Emanuel Miller Lecture
From Pogroms to "Ethnic Cleansing": Meeting the Needs of War Affected Children

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Children are both the direct and indirect targets during wars. They are directly affected by violence aimed at them and their families; they are indirectly affected by the distress caused to their families; they may be internally displaced or find themselves crossing borders as asylum seekers. Their experiences during and immediately after war militate against their developing in a safe, secure, and predictable environment. Their human rights are compromised and their mental health put at risk.

Whether in the country at and after war, or in the country that offers refuge, children's mental health needs have to be properly assessed and met. In many cases, children may only require a sense of safety and support via their family and school. In other cases, they require more complicated psychosocial interventions that address the various stress reactions they manifest.

This paper addresses these issues against the context of a major community-based programme in Mostar in Bosnia during the recent civil war there. It argues that we have reasonably good screening measures to identify children at high risk of developing mental health problems. It presents an hierarchical model of support and intervention whereby psychosocial help is delivered primarily through schools with only a small proportion of more complex needs being met by specially trained mental health professionals. There is a strong need to evaluate various methods of delivering help and to develop new ways of reaching needy children in a nonstigmatising way.

Keywords: War, refugees, stress, Post Traumatic Stress Disorder, Convention on the Rights of the Child.

Abbreviations: PTSD: Post Traumatic Stress Disorder.

Emanuel Miller was a remarkable person who left behind an enormous legacy that has greatly benefited children down the years. He was the youngest of nine children born to Abraham and Rebecca in Spitalfields, where Abraham had workshops as a manufacturing furrier (Lansdown, 1989). Abraham had arrived from Lithuania in the 1860s and I assume that this was following one of the many pogroms or "ethnic cleansing" as we have come to call such crimes against humanity.

The family had settled in a house once owned by Hughlings Jackson, the neurologist. Emanuel was schooled locally but instead of going in to the family business, he won a scholarship to the City of London School from where, in 1911, he went to St John's College Cambridge as an Exhibitioner. In the third Emanuel Miller Lecture delivered in 1974, Leon Eisenberg noted that Miller "had taken his tripos from Lord Russell and Sir Charles Sherrington and had been a pupil of Henry Head and Babinski" (Eisenberg, 1975). He moved on to the London Hospital to take his medical training and qualified in time to work with shell-shocked soldiers at the end of World War I. He then gained his Diploma in Psychological Medicine at Cambridge in 1919.

In 1926, he published his book on *Types of Body and Mind*, in which he is described as being "Neurologist to the Ministry of Pensions and clinical psychologist to the West End Hospital for Nervous Diseases". Later, he was to become a Fellow of the British Psychological Society and so from the earliest days he was committed personally to a multidisciplinary identity.

The first Child Guidance Clinic had been opened in the U.S.A. in 1921 and it was only 6 years later that the East London CGC was founded under Miller's direction. It opened its doors on 21 November 1927 and less than 2 years later Miller had started to publish descriptions of cases treated there. The neighbourhood catered for the children of successive waves of immigration, many of them refugees from terrors abroad. The upheaval in society following World War I and the Great Depression took their toll and from the start Miller espoused a multidisciplinary approach which viewed presenting problems within their broad social context.

In World War II, Miller again worked with children affected by war as well as their battle-shocked fathers. As we know, he went on to found the Association for Child Psychology and Psychiatry and Allied Disciplines and was one of the founding editors of our Journal. He wrote the first published article—an erudite account of his

approach to clinical work, which was always open to empirical evaluation.

And so I have decided to take as my theme for this Memorial Lecture not only Post Traumatic Stress Disorder (PTSD) in Children and Its Treatment, but more particularly to focus on the needs of child refugees in the wake of the grotesque ethnic cleansing that took place in Kosova earlier this year. Although the label "PTSD" was not dreamt up until after Miller's death, he was clearly familiar with its phenomenology both in adults and children. Had he still been around, I have no doubt he would have given sound advice to those communities that are scheduled still to receive refugees. No longer do refugees enter through the port of London and settle in the East End. Rather, successive governments have decreed that they shall be dispersed throughout the land — a further diaspora if not a full ethnic cleansing! All the more reason that as child mental health professionals we should share our knowledge and experience of how best to help these children and their families.

Refugees and Displaced Persons

Let us consider for a moment the contemporary scene in relation to refugees and displaced people worldwide. Since the ending of the "cold war" between the superpowers, the world is now realising that there are many local wars that give rise to real misery. The rise in nationalism and the civil wars associated with tribalism throughout the world are characterised by vicious targeting of the civilian population. UNICEF recently estimated that over 80% of the victims of today's warfare are women and children. Civilian populations are deliberately targeted; "ethnic cleansing" and massacres are almost commonplace; populations are held hostage and under siege; even international economic sanctions are used as weapons in the struggles.

