together with strong emotions of the child;
 - The child tries to control its behaviour in order to gain approval of caregivers and avoid punishment.
- Internalization of standards/norms for behaviour starts to develop:
 - Child evaluates its own performance; feeling good if it has done well and bad if it has not;
 - Child starts to learn the expectations caregivers have about behaviour.
- Beginning of pro-social behaviour – capacity to feel empathy / compassion for others:
 - Child starts to console distressed peers;
 - Child starts to hold back aggressive behaviour.

Identity Development

- Increasing sense of self importance:
 - Child starts to insist on having things its own way;
 - Child starts to pursue its own goals.
- Increasing self-recognition:
 - Child learns to recognize itself in a mirror.
- Egocentrism:
 - Child tends to find its own needs and points of view more important than those of others;
 - Child's awareness grows that others have thoughts, feelings and intentions that may be different from it's own.
- Start of separation-individuation (in relation to attachment with primary caregivers):
 - Child becomes more vulnerable to the fear of separation and more likely to show attachment behaviour.
- Beginning of a sense of identity:
 - Independent / autonomous behaviour;
 - Using the words "I", "me", "my", and "mine";
 - Starting awareness of differences in gender.

2.4 Preschool Development (3-6 Years of age)



(Preschool children in Uganda)

The preschool period is a great transition in development. The child evolves from an egocentric toddler with limited capacity for understanding the self and the world into a child of the middle years, who has much in common with adults, in that the child can think logically, maintain self-control, and empathize with others. Cognitively, the preschooler gradually moves to thinking that is more logical, shows understanding of cause and effect, and distinguishes between fantasy and reality. A major effect of these cognitive changes is that by age 6 the child's view of self begins to be more realistic. Relationships with peers become very interesting to the preschooler and have implications for development. In interactions and play with peers the preschooler gains skill in empathy, perspective taking, negotiation and cooperation, and begins to experience the pleasures of friendship.

Attachment

- Attachment relationships with primary caregivers are strongly established;
- Child starts to put into words the needs it has regarding attachment with caregivers, rather than only expressing in action;
- Child learns to deal with separation better, because of:
 - growing memory;
 - growing sense of time; the child can understand better when a parent will return.
- Attachment relationships are expanded to relationships with non-parental caregivers and peers.

Social development

- Social skills and abilities develop through interaction and play with peers:
 - negotiation about play scenarios;
 - conflicts between peers;
 - competition between and exclusion of peers.
- Pro-social interaction is developing and becoming more frequent, through:
 - identification with adult role models;
 - growing empathy for and understanding of perspectives of others.
- Through peer interaction and exposure to pro-social values in preschool settings:
 - growing skills in cooperation and sharing;
 - development of problem-solving skills;
 - decrease in egocentrism;
 - growing identification with peers, motivating the child to make interactions with them pleasurable.
- Friendships based on common play interests develop.

Language and communication

- Gradual increase of vocabulary (about 50 words each month);
- Speech becomes clear and easy to understand;
- Ability to produce grammatically complex sentences involving 8-10 words;
- Speech begins to accompany behaviour and play:
 - the child describes and directs his behaviour in this way;
 - increased use of verbal approaches in social interaction and conflict resolution.
- Interactive play starts to depend on language;
- Language becomes the child's primary means of communication as opposed to action.

Play and symbolic communication

- Play tends to be imaginative, dramatic and interactive:
 - exploring reality and social roles;
 - coping with stress;

- expressing fantasies and wishes;
- expressing negative, forbidden or “impossible” impulses.
- Clear distinction between real and pretend play:
 - this helps child to distinguish between fantasy and reality.
- Play provides opportunities for practicing cognitive skills, such as:
 - cause-and-effect thinking;
 - construction of stories;
 - taking perspective / a point of view on reality;
 - problem solving;
 - exploring alternative interpretations of reality.

Cognitive development

- Improved memory, increases the ability to:
 - remember new information;
 - categorize new information;
 - have an overview / make generalizations.
- Developing cause-and-effect thinking:
 - increased attempts to see causal connections between events;
 - limited ability to think logically and emotional arousal may lead to mixing up cause and effect.
- Egocentric (self-centred) thinking persists:
 - limitations in correct understanding of reality;
 - inability to imagine a different viewpoint on reality;
 - reversal of cause and effect;
 - attributing the causes of events to the self (blaming oneself for what happens).
- Combining fantasy and reality are common:
 - when thinking is influenced by emotional arousal;
 - when there is need to find “hidden” information (i.e. figuring how a seed becomes a plant, where babies come from, or why there is fighting going on).

Development of coping mechanisms

- Increased feeling of control and less vulnerable to anxiety;
- Improved control of impulses / urges;
- Improved communication providing reminders of rules, prohibitions and expectations;
- Ability to transfer real-world concerns and anxiety through fantasy play;
- Coping mechanisms include: denial, regression.

Moral development

- Behaviour is directed by rules with reminders and reinforcement of adults:
 - child can follow the rules at school or home;
 - child has difficulties abiding the rules of a game (child cannot emotionally tolerate losing, and fantasies stimulated by playing a game are more important than rules).
- Increased control of negative or impulsive behaviour, because:
 - child wants to maintain the friendship of peers;
 - child wants approval of peers / adults.
- Moral values are gradually internalized through:
 - constant monitoring by caregivers; setting limits and praising good behaviour;
 - increased expectations from caregivers;
 - identification of child with values of caregivers;
 - increased capacity to empathize with / feel compassion for others;
 - increased orientation on peers (see above).

- Gradual internalization of moral values, resulting in:
 - the establishment of a conscience;
 - knowing right from wrong;
 - monitoring of own behaviour, although not yet consistently;
 - feelings of guilt when misbehaving – guilt develops as a distinct emotion.

Identity Development

- Self-esteem is developed through:
 - receiving love and support from caregivers;
 - growing skills and abilities;
 - growing independence;
 - improved coping skills.
- Increased identification with others:
 - child strives to be like its caregivers;
 - child also takes on board characteristics of caregivers.
- Increased awareness of gender identity:
 - Including culturally based gender roles in play and peer relationships.
- Increased awareness of sexual identity:
 - sexual interests develop; fascination with the body and masturbation;
 - curiosity and anxiety about sexual differences.
- Increased awareness of racial identity:
 - minority children become aware of racial stereotypes;
 - impact of this depends on the experiences child has regarding stereotypes (positive experiences support self-esteem).

Some facts about pre-school age children worldwide:

- Every year nearly 11 million children die before they reach their fifth birthday (almost all these deaths occur in developing countries; $\frac{3}{4}$ in Sub Saharan Africa and South Asia (WHO, 2005);
- In 2003 12 million children were newly orphaned in southern Africa; a number expected to rise to 18 million in 2010 (WHO);
- Most deaths amongst under-fives are attributable to just a handful of conditions and are avoidable through existing interventions. These are: acute lower respiratory infection, mostly pneumonia (19% of all deaths), diarrhea (18%), malaria (8%), measles (4%), HIV/AIDS (3%) and neonatal conditions, mainly preterm birth, birth asphyxia, and infections (37%) (WHO, 2005);
- In 2000, 55% of preschool-age children suffered from stunted growth. 56% were underweight. (WHO).

2.5 Middle Childhood (6 to 11 or 12 Years of Age)



(Primary school children, Afghanistan)

The school-age child seems calmer, somewhat more serious, and less spontaneous than the preschooler. The child gradually comes to see the world as a place with its own laws and customs, which he or she must learn about and assimilate. The child shifts from seeing itself as at the centre of the world to realizing that the world is complex and that he or she must find his/her place in it. While imagination and play remain important to the school-age child, he or she increasingly establishes his/her sense of identity through a long apprenticeship of learning skills. School-age children learn that success is based on practice, which helps explain their intensity and persistence as they work on building skills. Middle childhood is also characterized by the child's capacity to maintain states of self-control, calm, and educability (Sarnoff, 1976). Important overall developmental tasks include: development and utilization of a sense of calm, educability, and self-control; development of real-world skills and a sense of competence; and the ability to establish one self in the world of ones peers.

Attachment

- In situations of severe stress (i.e. war or transitional periods, such as entry into school) the child might still seek the closeness of primary caregivers;
- In situations of mild stress the child will make use of independent coping;
- Rituals symbolizing the attachment continue: bedtime routines, gestures of affection, etc;
- Attachment needs are increasingly expressed in friendships with peers.

Social development

- Increasing orientation towards peers:
 - development of friendships;
 - development of social skills (i.e. sharing, negotiation, etc);
 - development of peer group norms and differences in status;
 - increased understanding of gender roles and behaviour.
- Pro-social interaction continues to develop:
 - internalization of values of caregivers and peers;
 - improved perspective taking - understanding viewpoints and social expectations of others;
 - increased awareness of feelings and intentions of others.

Language and communication

- Basic ability in syntax (*rules*) and grammar established;
- Increasing understanding of nuances in meaning of words;
- Increasing understanding of more difficult grammar;
- Increasing ability to put thoughts and feelings into words;
- Narrative ability; the child can tell an organized story;
- Increasing understanding of wordplay, jokes, figures of speech, metaphors.

Play and fantasy

- Important elements of play are:
 - Developing physical skills and intellectual competence;
 - Pleasure and emotional release;
 - Planning and strategizing.
- Fantasy play is increasingly ritualized and directed by rules:
 - Transferring feelings and wishes into imaginary scenarios;
 - Imagining oneself in more competent or grown-up roles.
- Growing interest in collections and hobbies.

Cognitive development

- Improved awareness of reality;
- Ability to think back over (*reflect upon*) and analyse experiences;
- Improved understanding of cause and effect;
- Ability to think logically can be applied to understand reality;
- Decline in egocentrism (less self-centered):
 - the child no longer thinks the world revolves around him/her;
 - child can distinguish better between subjective and objective reality.
- Development of cognitive abilities:
 - spatial and visual organization ability;
 - time orientation;
 - child can make distinctions between parts and wholes.
- Development of memory:
 - improved registration and categorization of memory contributes to mastery of academic tasks.

Development of coping mechanisms

- Application of cognitive skills to feel in control:
 - use thinking to delay acting on impulses;
 - conscious intention to stay focused on achieving goals.
- Limiting impulsive behaviour:
 - desire to receive approval of peers;
 - internalization of values, expectations, rules, and social norms (a conscience);
 - capacity to see and tolerate conflicting views.
- Psychological coping mechanisms become more effective in limiting anxiety (stress, fears).

Moral development

- Development of a conscience (*see above*);
- Cognitive understanding of reasons and norms for correct behaviour;
- Better understanding of and empathizing with others;

- Acceptance of authority and social norms supports obeying rules and expectations.

Identity Development

- Self-esteem influenced by:
 - awareness of skills and abilities;
 - status in peer group;
 - capacity for self-control (controlling impulses and behaviour);
 - ability to please oneself, not just others.
- Identification with caregivers, other adults and peers as role models;
- Increasing awareness of:
 - personal characteristics (also differences between past & present characteristics);
 - gender expectations;
 - racial and ethnic identity (negative stereotypes applied to the child).

Some facts about school-age children worldwide:

- Of school-age children in developing countries, 55% of boys and 46% of girls are enrolled in school. The gap is widest in South Asia, where 65% of boys but only 50% of girls are enrolled in school (UNICEF, 2000);
- Worldwide more than 130 million children ages six to eleven are not attending school. Nearly 60% are girls (UNICEF, 2000);
- An estimated 7 million children under the age of 14 are forced to work (South Asian Coalition on Child Servitude);
- An estimated 10-20% of children worldwide have one or more mental health or behavioral problems (WHO).

2.6 Adolescence (11 or 12 to 18 years of age)⁶



(Teenage girls, Israel)

Adolescence has often been described as a period of “storm and stress” (Hall, 1904). Although this is maybe somewhat of an exaggeration, with most adolescents going through this period without too much struggle, it is generally acknowledged that adolescence is a very sensitive period, in which

⁶ If not otherwise noted, this section is mostly derived from *The Development of Children*, chapters 16 and 17, by Michael and Sheila Cole (1989).

children experience great changes in physical, social, and psychological development. In the last transitional phase between child- and adulthood, the adolescent needs to develop more and more autonomy, a clear sense of (gender) identity, and an increased capacity to think abstractly. Reproductive maturity is reached, accompanied by significant bodily and hormonal changes. The first visible sign of the onset of puberty (the biological changes that lead to sexual maturity) is a spurt in physical growth, during which boys and girls grow at a faster rate than any time since they were babies. Almost all societies have the notion of adolescence. In most societies adolescence is marked by initiation ceremonies, or rites of passage, that are major public events (Schlegel and Barry, 1991; Delaney, 1995).

Attachment

- The need to establish trust; looking for people to have faith in and prove one's own trustworthiness to:
 - First an adolescent will seek trustworthy and admirable friends of the same sex;
 - Later the focus shifts to partners who find him/her attractive and love him/her.
- The need to establish trust extends to the bigger outside world (search for political ideologies and leaders worth supporting);
- Separation (from caregivers or friends) may have profound impacts. Signs of possible reactions are:
 - unwillingness to engage in anything;
 - lack of enthusiasm for school;
 - no hope for the future;
 - no interest in having or making friends.

Social development

- Adolescent is searching for a balance between:
 - his/her own desires and ways of doing things;
 - the expectations and requirements of caregivers;
 - the expectations of the community;
 - the rules and norms of the peer group (peer pressure).
- Greater self-knowledge through the process of mutual reflection with close friends:
 - Young people may tend to discuss their problems, feelings, fears and doubts with best friends rather than with their parents.

Language and communication

- Language becomes still more complex:
 - using more difficult concepts and words;
 - ability to understand and verbalize feelings and thoughts.
- At the same time the adolescent may often feel "misunderstood" by parents, family and friends (and he/she might even find it difficult to understand him/her self!).

Play and fantasy

- Fantasy is often close to, but at the same time very far from reality:
 - like dreaming about being the most popular girl or boy in school, or the best football player in the team, etc;
 - adolescents often fantasize about certain idols / heroes they can worship, love and adore;
 - fantasies become more and more invaded by sexual dreams and wishes.
- Play is still more ritualized and social:
 - extra-curricular activities like: sport, drama clubs, art schools, youth clubs, etc;

- play is also a way to release energy and stress;
- and play is used to express one's separate identity and interests, with like minded peers.
- Adolescents want to be taken serious, in relation to play, school, work, home chores, etc:
 - no acceptance anymore of being provided with activities by caregivers;
 - need to have an active role in deciding and shaping their own activities.

Cognitive development

- Developing more efficient strategies for solving problems;
- Increased ability to use abstract verbal concepts:
 - adolescent can understand and relate two or more abstract concepts and recognize uncertainty and contradictions.
- Increased thinking about possibilities:
 - thinking about alternative possibilities that are not immediately present to their senses.
- More systematic thinking ahead:
 - thinking about what they will do when they grow up.
- Increased thinking through hypotheses:
 - thinking that requires them to create and test theories and assumptions.
- Increased thinking about thoughts:
 - thinking about one's own thought processes becomes more complex.
- Thinking beyond conventional limits:
 - rethinking essential issues of social relations, morality, politics and religion;
 - this may also explain youth's idealism and search for heroes.

Self control

- Adolescents are often very susceptible to mood swings (one moment happy, next moment sad), because of all the psychological and biological changes:
 - This may make adolescents more prone to alcohol and drug abuse (combined with problems in identity formation and peer pressure).
- Due to their lack of self-control, accidents and (accidental) suicides are much more likely to happen to adolescents;
- Finding ways to control sexual desires:
 - Adolescents often have a high sex drive, but it is important they find ways to regulate their behaviour, to adjust it to norms and expectations of their culture, and to those of the partner(s) they may find.

Moral development

- Increased thinking, on a higher philosophical level, about what is right and what is wrong;
- Adolescents are often attracted by and pulled towards political ideologies.

Identity Development

- Identity confusion:
 - Adolescents often go through a period in which they feel lost and don't know who they are;
 - They may experiment with different gender/sexual identities to discover more about them selves;
 - It's important that they find a solution for these problems and that at the end of adolescence they have a clear sense of their own identity.
- Establishing autonomy / independence:

- An adolescent needs to choose his/her own path in life instead of just going along with decisions imposed by parents;
- The adolescent needs to take initiative, including setting goals for what he/she wants to become.

Some facts about adolescents worldwide:

- An estimated 10.4 million children currently under age 15, most of them in Africa, have lost their mothers or both their parents to AIDS; the majority of them adolescents;
- Approximately 1 out of every 10 births worldwide is to an adolescent mother- about 13 million infants each year. Every year at least 60,000 adolescents die from problems related to pregnancy and childbirth;
- In developing countries the majority of soldiers in armed conflicts are 10 to 24 years old. There are an estimated 300,000 child soldiers at any given time;
- Approximately 1 million children enter the sex trade every year;
- Worldwide some 250 million children and teenagers will eventually die as a result of their tobacco habit;
- Approximately 4 million adolescents attempt suicide each year – of these at least 100,000 are successful.

(All taken from UNICEF's Adolescence: A Time That Matters, 2002)

Chapter 3 Child Development: Problems in development

3.1 Introduction

This chapter describes many of the psychosocial problems that can occur in childhood. It is again by no means exhaustive, but it gives staff tools to observe and differentiate between kinds of problems children may face in their lives, or express in their behaviour. The choice of the different problems described in this chapter is based on the likelihood that War Child field staff may encounter children with such problems. It is again important to note that, although most of the problems described in this chapter are cross-culturally valid, there will be important differences in individual and cultural expression, and differences in how children, families and communities deal with these problems.

When we describe the different psychosocial problems that can occur in childhood, we have to look at them from the transactional, ecological perspective. Problems may have many different causes, and how these problems emerge or develop will depend on the constant interaction between biological, psychological and social processes. In many ways a rigid distinction between psychological and social problems is therefore artificial. For example, child abuse and neglect by caregivers (a social problem) can lead to serious psychological disorders, such as depression or a disruptive behaviour disorder; or a child with a mental handicap (something he or she is born with) may develop behavioural problems because of maltreatment by people in his community; or children with physical handicaps, with normal cognitive skills, end up on the street because opportunities for learning are denied to them because of their disabilities. Examples of the interconnectedness between biological, psychological and social problems are endless. One could even argue that all problems in childhood are psychosocial by definition.

Another point of concern in this regard is that there is sometimes a tendency in war-affected areas to attribute all (psychosocial) problems to the conflict (e.g. children are hyperactive because of bad experiences during the war, or children are aggressive because of the violence they saw in the war). This chapter enables War Child field staff to better differentiate between those child problems directly caused by a conflict, and problems that may be caused by other factors (although these distinctions are of course not always that clear). Neither this chapter, nor the accompanying training in child development, however, gives War Child field staff the capacity to *diagnose* children. If field staff feels there are particular concerns surrounding a child, or a group of children, concerns that cannot be addressed in regular War Child activities, they should always seek further advice from a trained child psychologist, either from within the War Child organization or from another agency (professionals from INGO's such as for example MSF may provide this assistance, or properly trained staff at national mental health facilities).

Basic knowledge of problems in child development is necessary for War Child field staff not, as said, to diagnose, but to observe and *recognize*. Staff should be able to distinguish different problems children may have, so they can provide adequate care. Not that staff need to provide such care themselves (as that will often not be possible), but by *referring* children to the appropriate facility, agency or professional(s) that can help. If such external care is not available, recognizing certain child problems is still relevant to adjust interventions as much as possible and to make sure that no harm is done to the children in question.

Build up of this chapter

There are many different ways how problems in child development can be categorized. In this chapter we will use the following distinction:

- Children with disabilities;

- Developmental disorders;
- Externalizing disorders;
- Psycho-somatic disorders (psychological disorders causing physical suffering);
- Anxiety disorders (including Post Traumatic Stress Disorder);
- Mood disorders;
- Psychotic disorders;
- Psychological problems caused by substance abuse (addiction);
- Psychological problems caused by abuse (within the family).

In the last section of this chapter we will discuss how these problems in child development relate to the situation of children growing up in war-affected areas, using the Psychosocial Problems Pyramid as a framework.

3.2 Children with disabilities

3.2.1 Introduction⁷

Disabilities are part of life, and children with disabilities can be found in every society, every culture and every community throughout the world. People with disabilities have the right to respect and support in order to ensure their full participation and equality in society.

Attitudes towards people with disabilities vary among different cultures and religions, as does the notion of what is meant by disability. In simplistic terms, a disability can be defined as a kind of impairment that makes it difficult for the person concerned to do what other people are able to do. Disabled people may have problems in learning, impaired speech, hearing or vision, or find it difficult to move about (e.g. because they are paralyzed). Some may behave strangely, or have fits or seizures.

Just how disabling a handicap may be is determined by the attitude of the surrounding community. Certain beliefs, religious notions, and lack of understanding determine people's attitudes towards disability. This applies equally to governments, institutions, NGOs, teachers, parents and, not least, ourselves. Thus, in many cultures, girls and boys with disabilities find that their human dignity is impaired: not only do they have to struggle with their own disabilities, but they also have fewer opportunities for individual development. They risk being hidden away, as though they were inferior in some way. They also risk being oppressed, abused, and exploited. In some cultures, having a disabled child may be regarded as shameful or as a punishment from God. There may even be a belief that disability can affect anyone who touches the person who has it.

In extreme situations, such as war, flight from war, or displacement, the plight of children with disabilities becomes much harder. Although the needs and rights of children with disabilities are basically the same as those of other children, in situations of conflict and displacement it becomes more difficult to ensure that these needs are met. One of the results of conflict situations is often an increase in the number of boys and girls with physical or mental handicaps.

In setting out to work to assist children with disabilities and their families, it is important to be aware of the kind of ideas and pre-conceived notions about disability that prevail in that local community and to work with respect for those attitudes (even if we do not agree with them). But the step before that is to

⁷ This introduction paragraph is mostly derived from *Disability*, by Actions for the Rights of Children (ARC), Save The Children 2001 (www.savethechildren.net/arc/).

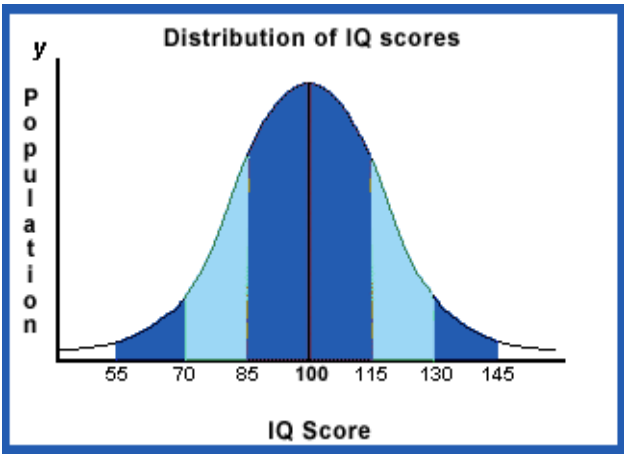
understand and acknowledge our own attitudes towards the issue of disability. We all carry round with us pre-conceived notions and attitudes which are not necessarily grounded in fact, and which we therefore need to reconsider before starting to work on these issues.

We will first describe mental handicaps (3.2.2) and then physical disabilities (3.2.3)

3.2.2 Mental handicaps

Although referred to differently through time and across cultures (e.g. mental retardation, mentally challenged, learning disabilities, stunted intellectual development, etc.), mental handicaps are commonly understood to be problems in cognitive (intelligence) development, leading to considerable gaps in the ability to function normally.

In a normal population, intelligence (as measured by so called IQ tests) is usually distributed in the following manner:



People with mental handicaps are considered those with an IQ or intelligence score below 70. The following division is usually applied:

Mild mental handicap	IQ score of between 50-70
Moderate mental handicap	IQ score of between 35-50
Severe mental handicap	IQ score below 35

People with an IQ score between 70 and 85 are not considered mentally handicapped, but it is recognized that their below average cognitive skills may lead to considerable problems in daily functioning.

Mental handicaps can be caused by genetic problems, infectious diseases contracted by the mother during pregnancy, brain damage incurred during child birth, infectious diseases contracted by the child during the first year of life or accidents that lead to brain damage (in about 20% of the cases the cause for the mental handicap is actually unknown). In any given population around 10% of the people will have some type of mental handicap. It is important to keep in mind that a mental handicap is never anybody's fault and that it is also not possible to be "cured" from a mental handicap. Most people with mental handicaps will need lifelong care and support from others.