Whether it be in Vietnam, Cambodia, Rwanda, or Bosnia, these modern wars result in many families with young children fleeing for safety. "Ethnic cleansing" in Yugoslavia deliberately caused hundreds of thousands of people to leave the places they grew up in and try to get refuge elsewhere. Simply to escape the fighting and risk of reprisal, people uproot and seek safety in other countries. The result is that it has been estimated that there are over 19 million people who are refugees (within the formal meaning of the term as defined by the 1951 UN Convention) with a further 27 million people living in refugee-like situations and 25 million being internally displaced but not having crossed any international border (Rutter, 1994). It does not take much imagination to think of the experiences children may have had in fleeing from their homes under threat, witnessing fighting and destruction, seeing violent acts directed at their loved ones, leaving their friends and possessions behind, marching or being transported in crowded vehicles, spending months in transit camps, and eventually finding temporary respite in a country at peace while the authorities decide whether the family can be granted permission to remain legally and indefinitely.

Put this way, it can be seen that the experiences that many refugee children have faced are contrary to what most people consider to be the basic needs of every child: the need for continuity of care by a loved one; the need for shelter and food; the need for safety and security; the need for good schooling. All these are compromised. One has only to read the *Declaration of Amsterdam—The Declaration and Recommendations on the Rights of Children in Armed Conflict* adopted by consensus at a meeting in Amsterdam on 21 June 1994 (Aldrich & van Baarda, 1994) to appreciate how difficult it becomes to meet the needs of children displaced in such dreadful circumstances.

At present, there seems to be no end to the number of bitter local wars that result in children being displaced from their homes, with or without their families. It means that most Western European countries have a sizeable number of refugee children living within them, and the United Kingdom is no exception. Most large cities have known refugee communities within them, and in London, there can be scarcely a school that does not have some refugee children on roll. The educational needs of these children have been recognised for a long time (Rutter, 1994), even if they are not always adequately met. Meeting the child's educational needs and providing a semblance of stability into part of their daily life is an important aspect of meeting their overall mental health needs. This paper will examine some of the responses of refugee children to their losses and the traumatic events that have befallen them, and examines some of the ways that education, health, and social services can work with other community-based agencies to provide emotional support to refugee children.

Stress Reactions in Children

Major stress reactions have been known to occur for centuries and it is ironic that it has been in the aftermath of major wars that our understanding of people's reactions to life-threatening experiences has been advanced. It was not until the persisting problems of Vietnam veterans were better documented that it was realised that three major groups of symptoms—distressing recurring recollections of the traumatic event; avoidance of stimuli associated with the trauma; and a range of signs of increased physiological arousal—formed a coherent syndrome that came to be labelled Post Traumatic Stress Disorder (PTSD; American Psychiatric Association, 1980; Horowitz, 1976).

PTSD is classified in formal psychiatric diagnostic schemes as an anxiety disorder. It was increasingly described as "a normal reaction to an abnormal situation", and so, logically, it was queried whether it should be regarded as a psychiatric disorder at all (O'Donohue & Eliot, 1992). Indeed, debate still rages as to whether such a "disorder" can legitimately be diagnosed in people from different cultures. However, for present purposes, it provides a useful framework within which to examine children's reactions to major stressors.

It is, of course, not only the "objective" nature of the stressful experience that matters, but how the child subjectively interprets that experience. There can be wide individual differences in reactions to what, to the outsider, may appear to be very similar experiences. There have been relatively few studies of the effects of major trauma on children so that the full range of post-traumatic symptoms and their prevalence at different ages are not clearly established. The psychiatric classificatory systems of the American Psychiatric Association (1994; *The Diagnostic and Statistical Manual* or *DSM*) and the World Health Organisation's (1994) *International Classification of Diseases* (*ICD*) both provide diagnostic criteria that have been valuable in focusing the attention of

researchers and clinicians on the disorder, but there is still a need for careful descriptive studies of representative groups of traumatised children to establish the natural history of the disorder in children.

I have described in detail elsewhere the reactions of children and adolescents surviving life-threatening disasters (Yule, 1992; Yule & Williams, 1990). They show a wide range of symptoms that tend to cluster around signs of re-experiencing the traumatic event, trying to avoid dealing with the emotions that this gives rise to, and a range of signs of increased physiological arousal. There may be considerable comorbidity with depression, generalised anxiety, or pathological grief reactions. However, there is still a place for good clinical-descriptive studies that are *not* driven by 17 points from DSM!

Developmental Aspects

Many writers agree that it is very difficult to elicit evidence of emotional numbing in children (Frederick, 1985). Many do show loss of interest in activities and hobbies that previously gave them pleasure. Preschool children show much more regressive behaviour as well as more antisocial, aggressive, and destructive behaviour. There are many anecdotal accounts of preschool children showing repetitive drawing and play involving themes about the trauma they experienced.

Although parents and teachers initially report that young children do not easily talk about the trauma, recent experience has been that many young children easily give very graphic accounts of their experiences and were also able to report how distressing the re-experiencing in thoughts and images was (Misch, Phillips, Evans, & Berelowitz, 1993; Sullivan, Saylor, & Foster, 1991). All clinicians and researchers need to have a good understanding of children's development to be able to assist them express their inner distress.