Although a mental handicap can be clearly visible (e.g. children with Down syndrome, see picture below), this is definitely not always so. Sometimes children with a mental handicap may look completely normal. In a way this can be an extra handicap, since such a child is not easily recognized

by his environment as having a mental handicap. Parents, teachers and peers may have expectations of such a child that are not realistic, possibly causing behavioural and psychological problems. It may take considerable time before the mental handicap is discovered. This is one important reason why one should always be careful when judging why a child is behaving in a problematic way or why he or she is being depressed: the child may simply have too many demands made on him or her. Cognitive abilities may not be developed enough to enable him or her to deal with a certain situation (such as for example sitting in a regular class room).



Young girl with Down syndrome

The most common genetic chromosomal disorder is Down syndrome (1 per 600 live births). Down syndrome includes significant mental handicaps, poor muscle tone, distinctive facial and hand characteristics, and, sometimes, serious heart and gastrointestinal defects (Shonkoff & Marshall, 2000).

Not only may it sometimes be difficult to recognize that a child has a mental handicap; it is often not the only problem such a child has. Mental handicaps are often seen in combination with many of the problems that will be discussed later on (especially Autism and ADHD). This may complicate matters even more. Therefore a mental handicap is never just a gap in cognitive development; it will always affect other aspects of a child's functioning also. For example, it is very likely that a mentally handicapped child will possess lesser communication or social skills (or in general: will have fewer coping skills).

Children with mental handicaps are perceived and treated differently in different cultures. In many societies there is a certain social stigma involved: parents may be ashamed of these children and try to hide them from the outside world. Alternatively they may feel overly concerned for such a child, their desire to protect them from harm leading them to keep a child locked in the house. Because of lack of knowledge adults (and other children) may treat children with mental handicaps as if they are "lesser" beings, bullying them or, worse, abusing them physically.

It will depend on the severity of the mental handicap, as well as the support and care it receives from his social environment, in how far such a child can lead a happy, full filling life, according to its potential. Some mentally handicapped children will benefit most from the care they can receive in a special facility; others may be best off living with their families and community.

3.2.3 Physical handicaps

What follows are short descriptions of causes and forms of physical handicaps⁸.

Polio:

In many countries polio is still the most common cause of physical disability in children. In some areas, at least one out of every 100 children may have some paralysis (muscle weakness) from polio. Where vaccination programmes are effective, polio has been greatly reduced.

⁸ The descriptions of the forms of physical disability that are likely to be most prevalent in war affected countries are taken from David Werner's *"Disabled Village Children"* (1987), published by Hesperian Foundation, www.hesperian.org.

Polio is caused by a virus and the infection attacks part of the spinal cord, where it damages the nerves. In areas with poor hygiene and lack of latrines, the polio infections spread when the stool of a sick child reaches the mouth of a healthy child. Where sanitation is better, polio spreads mostly through coughing and sneezing. Only a small percentage of children become paralyzed when infected by polio. Most only get what looks like a bad cold.

The polio paralysis is not contagious after 2 weeks from when a child first gets sick with polio. In fact most polio is spread through the stool of non-paralyzed children who “only have a cold” caused by the poliovirus.

Often the paralysis will go away, partly or completely. Any paralysis left after 7 months is usually permanent. The paralysis will not get worse, but may leave the child without the capacity to walk, or an with unmovable arm, etc.

The chances of leading happy, productive lives for children with polio can be very good, provided the child is encouraged to do things for itself, for example to play with siblings, or to go to school and learn things. Intelligence is not affected by polio. Polio is not inherited and does not affect the ability to have children.

Cerebral palsy:

Cerebral Palsy means, “brain paralysis”. It is a disability that affects mostly movements and body position. It comes from brain damage that happened before the baby was born, at birth, or as a baby. The whole brain is not damaged, only parts of it, mainly the parts that control movements. Once damaged, the affected parts of the brain do not recover, or get worse. However the movements, body positions and related problems can be improved or made worse depending on how the child is treated and how damaged his or her brain is.

Causes before birth include:

- Infections contracted by the mother during pregnancy, e.g. German measles;
- Difference between the blood of the mother and the child (Rh incompatibility);
- Mother has diabetes or toxemia during pregnancy;
- Inherited (very rare);
- No causes can be found in 30% of children with polio.

Causes at the time of birth include:

- Lack of oxygen;
- Birth injuries;
- Pre-maturity - babies that are born early.

Causes after birth include:

- High fever due to infection or water loss from diarrhea;
- Brain infections (meningitis);
- There are many other causes including malaria and tuberculosis.

Cerebral Palsy is not contagious - it cannot be passed from one child to another. Cerebral palsy does not affect intelligence. The possibilities for these children to lead normal, happy lives will depend on the severity of the handicap and the support of their environment.

Spina Bifida:

Spina Bifida is a defect that comes from a problem in the very early development of the unborn child. It happens when some of the backbones do not close over the centre tube of nerves. As a result a soft unprotected area is left, which may bulge through the skin as a dark bag. The future of a child with spina bifida depends on how serious the defect is, the medical care available, and the level of family and community support. A child with a defect that is low down on the back usually has less paralysis and has a good chance of living a full and happy life.

Spinal cord injury:

This results from an accident that breaks or severely damages the central nerve cord in the neck or the back, e.g. falls from trees or animals, car accidents, diving accidents, bullet wounds. How much of the body is affected depends on the level of the injury along the backbone. The higher the injury is the greater the area of the body that is affected.

When the spinal cord is damaged so completely that no nerve messages get through, the injury is said to be complete. Feeling and controlled movement below the level of the injury are permanently lost. If the injury is "incomplete" some feeling and movement may remain, or feeling and controlled movement may return little by little during the course of several months. In incomplete injuries, one side may have less feeling and movement than the other. A person with complete spinal cord injury in the neck has no chance of walking. He or she will need a wheelchair.

Fits (Epilepsy)

Fits are sudden usually brief, periods of unconsciousness or changes in mental state, often with strange jerking movements. One out of every 10 to 20 children has at least one fit by the age of 15. But only one in 50 of these children go on to have chronic fits - a condition known as epilepsy. Fits come from damage to, or an abnormal condition of the brain. It is usually caused by injury to the brain. Injuries may be before birth, during birth or at any time after. The same causes of brain damage that result in cerebral palsy can cause epilepsy. In fact, cerebral palsy and epilepsy often occur together. Meningitis (an infection of the brain) is a common cause of this combination. In small children common causes of fits are high fever or severe dehydration. Causes can also be hereditary. Approximately 1/3 of those who suffer from fits have a family history of the condition, while for some 1/3 of those with epilepsy the actual causes are unknown.

A fit can begin by things like a sudden fear or cry of the child. The child should be protected by lying it down on a soft mat or other place where it cannot hurt herself. When a big fit starts the child should not be moved, unless it is in a dangerous place. It should be protected against injury, but no force should be applied to control the child's movements. Sharp or hard objects near the child should be removed. No things should be put in the child's mouth while it is having a fit - no food, drink, medicine, nor any object to prevent the child from biting its tongue. Between spasms, the child's head should be turned to one side so that saliva can drain out of the mouth and to ensure that the child does not breath fluid into the lungs. After the fit is over, the child may be very sleepy and confused. It should be left to sleep.

Blindness and difficulty seeing:

Difficulty in seeing can be mild, moderate, or severe. When a person sees very little or nothing we say he/she is blind. Some children are completely blind; they cannot see anything. However, most children can see a little. Some can only see the difference between light and dark, but cannot see any shapes. Others can see shapes of large objects, but none of the details.

Some children with cerebral palsy or other disabilities are also partially or completely blind. Parents may not realize this and think the child is slow in its development, when in fact blindness may be the major cause. Even if a child has no other disability, blindness can make development of early skills slower and more difficult. If a child does not look at, reach for, or take an interest in things around, one should check if it can see and hear properly.

Common causes for blindness include:

- “Dry eyes” especially common in parts of Africa and Asia. It results when a child does not get enough Vitamin A (naturally in fruits, vegetables, milk, and meats). Dry eyes develop in children who are not regularly fed and it often appears or quickly gets worse when the child gets diarrhea or has measles, whooping cough or tuberculosis. It is much more common in children who are not breast-fed;
- Trachoma is the most common cause of preventable blindness in the world. It often begins in childhood and may last for months or years. If not treated early, it can cause blindness. It is spread by touch or flies and is most common in poor and crowded living conditions. It can be prevented by keeping the eyes clean and keeping flies away;
- River blindness is a very common cause of blindness in parts of Africa and Latin America. It is spread by a kind of black fly that breeds in rivers and streams;
- Measles, which can injure the surface of the eyes. Especially common in Africa and in children who are poorly nourished;
- Brain damage causes blindness in many children, usually in combination with other disabilities, e.g. cerebral palsy.

Deafness:

A few children are completely deaf, but most children with hearing problems can still hear some things. Parents often notice that their child cannot hear, because the child does not turn its head or respond even to loud sounds. Some children who are partially deaf hear a little when people speak to them. They may slowly learn to recognize and respond to some words, but many words they do not hear clearly enough to understand. They are slow to begin to speak. Often they do not speak clearly, mix certain sounds, or seem to “talk through their nose”. Unfortunately sometimes parents, other children and teachers do not realize that the child has difficulty in hearing. They may treat the child as if it is mentally slow or “dumb”. This only increases the child’s problem. For a child with hearing loss the biggest problem is learning to communicate; because it cannot hear the words clearly it is much more difficult to learn to speak.

Common causes before birth include:

- Hereditary - in certain families although the parents may not be deaf. Usually the child has no other disability and learns quickly;
- Measles during early pregnancy.

Common causes after birth:

- Ear infections especially long lasting repeated ear infections with pus present;
- Meningitis.

3.3 Developmental disorders

There are several so-called developmental disorders. We will describe the two most common.

3.3.1 Autism

There are different types of autism, some milder in their symptoms. Problems in making contact are the common feature for all of these types. It is important to realize that, although there are autistic people with normal cognitive development, the vast majority also has a mental handicap.

Autism is a well known (at least in the West), but very rare disorder. It occurs in approximately fifteen out of every 10,000 births and is four times more common in boys than in girls. Autism is first and foremost a contact disorder. Children with autism make little, real contact with others in their social environment. If they do make contact it is often very bizarre, or at least not like any other normal form of contact.

Some important features of autism include:

- It starts before the child is 30 months old. This means that signs of autism are already clearly noticeable when the child is still a baby; these signs include a delayed development in following the movements of other people's heads, or lack of interest in listening to the voice of other people. Autistic children also don't seek attention from their parents as normal babies do;
- There is a pervasive, enduring lack of responsiveness to other people (hence it is a contact disorder). Autistic children seem to live in a world of their own. Examples of this are: lack of eye contact, treating other people as if they were inanimate objects and a dislike of being touched;
- There are significant gaps in language development. Speech (if present at all) is very strange. Examples include "echolalia" (a constant repeating of the same word or sound the child has heard) or mixing up the words "I" and "You";
- There is a bizarre response to various aspects of the environment. Examples of this are a strong resistance to change (an autistic child can go completely crazy if the daily routine is broken), or a peculiar interest in certain items (many autistic children can for example gaze for hours at a clock). Very recognizable is also the "rocking" movement that many autistic children make. They bow their upper body repeatedly while flapping their hands for long periods at a time. Another often observed behaviour is repeating the same action for a very long period of time (like for instance spinning a top for hours in a row).

Since autism is such a rare disorder, it may remain under-diagnosed. Especially in non-western countries where knowledge about the disorder is often lacking, a lot of children who are called "mentally sick" may actually suffer from an autistic disorder.

It is still unclear what causes autism, but most likely it has a biological origin. There is no standard, universally accepted treatment of autism. In fact there is still a lot of controversy over whether autism is treatable at all. What is known however, is that these children are happier and showing less problematic behaviour, if they are in a safe, structured environment. Lack of perceived safety and sudden changes in routines often have a very detrimental effect on these children.

3.3.2 Language/speech disorders:

Language is the ability to understand and produce complex symbols that have a certain meaning within a social context. Speech, the ability to produce meaningful sounds, is one of the expressive forms of language. Besides that there is written, gesture/sign and inner language. Every normal child is born with language capacity, but without exposure to a language model in a social context, this

cannot develop to real language use. Language development also depends on the biological maturing of the brain.

When the level of language development is relatively low in comparison with the non-verbal intelligence, and when the language problems interfere with learning or social functioning, we speak of a language disorder. Besides delayed and slow learning of language, children with a language disorder show the following symptoms:

- Limited vocabulary;
- Makes many grammatical mistakes;
- Speaking in short, often incomplete sentences and lack of understanding of long, complex sentences;
- Problems in using language in the social context (problems in starting and keeping up conversations).

A speech disorder can take the following forms:

- the incomplete use of certain speech sounds that would be adequate for the age and dialect of the child;
- stuttering (repeating sounds, pauses in a word, etc.).

To what extent children in a certain population are likely to have a language/speech disorder is not known. Genetic influences are most probably a risk factor that, in combination with environmental circumstances, can lead to problems in language development.

It is important to differentiate between language/speech disorders and other problems in language development. For example: deaf children, children with a mental handicap, or autistic children, will also often have a delayed or slow language development.

How much a language/speech disorder will affect the life of a child will again depend greatly on the support and understanding it will receive from the environment. However, since language is such an important component of human relationships, it is clear that children with such disorders may often develop serious psychosocial problems as a consequence.

3.4 Externalizing disorders

These are disorders in which the main feature is the disruptive behaviour of the child.

3.4.1 Attention Deficit with Hyperactivity Disorder (ADHD)

Attention Deficit with Hyperactivity Disorder (ADHD) is a disorder that affects approximately 3-5 % of all children (although in America some specialists put this figure as high as 15%). The disorder is most recognizable by its main features: severe problems in concentration and an extremely high level of energetic behaviour (children with this disorder are often described as having an internal, unstoppable little motor).

The most important signs or symptoms are:

- Inattention (the child cannot finish anything it starts, is easily distracted, cannot concentrate);
- Impulsivity (the child acts before thinking, jumps from one activity to another);
- Hyperactivity (the child runs about, climbs on things, cannot sit still, is always on the go).

The causes for this disorder are still unknown, although it seems more and more likely that they are of a genetic-biological nature. This means that a child with ADHD is born with it; it is not something that a

child can “catch” later on in life. It also means that ADHD cannot be cured, but the symptoms of ADHD tend to become less severe in adulthood. It is a disorder that affects boys more than girls: boys are diagnosed with it three times more than girls.

Despite the fact that ADHD cannot be cured, some drugs have a proven positive effect on the behaviour of these children. These medicines are however rarely available in non-western countries.

As is the case with mental handicaps, ADHD may often not be recognized as such. Caregivers and peers may be very annoyed by the uncontrollable behaviour of these children. Parents may inflict heavy (corporal) punishments, and in time may become more and more despairing of how to deal with the child. Teachers may similarly be very negative towards such a child, since they consider their behaviour to be rude and aggressive. Peers may turn away because they are afraid of them, thus isolating the child socially. This in a way is even more tragic, since all these negative reactions may only serve to aggravate the problematic behaviour of a child with ADHD. Harsh punishment by parents and caregivers may decrease the self-esteem of these children still further, increasing their sense of lack of control. Given these –often- sad pedagogic conditions, it should come as no surprise that a large percentage of people in criminal institutions are diagnosed with ADHD. There is a big risk for children with ADHD to end up in a down-ward spiral, eventually becoming criminal, anti-social elements.

Children with ADHD are usually of normal intelligence, but as mentioned above, many children with mental handicaps might also show symptoms of ADHD.

Besides giving them medication, it is known that children with ADHD thrive best in an environment with a very clear, predictable structure and few distractions. The provision of such an environment often leads to significant improvements in their ability to concentrate and to control their impulses. It can easily be imagined how this is difficult to achieve in a classroom situation, with about thirty or forty children, screaming and running about. Therefore these children are usually better off in smaller educational settings. If this is not possible, setting them close to the teacher may improve things. Other ways of improving the situation for them in a class-room (or another setting with many other children):

- give them one task at a time;
- break their work up in smaller parts and check their work more often (positively of course!);
- give them opportunities for permitted moving (like asking them to clean the table, bring the chalk, etc.);
- give them shorter tasks and some reward afterwards (for example: if the child has worked well for 20 minutes he can have a little walk);
- teach them how to think first and then do things;
- stress the child’s positive qualities and achievements;
- adjust expectations to the child’s good and bad days;
- upon losing your temper, apologize to the child and explain why it happened (Mikus Kos, 2005).

It’s important that parents and other caregivers are informed about the nature of their child’s problems (if a diagnosis indeed shows that it is ADHD). Often it’s difficult for parents to understand that their child’s behaviour is not because the child wants to be bad, but that it simply has a problem in regulating his behaviour, something the child cannot help. The same kind of advice as above can be given to the parents. This, together with bringing in to the home situation more structure and predictability to the home situation, will often improve the behaviour of these children considerably.

That in turn can change parents' perceptions and feelings towards their child, creating a positive transformation of the family relationships.

3.4.2 Disruptive Behaviour Disorders

Like other psychological disorders the emergence and continuation of behavioral disorders can be best understood from the interplay between biological, psychological and social factors (Hill, 2002).

Some of the symptoms include:

- the child is often angry;
- the child often fights with grown ups;
- the child often refuses to do what he or she is told by adults;
- the child often annoys others on purpose;
- the child is often hateful and vindictive.

In any given population 2 to 3 percent of children will display a disruptive behavior disorder. There are some risk factors for the development of this disorder, such as low verbal intelligence, ADHD, and child abuse. Again: it is the interplay with environmental risk factors that can lead to such a disorder. Any form of treatment will need to take into account the exact factors in the child and his or her environment that are causing and sustaining the disorder.

3.5 Psycho-somatic disorders (psychological disorders causing physical suffering)

These are disorders in which the child experiences physical suffering (such as stomach aches, head aches, etc.), while there is no evidence of a physical, medical problem. The prevalence of such disorders is not known, but it may be as high as 10% in a "normal" population. The causes are also not really known yet, but genetic factors, a high level of experienced stress and inadequate coping mechanisms seem to play an important role. In war-affected countries it is sometimes reported that children and adults have more psycho-somatic complaints.

3.5.1 Anorexia and bulimia nervosa

Two of the most well known psycho-somatic disorders are *Anorexia and bulimia nervosa*. These are typical disorders of adolescence and mostly affect girls (90 to 95 % of patients are girls). Anorexia nervosa is marked by extreme weight loss and a very disturbed eating pattern. Girls who are affected will often have fasting periods, alternated by periods in which they eat a lot, after which they will make them selves vomit. This is all accompanied by an intense fear of becoming fat and a distorted body image. Bulimia nervosa usually starts in the second half of adolescence, sometimes after a history of anorexia. This is mostly marked by intense eating binges (the adolescent will be stuffing her self with large quantities of food). Both eating disorders are very serious (especially anorexia nervosa) and often chronic. These disorders affect probably 1 to 2 % of adolescent girls (although in western countries there is a feeling that these numbers are rising). There is not one known cause for these eating disorders, but social, neurobiological, and genetic mechanisms all seem to play a part. Some say that all of the advertisements with beautiful, skinny models, which we see in many (western) media today, have a negative effect on girls because they try to copy these models. There are various treatments for these disorders, but the success rate is generally not that high. Up to 10 % of anorexia patients may eventually die as a consequence of their extreme weight loss.

3.6 Anxiety disorders

There are several anxiety disorders; all have fear and higher states of arousal as marking signs.

- Separation anxiety disorder: children with this disorder experience intense fear when separated from primary caregivers, or have an intense fear that such a separation will take place; causes include insecure attachment (see Chapter 1, paragraph 1.5.1);

- Generalized anxiety disorder: child is extremely afraid and worried about certain events or activities (like for example school);
- Specific phobias: children have an irrational fear that persists even after the source of potential danger is gone; this can be a fear for certain animals, such as spiders, a fear of natural elements, such as water, a fear of blood/injections/wounds or a fear of a specific situation (such as being in a bus, flying, or being in closed spaces);
- Social phobia: a child with social phobia has a persistent fear of social situations and therefore tends to avoid such situations;
- Obsessive compulsive disorder: the child has reoccurring thoughts and acts that the child experiences as intrusive and not of his own, such as for example having to make the same movement again and again; the child cannot resist these urges and they bother him or her in daily functioning.

3.6.1 Post Traumatic Stress Disorder

In the War Child context the most relevant anxiety disorder (or at least the one we hear most about) is *Post Traumatic Stress Disorder (PTSD)*. PTSD can occur after a traumatic experience, an experience which the child has been a witness to, or in which s/he was confronted by a situation that has or could have led to the death or severe wounding of the child or others. Reactions of the child during this experience included intense fear, helplessness or horror.

Symptoms of PTSD include:

- Reliving of traumatic experiences (e.g. memories, nightmares);
- Avoiding stimuli related to traumatic experiences (e.g. avoiding talking about it, avoiding certain situations);
- Heightened state of agitation (e.g. difficulty sleeping, concentration problems).

Which and how many children will develop PTSD after one or more traumatic experiences is not known. Different studies carried out in different places reveal very different outcomes, although in general the occurrence of PTSD seems to be quite low.

Factors that seem to influence someone developing PTSD are:

- the severity of the experience (how life threatening it was);
- the proximity of a person to the traumatic experience (the closer a person was to the event, the more likely PTSD is to develop);
- the duration and frequency of traumatic experiences increases the seriousness of the symptoms;
- life experiences after the traumatic experience (such as for example moving to an IDP camp after a village was bombed) may affect the development of PTSD.
- some other risk factors for the development of PTSD are insecure attachment relationships and already existing psychological problems of parents.

It is important to realize that many of the psychological reactions that individuals have to a traumatic experience can be seen as normal reactions to an abnormal situation. These reactions can even have an important function in the process of coping with the experience. Only if the problems are very severe, causing intense psychological suffering, or when the problems persist (for longer than 6 to 8 months), one should be worried that a child may have developed PTSD.

An effective treatment for PTSD is not yet clearly developed. Although Eye Movement Desensitization and Reprocessing (EMDR) seems to be quite effective for adults, the results that this method has on children are not really known. How the disorder progresses will again depend a lot on the care,

understanding and support a child can receive from its direct environment. In general symptoms of PTSD tend to diminish after one to three years.

3.7 Mood disorders

For a long time it was thought that children don't suffer from mood disorders like depression, but nowadays child professionals are convinced that children can also be afflicted by these disorders. From research it is estimated that 2-5% of younger children and 10-20% of adolescents in a "normal" population at one time or another go through a mood disorder.

There are three forms of mood disorders:

- Depression. Symptoms include: depressive mood during most of the day, almost every day, as is expressed in subjective remarks –child says s/he feels sad or empty-, or as is observed by others –child looks sad-; in children depressive mood can also be expressed by an agitated state; clear loss of interest and pleasure in almost all activities; clear loss of weight without dieting; sleeping problems; loss of energy; less capacity to concentrate; thoughts about dying or suicide;
- Bipolar disorder. Symptoms include: alternation between manic and depressive states. In the manic state a child is hyperactive, talks a lot, feels fantastic, etc; in the depressed state symptoms are the same as the ones mentioned under depression;
- Suicidal thoughts, suicide attempts and suicide (these are usually caused by depression).

Mood disorders are very complex. Genetic, biological, psychological, and social factors all play a role. None of these factors can be said to be the most important. Therefore medication, psychotherapy, psycho-education and interventions in the social environment, are all important in the treatment of mood disorders in children and youth. The first step in any treatment of depression is giving information to the patient, their family, and other caregivers (like teachers) about what depression is.

3.8 Psychotic disorders

The most important psychotic disorder is *schizophrenia*. This is probably the most serious and debilitating psychiatric disorder that exists. It is very rare in childhood, but sometimes signs of an emerging schizophrenia can be seen earlier, especially in adolescence.

Symptoms of schizophrenia include:

- Delusions;
- Hallucinations;
- Disorganized speech (e.g. losing track, incoherent);
- Very chaotic behavior;
- Negative symptoms, like lack of expression, not talking anymore, apathy.

Some 0.5 to 1 % of the population (in Western countries) suffer from schizophrenia. The average age of onset is 19. A complex interplay of biological, psychological and social factors lead to the disorder. It is clear that one has to have a genetic predisposition to be susceptible to the disease (if one of the parents has the disorder there is a 10% chance that the child will develop it too). Stress factors will however determine in how far schizophrenia will affect an individual who has a genetic predisposition (a traumatic experience or drug abuse may for example set off the disorder). When enough protective factors are in place, such as good family circumstances, a good social support structure, and good coping mechanisms, the disorder may not develop in a genetically predisposed child.

Treatment of schizophrenia is difficult, but will always have to include certain medication. Around 30% of patients receiving treatment will be able to lead normal lives; around 30% will show improvement

because of treatment; around 40% will show no improvement at all and will need life long, institutional care. There is a high risk for suicide attempts by patients with schizophrenia/psychotic disorders.

3.9 Psychological problems caused by substance abuse (addiction)

Adolescence is the phase in child development where children start to separate from their parents and develop their own personality. Experimenting (with their appearance, their sexuality, and certain substances) and orientating on peers are part of growing up. There is no harm in this, but there are risks.

The road to substance abuse (alcohol, drugs) usually follows the following pattern:

1. Experimenting (to see what are the effects of a certain substance);
2. Regular recreational use (child starts using the substance as a means to escape and for comfort; tolerance to the substance is built up, school results drop and the child distances him- or herself from friends that don't use, etc);
3. Abuse (the substance has become the central part in a child's life; social life has become dysfunctional, the child gets in trouble with justice and police and physical endangering situations occur. Children who begin using substances at the age of 11 or 12 are at particular risk of ending up in the abuse phase);
4. Dependence and compulsory use (the child has developed a considerable tolerance to the substance, has no control anymore about how much they use and cannot stop using; if the child does not receive outside help, s/he may never be able to overcome the addiction).

Although the above are the usual steps leading up to a full-blown addiction, the process can be quite different for children in war-affected areas. For example, commanders or fellow child soldiers often first introduce child soldiers to drugs. They may be told that the drugs make them invulnerable. And street children often start sniffing glue to overcome their hunger and to forget about their daily worries. An increase in drug and alcohol abuse amongst children and youth is often reported in war-affected areas.

Depending on the drugs, substance use will lead to changes in mood (e.g. depression or euphoria), thought (e.g. disturbed concentration and psychosis) and behavior (e.g. loss of control, apathy or a heightened state of alertness). Why and how children become addicted will depend on many factors, such as the availability of certain drugs, peer group pressure, family circumstances, and social situations. Also a certain genetic predisposition can play a role (e.g. alcoholism sometimes runs in families). Treatment of addicted children is a complex undertaking, which requires a concerted effort by all of the agencies and social support networks involved. Measures, such as awareness-raising on the dangers of alcohol and drug abuse in schools and communities, can possibly serve an important function in the prevention of substance abuse.

3.10 Psychological problems caused by abuse (within the family)

The family environment is for most children, especially younger children, the most important mediating factor in development. Risks and problems in this environment can lead to serious psychological disturbances.

The most serious problem is child abuse, which can take different forms:

- Physical abuse;
- Psychological abuse (caregivers constantly humiliate, bully, frighten the child);
- Physical neglect (caregivers withhold the child of necessary care, e.g. food, sleep, medicines, etc);

- Psychological neglect (caregivers withhold from the child what is necessary for mental health, such as attention, respect, safety, warmth, love, etc);
- Sexual abuse.

Child abuse is often a consequence of a too big difference between the pedagogic competencies of the caregivers and the problems of the child for whom they are caring. This means that parents with little pedagogic competencies may resort to child abuse even if the problems of a child are limited, whilst competent parents will only resort to abuse if a child is very problematic. There is a higher risk of lack of pedagogic competency in parents who are very young, parents who have been abused themselves as children, mentally handicapped parents, parents addicted to alcohol or drugs, and parents with psychological disorders or limited cognitive skills. How much child abuse takes place in families is difficult to detect and will differ per situation. In war-affected areas it is often reported that child abuse has increased after the conflict. This may have to do with the fact that many parents are “over stretched” and cannot cope with the needs and demands of their children.

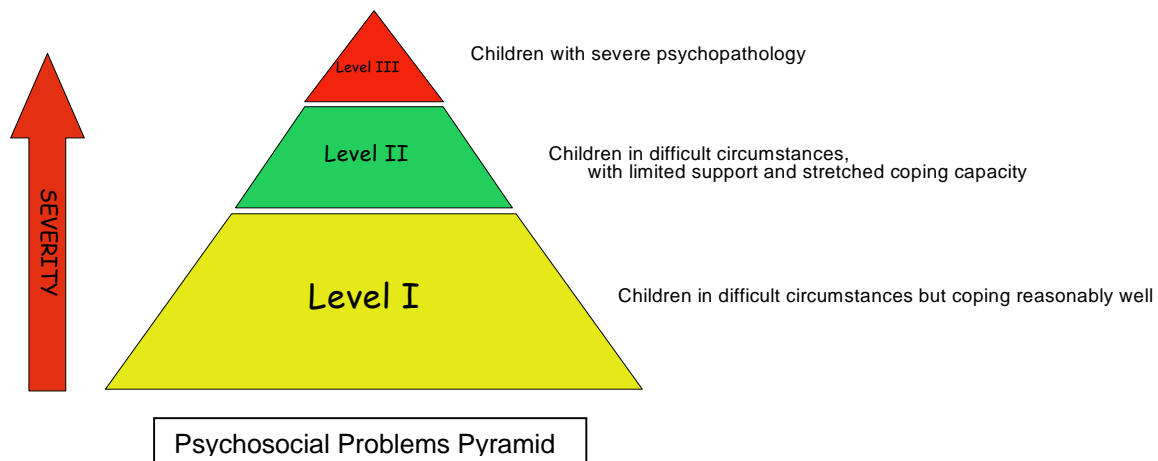
Child abuse can have immediate effects (in the most serious cases: death) and long-term consequences. This will depend on the kind of abuse. Physical abuse for instance can lead to aggressive or self-destructive behavior and depression. Psychological abuse can also lead to aggressive behavior later on, and to a lack of development of empathy. Physical neglect increases the risk of an early death or neurological disturbances. Serious psychological neglect, especially in the early years, can lead to problems in the capacity to form attachments. Behavioral problems and depression are also associated with this form of abuse. Sexual abuse can of course have many physical consequences, including pregnancy, genital injuries and STD's⁹. Besides these, sleep disturbances and changes in eating patterns are common, as are emotional reactions (fear, anger, guilt). In the long-run sexual abuse can lead to anxiety disorders, depression, eating disorders, psycho-somatic disorders and substance abuse. It should however be noted that not all sexually abused children develop psychological problems. A lot will again depend on the care, support, and understanding they receive from the social environment after the abuse has taken place.

3.11 The Psychosocial Problems Pyramid

As can be seen in the previous paragraphs, there are many problems that can occur in childhood. There is tendency to explain all of the problems that children have in war-affected areas as a consequence of conflict. Although problems can be caused directly or indirectly by a conflict, this is by no means always the case. In fact it is very likely that many problems blocking healthy child development in war-affected areas could also occur in a “normal” environment. Many of these problems have a genetic-biological origin. Also, some familial and community environments contain a high level of risk factors, unrelated to war. War and its aftermath will however often increase the risks for children from these already vulnerable groups.

⁹ STD's: Sexually Transmitted Diseases

The psychosocial problems of children living in a war-affected area can be visualized as follows¹⁰:



Level I: The broadest segment of the population consists of individuals who may have been less directly affected by the crisis and whose families and community support structures are still largely intact. Children and adults in this group face many problems (destroyed houses, lack of access to education, lack of time and space for play, dangerous environments, e.g. mines, etc), but most of the reactions that children may display can be considered “normal” in an abnormal, (post-)conflict situation (such as sleeping problems, aggressive behaviour, withdrawn behaviour, anxiety, etc). When given adequate attention and support, these reactions will disappear for the majority of this group over time.

Level II: A second segment of a community consists of children from vulnerable groups that possess limited coping mechanisms or social support structures to fall back on. It can be for example children with physical and mental handicaps, or children that have milder psychological problems. Or these are children who have lost family members in the violence, witnessed deaths, or have become victims of violence. Children from this level are significantly distressed, and may be experiencing despair and hopelessness, but their social and psychological ability to function has not yet been overwhelmed. This group is at particular risk of psychological and social deterioration if their needs are not addressed through timely community and social support mechanisms.

Level III: In any given population, a small percentage of people will require professional mental health care. In a conflict setting, this number may be higher as the psychological and social functioning of some children and adults may be severely compromised. This is a small group, generally estimated to be ten percent or less of the overall population. Children who were having psychological problems or disorders prior to the conflict, and those who were forced to view, experience, or commit extremely violent acts are likely to fall into this category. For this group, more time-intensive, individualized approaches are likely to be the most appropriate responses, where social and cultural resources permit. For the children who require this more specialized care, one-on-one attention can sometimes be provided in the form of traditional rituals or other local cultural practices, and should not be limited to Western-derived responses such as psychological counseling.

¹⁰ The Psychosocial Problems Pyramid is based on Arntsen & Knudsen (2004). It's good to note that this kind of pyramid could more-or-less apply to any given population, war-affected or not war-affected. Depending on the situation, the number of people in level I and II will differ, but usually the number of people with severe psychopathology (level III) will be very small.

War Child's preventative programmes create psychosocial support for children with level I and level II problems. The aim is to support the healthy development of children by improving their situation, and to prevent children from level I slipping to level II, and children from level II slipping to level III. Our interventions are however not suited for, or aimed at supporting children with problems at level III. This is not to say that these children don't deserve adequate support, but War Child is simply not capable of providing such support. Specialized psychiatric care is a very complicated, cost and time consuming matter; it is therefore no wonder that this kind of care is hardly ever available in the poorer countries of the world. However, the fact that we cannot provide adequate care for children from level III does not exempt War Child from the responsibility to do the best it can, should children with such severe problems be encountered. As was mentioned in paragraph 3.1, it is therefore very important for War Child staff to be able to *recognize* that children have problems, and -when needed- to *refer* children to people, facilities and organizations that can help. For that reason every programme should have a very elaborate "social map" that entails an area overview and referral contacts of all the persons and organizations involved in childcare. If specialized care is not available, recognizing certain child problems is still relevant so as to be able to adjust interventions as much as possible, and to make sure no harm is done to the children in question.

Besides recognizing problems it's important to determine their causes. Any preventative psychosocial program that wants to help children in war-affected areas adequately and effectively has to start from the knowledge of what is causing the children's problems and the specific risks facing them.

An example: a child may be showing problems in concentration and very hyperactive behaviour. If we assume that this is caused by the fact that he has witnessed horrible things during a conflict, or because in his current home situation there is little attention from his parents, the way to help him would be very different than if the cause is ADHD. In the first case a War Child intervention may be effective in reducing his problematic behaviour, or maybe the child just needs somebody he can talk to. But if the cause is actually ADHD such interventions won't really help. A much more elaborate and intensive strategy to reduce the problematic behaviour would need to be developed, including the school, a doctor and parents and family in the approach, and -if possible- the prescription of medicine to the child.

Another example: a girl is very withdrawn in the class or creative workshop situation. People say she was not like that before the war and that it must be because of what happened to her and her family. Although she seems to enjoy the War Child activity her behaviour does not really improve. It could well be that this girl is not "traumatized" but that she actually has some form of mental handicap, or maybe some kind of problem in hearing or sight. She therefore finds it harder and harder to understand the instructions of adults. Her withdrawn behaviour is merely an expression of her frustration. An intervention for this girl would need to be much broader and far reaching than for instance the War Child workshop method.

The above are just examples, but one can easily think of more situations where problems of children in a war-affected area could be wrongfully explained by the fact that they are growing up in such a place. Again, it's not up to War Child field staff to diagnose children, but awareness of the possible causes of problematic behaviour is necessary if we want to provide adequate and effective care.

Some things should therefore be kept in mind whenever we plan programmes, or when we work with children directly:

- The most vulnerable children prior to a conflict are also the children likely to suffer most from that conflict. These are usually the children who already had problems, such as mental

handicaps, psychological disorders and physical handicaps. But it also includes those children who were in risky environments to begin with, such as children with a parent with a psychological disorder, or children from a poor background, etc. Interventions should not separate these children, but we should always make sure that our interventions *include* them in one way or another. A focus on strengthening specific protective factors for these children (for example, care from family, community or authorities; or (special needs) education) may be in order to ensure that the rights and needs of these children are met;

- Psychosocial problems of children may have many different causes. It's often very difficult to link one exact cause to one effect. This complicated nature of children's problems in development make a careful analysis of all risks and protective factors influencing children and their environment even more of a necessity (what this could or maybe should mean in practice will be described in chapter 5). There is often overlap and similarities in the symptoms of the different psychosocial problems children may have. This can make it very complicated to determine what the "main" problem is, the problem that would need most attention for things to improve. For example, symptoms of schizophrenia can easily be confused with symptoms of drug abuse, or a deaf child who is withdrawn because he does not understand what is happening, may be mistakenly seen as mentally handicapped, or the sleep problems associated with PTSD could distract from the real problem that might be depression, etc. What complicates things even more is the fact that having one problem makes children more at risk of developing other problems too.

Chapter 4 Child Development: Risks and protective factors in war-affected areas

4.1 Introduction

Children growing up in war-affected areas will very often show remarkable resilience and may well develop according to their potential. At the same time it has to be acknowledged that growing up in conflict poses particular threats to healthy development. In this chapter we will explore the specific risk factors to child development in war-affected areas. In the second part we will discuss protective factors, which -to a certain extent- can counter-act the negative impact war can have on children's development.

4.2 Risk factors in war affected areas¹¹

4.2.1 General notions on risks of children in war affected areas

Risk factors facing children in war-affected areas may often be similar to risks experienced by certain vulnerable (groups of) children growing up in other, non war-affected environments (for an overview of possible risk factors see Chapter 1, paragraph 1.6.3.). But in addition to these there are risk factors that are quite profound in war-affected areas and often afflict many children living in such circumstances.

Throughout this section, it is important to remember that child-rearing practices vary a great deal between different cultures. Much of the research on risks to healthy child development (separation and loss for example) has taken place in western societies and cannot simply be transferred to other cultural settings. Therefore it is important, within any particular context, to examine how children have reacted to the situation facing them. This requires a careful assessment that directly accesses the views, wishes, and feelings of the people involved: the children, their caregivers, community leaders, teachers, etc.

Children living in war affected areas risk experiencing a number of threats to their development and well-being. These typically involve intense fear, witnessing and perhaps experiencing brutal violence at close quarters, witnessing the destruction of property (possibly including their own homes), and the necessity of fleeing in panic. Children living in a situation of more prolonged conflict may have to face the constant anxiety of fighting or bombing intruding into their lives, and coping with the presence of land-mines or unexploded ordnances. Many of these experiences can have both immediate and longer-term effects on children's development and well-being.

The immediate effects of such events on children depend particularly on:

- the meaning of the event for the child (and his/her family) and, most importantly, whether the event caused the loss of one or both of his/her parents or caregivers;
- the stage of development of the individual child;
- the personal characteristics of the child;
- the presence or absence of supportive adults, particularly familiar caregivers;
- whether the child was personally involved either as a victim or perpetrator.

Longer-term developmental effects may depend on factors such as:

- how those in the child's immediate environment react to the changed behavior, appearance, or social status of the child;

¹¹ This section is mostly derived from *Child and Adolescent Development*, by Actions for the Rights of Children (ARC), Save The Children 2001 (www.savethechildren.net/arc/).

- the degree to which highly significant losses can be replaced;
- the degree to which further traumatic experiences can be avoided;
- the extent and quality of assistance which the child and family receive;
- the extent to which the events have changed the child's "life-plan" (his or her anticipated life course covering such things as where he or she lives, type of life-style, expectations for the future. For example, institutionalization following the loss of parents or caregivers).

Young children (1-6 years of age) who have had frightening and confusing experiences may regress, which means that they lose (usually temporarily) developmental gains such as speech or control of bladder and bowel. Disturbances in sleep and eating habits are also common. These kinds of reactions may be compounded in situations where the parents or other caregivers become depressed or anxious and may have less energy for and interest in the child. Where traumatic experiences are compounded by the loss of parents or other caregivers, or separation from them, reactions and distress may be greatly magnified (see paragraph 4.2.2. below). The apparent loss of capacity to play is sometimes observed, or children become preoccupied with themes of violence, death etc. in their play and drawing.

The developmental effects of living in violent circumstances and experiencing frightening events on *school age children (6-12 years of age)* usually have to do with their capacity to form relationships, and to learn. The capacity and will to form relationships can be disturbed by experiences which destroy trust and which create fear and suspicion in others. This is especially significant where children lose people close to them, whether through death or separation. Children can become depressed and hence unable to mobilize interest in learning. Children who become withdrawn can easily be overlooked in the classroom, especially if there are many children. Others may retain their will to learn but be troubled by flashbacks (sudden intrusive images of a traumatic experience that can disturb concentration and motivation). Other symptoms include an increase in aggression and various physiological complaints such as headaches, loss of appetite and energy, mood changes, and other signs of anxiety. Older children may also display a sense of guilt that they have survived when others have not.

During the *adolescent period (12-18 years of age)*, exposure to violent and frightening experiences can have a particularly profound effect. The adolescent's capacity for learning and for forming relationships can become disturbed. In some cases, faced perhaps with the loss of educational opportunities and a disturbed developmental life-course, many adolescents may come to sense a lack of meaning in life and future perspectives. Young people of this age can experience many of the symptoms that may affect younger children: extreme fear and anxiety may cause a delay in the onset of puberty (the biological growth spurt that marks the beginning of adolescence). Criminal activity with peers, drug and substance abuse and other forms of anti-social behavior may represent a form of meaning, as well as an outlet for deep frustration. The vulnerability of adolescents to voluntary recruitment into armed forces reflects the severe impact of living in a war-affected area at this crucial stage of development.

4.2.2 Possible impacts of war on attachment

As was clarified earlier (Chapter 1, paragraph 1.6.1.), having a secure attachment with caregivers is one of the most fundamental building blocks of child development. Most of the research into the effects of separation has been undertaken in western societies where there has been a strong emphasis on attachment to a single caregiver, usually the child's mother. In many other cultures, young children are attached to multiple caregivers (mothers, grandparents, older siblings, etc). Experiences of separation and loss will have differing impact depending on the child's age, level of cognitive (intelligence) development, emotional maturity, gender, and the nature and duration of the

separation. It will also vary between cultures. In general, however, it seems that infants are likely to react to separation with clear anxiety. The period from birth to 2 or 3 years is particularly important for the formation of bonds and the development of secure attachment behavior. Separation during this period has the greatest distress reaction, especially between about 6 and eighteen months of age. If separation is prolonged, it is not unusual for children to regress (revert to behavior typical of younger children). For example, the child may become more demanding and want to be fed, or refuse food altogether, may be more fearful at night, speak less clearly by reverting to "baby talk", become more fearful of strangers, and perhaps relinquish the achievement of bladder and bowel control.

The notion of attachment is not limited to the phase of early childhood. School-aged children may also react to loss and separation through certain forms of behavior, including denial, depression, increased aggression, sleep disturbance, and physical symptoms such as headache, stomach-ache and shortness of breath.

While adolescents may have learned self-control and ways to deal with grief, and have acquired cognitive skills to understand more about what is happening to them, they continue to benefit from the structure of family life. The opportunity for adolescents to receive support and guidance from adult mentors and role models allows for significant developmental gains, as the attitudes, beliefs and values they adopt during the adolescent period may become life-long. Separations can have long-term effects on both children and adolescents. However, it seems most likely that the majority of long-term effects are not a product of separation itself, but of the lack of adequate substitute care that follows after separation. It seems clear that separated children cope best when they are cared for by adults (or sometimes older siblings) who provide an appropriate level of affection, care, and stimulation. Good quality care is rarely available in an institutional setting. Wherever possible, children (especially those of pre-school age) should be provided with care within a family setting. Where children have experienced multiple caregivers (i.e. where caring tasks are shared, for example between the child's mother, older siblings, grandparents, etc.), the distress will probably be minimized if they are able to maintain contact with at least one of their previous caregivers. For this reason it is especially important that brothers and sisters should be kept together whenever possible. In cultures in which siblings have an important role, care within a supported child-headed family may be preferable to separation from siblings resulting in care by strangers.

In the context of separation and the provision of substitute care, another important feature of child development concerns the child's sense of time. Young children have yet to acquire the capacity to appreciate time as measured by the clock or calendar. The infant cannot use thinking to hold on to the image of the departed parent, while children aged around 4 - 6 years of age are more likely to grasp time as related to events such as "meal-time", "bed-time", etc. Children under the age of 5 may have difficulty in understanding the concept of death and may not realize that a deceased parent is not going to return. Reassurances that a separated child may be able to return to her parents within a few days/weeks/months may have little meaning and will provide little comfort.

It needs to be borne in mind that separation does not occur in isolation from other events. A child who is separated in war or flight will have to cope not only with separation (which may be permanent), but also with the possibly violent circumstances in which the separation occurred, and the loss not just of his or her attachment figure(s) but the loss of the family home and familiar surroundings. By contrast, the child who has been abandoned may have to cope not just with separation, but with the knowledge of being unwanted or rejected, and possibly with being neglected or abused during the months leading up to abandonment. Children may invent explanations of the circumstances of their abandonment, such as their own worthlessness. Separation is usually associated with other kinds of loss (of the family home, other familiar people, possessions, and familiar circumstances). Separated children

usually benefit from as much continuity with the past as possible. Remaining together with siblings, or maintaining one or two possessions can be extremely important to the child.

4.2.3 Child abuse as a result of conflict

Children with a background in conflict or displacement are at greatly increased risk of various forms of abuse and exploitation. The presence of one risk factor makes children more vulnerable to other risks, hence an accumulation of risks can occur. For example, the separated child may be at enhanced risk of abuse and exploitation, while a child facing abuse within the family may be at enhanced risk of recruitment into fighting forces.

The terms “exploitation” and “abuse” cannot be used in an absolute or universal sense; rather behavior towards a child that might be deemed to be abusive or exploitative needs to be seen against cultural norms and standards.

Child labour

In the area of child labour, for example, it is important not to impose a western concept of childhood (which largely excludes paid work) and not to make the blanket assumption that all forms of child work are exploitative or damaging to children’s development. On the other hand, some of the most damaging aspects of work can be psychological in nature and relatively invisible to the outside observer. Included within the definition of exploitative child labour is work that interferes with the child’s ability to access education whether because of the hours or any other reason. Children may be more susceptible to some types of work hazards than are adults because they are in the process of growth and have particular developmental needs: carrying excessively heavy loads can have a serious and permanent effect on the child’s growth. On the other hand, research has demonstrated that working children can have an extraordinary ability to weigh the complex costs and benefits of work.

In determining whether work is harmful, two sets of criteria may be used.

Firstly, the *objective conditions* of their work. This may include criteria as:

- the nature of children’s work activities;
- the nature of the work environment;
- the presence of specific hazards (physical and psychological);
- the nature of the employment relationship.

Secondly, the *subjective value* given to the work by the children themselves. For example, where children perceive that the benefits (e.g. pride in contributing to the family economy, satisfaction and learning derived from the work) largely outweigh the costs (e.g. working long hours), it seems that this may partly shield children from the worst effects of work. Again it is important to avoid assumptions about the impact of work on children. For example, it is often assumed that children should not be working because they should be in school. However, it is clear that many working children can only attend school if they earn enough to pay their own school fees and expenses. It is important that a thorough assessment is undertaken, which includes a careful attempt to understand the views of the children themselves.

Gender issues may also be significant. In some cultures, girls tend to carry an excessive burden of unpaid domestic work, sometimes in addition to paid work outside of the family. Frequently this is a factor in school enrolment figures, which show a bias in favor of boys.

Sexual exploitation and sexual abuse

In a war there is increased risk of sexual abuse and exploitation. This will frequently have severe and far-reaching effects, depending on the age, gender and temperament of the child, the nature and duration of the experience, the identity of the abuser and the quality of support received, especially from the child's family. The majority of sexually abused and exploited children will be girls, but it happens to many boys as well (there may be even greater underreporting of abuse against them than is the case with girls). The impact of sexual exploitation can be experienced on various levels, including:

- physical consequences - including genital injury, STD's and the contraction of HIV/AIDS, and unwanted pregnancy;
- emotional consequences can be the same as experienced after other traumatic experiences;
- in many societies, a sense of shame at having been violated, and especially if pregnancy results, can have severe consequences for the child;
- social consequences can include ostracism by the family or community -especially if the child is disbelieved or blamed for what has happened. In some cultures, sexual exploitation will have a negative effect on the child's chances of marrying;
- children can become even more psychologically distressed if the incident(s) is/are handled insensitively - e.g. aggressive interviewing of the child, insensitive medical examination, etc.

All of these can have both an immediate and long-term impact on children's development. Abuse within the family (whether physical, sexual, emotional abuse or neglect) can have particularly serious consequences for the child's development (see Chapter 3, paragraph 3.10). It will be important to consider not just the immediate physical and emotional impact of the abuse on the child. Abuse within the family constitutes a gross breach of trust on the part of the adults who are charged with the responsibility for caring for and protecting the child. Because of the child's age and developmental stage, he or she may be powerless to resist or protect him/herself from abusive behavior. Abuse is likely to continue until its causes have been identified and removed, or unless the risk of further abuse is minimized by the separation of the abuser from the subject of the abuse. However, removal of the abused child can sometimes place other children in the family at increased risk.

It is not uncommon for abused children to grow into abusing adults. For example, sexually abused boys are prone to become sexual abusers of other children, while emotionally neglected children may grow up without the personal knowledge of the importance of love and affection, which may have a negative effect on their own parenting skills later in life.

4.2.5 Children involved in fighting forces

There is a growing awareness of the particular needs of child soldiers and of other children who are involved in fighting forces.

One of the most challenging effects on children of such experiences is that they have spent a significant part of their childhood in a strictly hierarchical structure and have experienced a socialization process that serves the purposes of a military command. Clearly such experiences may make it difficult for children, upon release, to adjust and to re-learn new codes of behavior and develop relationships not based on power and fear.

Children who have participated in violence and killing have probably been given messages about what such actions mean from the vantage point of armed forces. Again, this may mean that children have to re-learn moral behavior and acquire the ability to make moral judgments appropriate to civilian life. Some children do realize the terrible nature of their previous actions and hence may suffer greatly

because of that realization and the guilt and shame associated with it. Girls who have been on active duty may find particular difficulty in adjusting to expected ways of how girls should behave in their society, and this may affect marriage prospects as well as adjustment to the role of wife and mother. Girls (but also boys) are at risk of rape and prolonged sexual abuse, and this may affect the normal development of age-appropriate and culturally acceptable behavior. In turn this can pose a challenge for successful social integration.

Some children (especially those who have had positions of responsibility in the fighting forces) may have particular difficulty in adjusting to civilian life where their status is no longer recognized. Even young children may have taken on adult roles, responsibilities, and authority. This may make it extremely difficult to return to the expectations associated with childhood, such as conforming to the norms and rules of school, or to the discipline and expectations of the family and community.

An essential aspect of rehabilitation is finding ways of promoting children's self-esteem and a sense of hope and confidence in the future. This may be particularly difficult for children who have been recruited, partly as a reflection of their own perceptions of the lack of opportunities available within their own community. Once these children reintegrate back into more normal life in the community many struggle with poor self-esteem and a confused sense of who they are. Because of difficulties reintegrating in to their communities and the lack of future prospect facing them, many keep longing for their former life in the fighting forces and are therefore vulnerable to re-recruitment.

One aspect of life within fighting forces that is not always recognized is that children may well have had some positive experiences, intermingled with many negative and brutalizing ones. For example, they may have been part of a highly supportive peer-group, they may have had a strong sense of purpose, perhaps with an ideology which, though possibly imposed through an indoctrination process, may have given a sense of meaning to their actions. They may also have had strong personal relationships with their commanders, despite the potential for exploitative and brutal aspects of these relationships. These more positive sides of their experience cannot always be readily replaced, but unless children do have opportunities for good adult and peer-group relationships, a sense of purpose and self-esteem, they are likely to experience great difficulties in returning to more normal civilian life in the community.

4.2.6 Other risks for children in war-affected areas

Apart from the four specific areas above, other common risks for healthy child development in war-affected areas include:

- *Physical risks, such as:*
 - Loss of the child's home, familiar circumstances, people, possessions, etc;
 - Crowded accommodation, lack of health services, and lack of clean water and adequate sanitation can conspire to pose particular threats to the health of the growing child. Inadequate immunization programs, lack of capacity to control infectious diseases and poor health services are likely to have a considerable impact on the healthy development of children and adolescents;
 - Malnutrition is closely linked to disease, especially infectious diseases. Under-nourished children have less resistance to disease, and once they have diarrhea or a respiratory infection, eat even less so that a cycle of disadvantage is set up which can quickly lead to death. Children's nutritional needs are significantly different from those of adults. Severe clinical malnutrition which can begin in the fetal state and continue into the first one or two years of life is associated with long-term effects on the

- development of the cognitive and behavioral aspects of development, as well as competence in motor functioning. Chronic malnutrition can lead to stunted growth;
 - Chronic poor health, often associated with malnutrition, can affect the child's natural inclination to explore and learn from the environment and opportunities for taking part in school and other social activities;
 - Physical injuries can also be associated with armed conflict. For example, bomb blasts can lead not only to shock and anxiety, but also to hearing loss, which in turn may affect school performance. Bombs, shells, bullets and landmines can cause a wide range of physical disabilities and psychological threats.
- *Social* risks, such as:
 - Loss of educational opportunities can have far-reaching effects on children's development. Children whose primary education is disrupted often find it difficult to return to schooling later in their childhood. Girls are particularly likely to be disadvantaged educationally. The absence of basic education violates the rights of children and often proves to be a life-long problem;
 - Lack of opportunities for play. Although children's play takes different forms for children of different ages and gender in different cultures, play is an essential and universal feature of childhood through which children explore, learn, co-operate, cope, and adjust. Through play, children not only develop skills and competencies, but also handle and re-enact difficult life experiences and express their feelings about them. In conflict and refugee situations, play may be inhibited by a number of factors, including pressures on the time of parents and other care givers, the possibility of their own anxieties making them emotionally unavailable to the children, lack of spaces for play, and anxieties about security, which may lead parents to restrict their children's movements.

4.3 Protective factors for children in war affected areas

The focus of War Child Holland's interventions is to strengthen five protective factors, which can counter-act many of the risks faced by children in war-affected areas. These factors have been formulated after intensive review of literature and practices of other organizations working with children in war-affected areas (e.g. Save The Children, 2004; SCF/ARC, 2001; Apfel & Simon, 1996; Boyden & Mann, 2000; Kosteck, 2005; Masten et al, 1999), and based on years of WCH's own practical experience.

The protective factors are:

- 1. Constructive coping mechanisms within the child**
- 2. Adult support**
- 3. Peer interaction**
- 4. Sense of normalcy and future prospect**
- 5. Safety and peace**

These five protective factors are important (and under threat; see the previous section 4.2) for children growing up in war-affected areas. Although careful assessment is always necessary to determine which risk factors are most endangering the healthy development of children, all WCH programs in one way or another have the aim of supporting these five factors. This preventative approach, which focuses on the strengths of children and their families and communities, will have the most potential for preventing psychosocial problems, and promotes opportunities for the healthy development of children in war-affected areas.

In the remainder of this section the protective factors are further explained.

4.3.1 Constructive coping mechanisms within the child

Adaptive reactions to stress are the result of coping mechanisms, which in turn are the result of a balance between more or less permanent risk and protective factors (Garmezy, 1985). Constructive coping mechanisms are those psychosocial skills or abilities that a child possesses and develops through life, that help him/her deal psychologically with situations. Constructive coping mechanisms increase the resilience of children against difficult experiences and enhance healthy psychosocial development.

4.3.2 Adult support

Parental warmth, expressed in both physical (e.g. hugs and kisses) and verbal ways (e.g. praise and expressions of fondness), has been found to be a universal phenomenon (Rohner, 1986). It also seems to have a universal association with positive psychosocial outcomes, such as psychological well-being, self-esteem, and academic achievement. Lack of parental warmth appears to have a universal association with negative psychosocial outcomes, such as aggression, school misconduct, emotional unresponsiveness, and depressive symptoms (Chen et al., 1998; Greenberger & Chen, 1996).

Every child needs both the physical, psychological and moral support from relevant adults in order to grow and develop in a healthy way (physically and mentally). Parents or direct caregivers can provide the best support a child needs. Children receiving warm attention and care feel safe and are better able to explore the world and develop different skills. Not only the support of parents or other close caregivers, but also the support from relevant others is essential (grandparents, aunts/uncles, teachers and other (para-) professionals). Through social interaction, children acquire gender and ethnic identities, internalize culturally constructed norms and values, participate in formal education and other social institutions, and learn to become functional members of their societies (Save The Children, 2004). At the same time negative attention from relevant adults (abuse, neglect, etc.) can be extremely destructive.

4.3.3 Peer interaction

Peer relationships are integral to play and children learn many of their social skills from their peers. Unlike adult-child relationships, peer relationships are based on equality between participants. Children can negotiate the terms of their relations with peers and friends in ways that are not possible with adults. They develop the capacity for friendship and solidarity based on reciprocity and mutual support. From one another, they learn lessons about what's right and wrong, about loyalty, and about what happens if you hurt someone's feelings or betray someone's trust.

Resilient children are more likely to have one or more close friends than children who do not adapt as successfully (Werner, 1990). The better able children are to form good, sustaining friendships and to be accepted and valued within their peer groups, the more apt they are to do well in school-and, in the long run, in life. Close friendships provide adolescents in particular with the basis for developing greater self-knowledge through the process of mutual reflection. Young people tend to discuss their problems, feelings, fears and doubts with best friends rather than with their parents. Children, especially good friends, help one another think things through more clearly and competently.

Peer relationships have also been found to be important for adolescents' well-being in different cultures (Greenberger, Chen, Tally, & Dong, 2000). But to keep in mind: adolescents in different cultures spend different amounts of time with their peers (e.g. Fuligni & Stevenson, 1995). Consequently, peer influence tends to vary.

4.3.4 Sense of normalcy and future prospect

A sense of normalcy, structure and future perspectives are important protective factors for healthy child development. Familiar routines, tasks, and rituals create a sense of security. Through a predictable environment the child is able to attach meaning and purpose to his/her life, and create a future perspective. In conflict situations many of those routines and structures are damaged. Communities fall apart, schools and health facilities cease to function, families are disrupted and in many cases the entire social fabric breaks down. Regular activities such as school, but also organized play, games and sports can help re-establish a sense of normalcy and future prospect for children. Parents and caregivers can be stimulated to create structure in the household. But also restoration of traditional practices and rituals can help to bring back a sense of normalcy. It has to be noted though that structure and routine can also be negative: over structured households, work or other heavy daily duties can put a burden on children.

Positive school experiences provide a source of strength amidst an otherwise chaotic environment and school is therefore a very important place for the psychosocial functioning of children. The benefits of a positive school experience can stem from academic pursuits but also from social success, a special relationship with a teacher, the opportunity to take positions of responsibility, or success in non-academic pursuits such as sport, music, and art (Rutter, 1987). Children seem most resilient in school (and home) environments that are warm and responsive, but also organized and predictable with clearly defined, consistently enforced rules, standards, and responsibilities; these characteristics appear especially important for children experiencing life changes such as displacement and separation (Werner, 1990). Within the school, both adults and peers are models of appropriate social behavior and in turn, can provide positive reactions in response to adequate social behavior of the child. This aids the development of feelings of social competence, which contributes to the development of self-confidence and positive attitude. Also, success in schoolwork or excelling at school related activities like sport or art, is a potent force for enhancing self-esteem and self-confidence. Both self-esteem and self-confidence have a positive influence on coping skills. Going to school also fills the daily life of children with purposeful activity; it gives structure and meaning to each day (Mikus Kos, 2005).

4.3.5 Safety and peace

Both physical safety and emotional safety are essential elements for child development. Children and adults cannot function properly in dangerous living conditions. In situations in which hatred, discrimination, and distrust are prevalent, children can be inhibited in their development. Children all over the world manifest emotional distress after exposure to overwhelming, life-threatening events through some form of behavioral change, developmental delay, or other disturbances.

Chapter 5 Child Development: Implications for War Child's practice

5.1 Introduction

Besides being a reference paper, this document also explains the child developmental framework that should form the basis for all of War Child's programming. In the previous chapters we have described what child development is, how it relates to growing up in war-affected areas, how it unfolds towards adulthood, and what possibly can go wrong. We will conclude this chapter with some general recommendations for the War Child practice.

5.2 Promoting child development in War Child programs

The War Child approach is preventative in nature: we aim to prevent the development of psychosocial problems, and we promote opportunities for the healthy development of children in war-affected areas. To achieve this we focus on the child and his social environment. More specifically we strengthen protective factors that can counteract certain risk factors most prevalent in conflict-ridden areas.

To promote child development in our programs in an effective way we have to first give attention to the following:

- In every phase of a project or programme we have to carefully analyze the risk factors threatening the healthy development of children. This analysis should take place at every level, from country level down to when we are implementing an intervention with a group of children or in a certain community;
- Problems in the development of children are usually caused by complicated, multi-faceted, and often inter-related causes. We should avoid simplification when we try to analyze these problems. We should also constantly realize that the presence of one risk factor can increase children's vulnerability to other risks;
- Interventions should (as much as possible) be "tailor made". This means that just promoting one or more of the five protective factors is not enough. It should be clear how an intervention contributes to the specific needs, problems, and rights of a beneficiary group. How does an intervention relate to the risk(s) facing those children? For example, promoting adult support may be the most important thing for a group of children age 6-12, while promoting a sense of normalcy and future prospect is the most important for adolescents in that same community. Both groups will therefore benefit from different kinds of interventions;
- We should always make sure that the children most at risk, the most vulnerable, are included in our interventions. This should however never lead to the stigmatization of vulnerable groups. The best way to avoid this is by adopting an inclusive approach: vulnerable children are reached by integrating them in interventions targeting broader groups¹².

Once we have taken the above into consideration, child development in War Child programs (in general) can be promoted like this:

1. Increasing coping skills by:

- Increasing opportunities for play and expression for children and youth;
- Increasing quality of education for children and youth;
- Increasing livelihood and life skills for children and youth.

¹² Although in certain circumstances it may be necessary to implement separate activities for such a group; for example, mentally handicapped children living in an institution, or a group of child soldiers participating in a DDR program. Also: individual children may need individual attention. This will usually fall outside the scope of War Child's possibilities, but efforts should none-the-less be made to support such children; for example, War Child Sudan helps certain street children to reunite with their families.

2. Increasing adult support by:

- Increasing awareness of and support for child rights by families, communities and society;
- Increasing awareness of and support for children's psychosocial development by families, communities, and society;
- Increasing capacity of (para-) professionals to support children's psychosocial development;
- Increasing protection of children and youth.

3. Increasing peer interaction by:

- Increasing opportunities for play and expression for children and youth;
- Increasing understanding between divided groups of children;
- Increasing quality of education of children and youth.

4. Increasing a sense of normalcy and future prospect by:

- (Re-) establishing social structures, rituals and traditions in community life;
- Increasing quality of education of children and youth;
- Increasing livelihood and life skills for children and youth.

5. Increasing safety and peace by:

- Increasing support for peace and reconciliation processes by communities and society;
- Increasing understanding between divided groups of children;
- Increasing protection of children and youth.

5.3 Involvement of children and youth in planning and implementation of War Child programs¹³

Child participation is a right as defined by the CRC. There are important child development aspects to this concept, which will be examined in this section. Participation literally means to take part in something, to have a hand in it, join in, share, be a party to it, and so on. In the context of War Child activities, child participation can be described as "listening to children, giving them space to articulate their own concerns, and taking into account the children's maturity and capacities, enabling them to take part in the planning, conduct and evaluation of activities, which may imply involving them in decision making" (Van Beers, 1995).

Participation as a child rights concept

The notion of participation is firmly embedded in the Convention on the Rights of the Child. Article 12 states 'State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the view of the child being given due weight in accordance with the age and maturity of the child'. In addition to this important provision, Article 13 refers to the child's right to freedom of expression. Article 14 refers to the child's right to freedom of association and of peaceful assembly. Article 17 stresses the importance of children's access to information.

But participation does not just happen: it needs adults to provide a facilitating environment to enable young people to participate in accordance with their emerging competencies.

Participation and child development

Participation is a vital aspect of child development, and can be examined under three headings:

1. Children are active in their own development;
2. Enabling children to participate can enhance their development;

¹³ This section is mostly derived from *Child and Adolescent Development*, by Actions for the Rights of Children (ARC), Save The Children, 2001 (www.savethechildren.net/arc/).

3. Child and adolescent participation can enable better decisions to be made.

1. Children are active in their own development

War Child adopts a transactional, ecological view to child development (see Chapter 1, section 1.3). This implies that children - from a very young age - are responsive to and participate in shaping their environment. Children are both influenced in their development by their environment, and in turn they influence it. A healthy, active baby, for example, will influence parents' behavior and will cause them to give him/her more positive attention than would a passive or constantly irritable baby. As children grow up, there is a recognizable sequence of their evolving capacity to participate, though there will be both individual and cultural differences about the actual ages at which particular competencies are developed.

Competencies for participating in social interaction and decision-making will include the following:

- language ability – the ability to communicate and to use language to collaborate with others;
- empathy - the ability to understand the feelings and views of others;
- abstract thinking - for example the ability to conceptualize an unseen process towards a non-concrete goal;
- an understanding of time;
- the capacity for controlling one's impulses - i.e. the immediate and self-centered satisfaction of needs and wishes;
- the ability to understand and accept that a participatory exercise may benefit people rather other than oneself;
- the ability to concentrate, listen, analyze, project one's point of view, etc;
- the ability to control emotions, especially anger and frustration.

In general, children aged around 5, 6 and 7 are able to participate in, and take decisions about activities which are very concrete and familiar and where the results show themselves immediately. From the age of around 8 and 9, children's competence in participation develops rapidly and by the age of 10 - 12, many of the competencies listed above will be acquired at quite a mature level, though care needs to be taken that the issues involved are understood fully. Experience suggests that, in general, adolescents are able to be very active participants and can be engaged in programs at a deep level. It must be remembered, however, that there will be significant cultural differences regarding the age at which particular competencies are acquired, as well as individual differences. There are also significant issues regarding both gender and the cultural value attached to the participation of children, which will be discussed below.

2. Enabling children to participate can enhance their development.

Participation involves listening to children, in a non-patronizing way, taking their ideas and opinions seriously, and (where appropriate) allowing them to take responsibility for making decisions. This can be validating for children and can serve to enhance their self-esteem and confidence, as well as enabling them to acquire skills such as those outlined above. There is also some research evidence that suggests that when children and adolescents have opportunities to participate meaningfully and to contribute to the environment in which they are involved, resilience is enhanced.

3. Child and adolescent participation can enable better decisions to be made.

At a broader level, program planning and development will be enhanced by child participation. For example: a youth club program will be most likely to meet the particular needs of young people if they are involved in a meaningful way in identifying the problems they experience, and in determining the focus of the program and the way it is to be run. They are also more likely to use the program if they feel some ownership of it.

Participation: cultural and gender issues

The idea of child participation may well challenge what is generally considered appropriate behavior for children in many societies and child-rearing traditions, and may be difficult to introduce in contexts in which it is the norm for “children to be seen but not heard”. This has to be weighed against some of the real advantages which can result from child participation, while a sensitive approach needs to be taken in order that the key players - staff, parents, the children themselves etc. - can see the benefits and not perceive participation as a threat.

Participation implies responsibility and it may be helpful to emphasize this fact when working towards a more participatory way of working. It is through the collaborative work with others that children as well as adults learn to exercise responsibilities. Real participation is unlikely to be achieved unless the staff involved in a program is really committed to it. One study has suggested that staff members working within a hierarchical, authoritarian organization that does not encourage staff participation are likely to find the idea of child participation difficult.

Gender issues can be highly significant. In many contexts, there may be more organized opportunities for boys to participate than girls, which may reflect both cultural attitudes towards gender, and the fact that girls often have a greater burden of work placed upon them in the home. It is not uncommon to find programs designed mainly around the needs of boys, especially in refugee camps where they may be more visible - and perhaps perceived as being more potentially troublesome - than girls. Particular care may need to be taken to ensure that girls become actively engaged, and to ensure that boys do not dominate participation in decision-making.

Participation: implementation issues

Although War Child promotes the principle of child participation, field staff frequently may feel that it is difficult to apply in a meaningful way, especially in cultures in which the idea is unfamiliar.

Van Beers' definition (see above) helps to highlight two distinct aspects of participation: at a basic level, it can involve children in articulating their ideas and concerns and taking part in something; at a more sophisticated level, it involves empowering them, enabling them to make decisions, take autonomous action, organize themselves, etc. Programs may seek to involve young people in the former way but not the latter, or vice versa. For example, in a peace education program, the approach can be highly participatory, with children very actively involved in their own learning, but this basic level of participation could take place within a setting in which the program's objectives, the curriculum, teaching methods etc. have been developed by adults without any involvement of the children. In this sense, children are being actively involved in a participatory way in the program activities, but may not be empowered through involvement in the planning, conduct and evaluation of the program. This may, of course, be entirely appropriate, depending on the circumstances.

Effective participation cannot be something “added on” to a program, but needs to be embedded in the program on the basis of very careful thought and planning. Efforts to help children “express their views” sometimes become rather prescribed, providing narrow and limited avenues for particular children or youth to speak to an audience of adults. Indeed, all too often such agendas have not emerged from children themselves, and it is not always clear that selected views in a formal context are representative of the broader population of children. A developmental perspective on participation emphasizes the fact that the nature and format of participation does not fit a pre-set template or fixed time frame. Rather, genuine participation must evolve according to basic principles of child development and within the given cultural, socio-economic and political context.

Appropriate and effective child and adolescent participation requires consideration of the following questions:

1. What are the objectives of involving young people? Are they appropriate to the children's emerging competencies and skills?
2. In what areas and aspects of the program are young people being involved? What are the appropriate limitations of child participation in this context?
3. What are the local cultural attitudes towards child participation? How will participation be explained to the young people, parents, and community leaders? What difficulties can be anticipated and how will they be overcome?
4. What methods and techniques will be used to involve young people?
5. Have gender issues been thought about and addressed? Will the participation of girls, or of boys, require particular approaches or techniques?
6. Is the staff committed to child participation? Have they experienced the benefits of participation themselves? Do they see it as any kind of threat to their own position, and if so how will this be addressed?

5.4 General recommendations on integrating the child development framework in War Child

Throughout this paper it was stressed that stimulating and supporting the healthy psychosocial development of children in war-affected areas is the main objective of War Child's programmes. This is achieved through a twofold preventative approach, aimed at preventing the development of psychosocial problems and the promotion of positive child development. For such an approach to be effective several practical considerations and recommendations need to receive attention (besides the ones made in paragraphs 5.2 and 5.3):

- All War Child field staff (this includes ex-pat trainers, content supervisors and project coordinators) will be thoroughly trained in the use and implications of the child development framework. Such training will include, besides the issues described in this paper, observation techniques, referral methods and child and adolescent participation techniques. This training will be developed and implemented by a child development specialist from the Methodology Department at HQ, during the period 2007-2008;
- All War Child field staff (again including ex-pat trainers, content supervisors and project-coordinators) will be thoroughly trained in the Rights Based Approach (RBA). As was made clear in Chapter 1, paragraph 1.4 (and in other parts of this paper), the promotion and implementation of the CRC offers great possibilities for support to healthy child development. An important component of such training should be to raise awareness on the interconnectedness between child development issues and child rights. This training will be developed and implemented by a RBA specialist from the Methodology team at HQ, during the period 2007-2008;
- War Child will develop (more) fact sheets or reference papers on child development issues related to specific groups of vulnerable children (child soldiers, child prostitution, street children, children with disabilities, children in IDP/refugee camps, etc.), that can be of practical use to field staff;
- War Child will further develop (more) practical tools to assess risk factors and problems in child development (possibly from a RBA perspective), that can be used in assessments at every level of program implementation from country assessment through to location, community and child level (the already developed Child Observation Checklist in the PME toolbox is an example of such a tool);
- War Child will create a more elaborate child psychology "helpdesk" function within the Methodology team at HQ. With this we mean that field staff, if they feel this is needed, can make contact with a child development specialist (or specialists) at HQ who can advise them

on the approach for a specific child or group of children. If deemed necessary this same child development specialist(s) can be temporarily assigned to a team to assist in assessment, design and implementation processes.

These recommendations and the further development of the child development framework will be implemented under the coordinating lead and supervision of a child development specialist from the Methodology Department at HQ, during the period 2007-2008.

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