Almqvist and Brandell-Forsberg (1997), in their pioneering studies of stress reactions in preschool child refugees in Sweden, have shown how objectively scoring children's play with small dolls can yield reliable information that indicates intrusion and avoidance. Scheeringa, Zeanah, Drell, and Larrieu (1995) approach the problem by a priori classification of child behaviours that they judge to be the developmental equivalent of the adult symptoms. This carries a logical problem—if you change the criteria for reaching a diagnosis with children, is the end-point diagnosis indicative of the same condition as in the adults? Only independent construct validity studies will tell, and to date none has been published using these suggested criteria.

Pynoos (1994) has articulated the most complex developmental theory of PTSD in childhood. The problem with it is that it is theory driven and as yet has little empirical backing. Yet, this is the "developmental-trajectory" model—heavily influenced by psychoanalytic models—that leads to the expectation that the younger the child is when it is traumatised, the more it will be knocked off developmental course. But is this true?

Bailly (1999) has argued, in part, that the child's level of cognition and language development are absolutely crucial in determining how that child will react to a particular traumatic experience, and this is echoed by Keppel-Benson and Ollendick (1993). Recent studies on memory indicate that despite the clinical discussions on the effects of very early abuse, children have no accessible memories before language is established. So how can we talk about traumatised infants? How are the classic studies of Spitz and Bowlby to be re-interpreted in this experimental age?

Incidence of PTSD in Children

We are now beginning to get better estimates of the incidence of PTSD in children and adolescents following specific events as the ways of assessing and diagnosing are improving. Pynoos et al. (1987) examined the occurrence of PTSD in 159 children 1 month after an attack by a sniper on their school playground. Seventy-seven per cent of the children in the directly threatened group developed moderate to severe PTSD. Following the sinking of the cruise ship *Jupiter*, half the adolescents developed PTSD with many more having subthreshold disorders (Yule et al., 2000).

Following our pilot study of the incidence of PTSD among children presenting at Accident & Emergency following road traffic accidents (RTAs; Canterbury, Yule, & Glucksman, 1993), there have been six other British studies that have closely followed our methodology (Canterbury et al., 1993; DiGallo, Barton, & Parry-Jones, 1997; Ellis, Stores, & Mayou, 1998; Heptinstall, 1996; Mirza, Bhadrinath, Goodyer, & Gilmour, 1998; Stallard, 1998). Overall, they report that around 33% of children who experience an RTA but who are not so seriously ill as to have lost consciousness go on to develop PTSD—a sizeable and previously unrecognised pool of psychopathology. The Child Accident Prevention Trust has recently published materials for professionals, parents, and children to alert them to the emotional aftermath of accidents (Troyna, 1998). In addition, there is now good evidence from both civilian and war studies for a strong exposure–effect relationship (Yule, 1998). There is also cumulative evidence that different types of traumatic event have different potential for causing PTSD. Thus, overall we now know that PTSD can be a common reaction after a life-threatening event. But what of its natural history?

Table 1

Estimated Incidence of PTSD Following Road Traffic Accidents

Study	Age range (years)	No.	Estimated % PTSD	Time
Canterbury et al. (1993)	8–16	28	< 21	11 months
Heptinstall (1996)	7–16	20	50	4–6 months
DiGallo et al. (1997)	5–18	57	14	12–15 weeks
Mirza et al. (1998)	8–16	119	45	4–7 weeks
Ellis et al. (1998)	6–16	45	44	4–7 months
Stallard (1998)	5–18	119	35	3–11 weeks

Natural History

There are very few longitudinal studies that indicate the natural history of PTSD in children and adolescents. We have just submitted the first of our papers on our 7-year follow-up study of adolescents who survived the sinking of the cruise ship *Jupiter* in 1988.

Comparing the approximately 200 survivors with about 100 controls, we found that 52 % of the survivors developed PTSD, mainly in the first 4–6 weeks after the sinking. A few developed it later—often on the anniversary—but these were mainly just subthreshold earlier. So we can agree with the adult literature in finding that in civilian disasters (as opposed to the Vietnam War), delayed-onset PTSD is rare.

Fifteen per cent still had symptoms of PTSD at the end of the 7 years and so PTSD is neither a rare nor a minor consequence of a single acute traumatic event. And PTSD was not the only symptom—significant depressions were also sparked off by the trauma.

Treatment of Stress Reactions

Crisis intervention: Critical incident stress debriefing (*CISD*). Debriefing was originally developed to assist emergency personnel adjust to their emotional reactions to events encountered in the course of their rescue work. It makes use of group support techniques within a predominantly male, macho culture where expressing and sharing feelings is not the norm. The technique has now been adapted for use with children following a wide variety of traumas (Dyregrov, 1991). However, the very nature of refugee children's experiences means that it is unlikely that classical debriefing techniques will be used in the place of sanctuary. Even so, the technique is nowadays so widely discussed following a major incident that for the sake of completeness it is described here.

Within a few days of an incident, the survivors are brought together in a group with an outside leader. During the introductory phase, the leader sets the rules for the meeting, emphasising that they are there to share feelings and help each other, and that what goes on in the meeting is private. The information should not be used to tease other children. No one *has* to talk, although all are encouraged to do so. They then go on to clarify the facts of what actually happened in the incident. This permits the nailing of any rumours. They are asked about what they thought when they realised something was wrong, and this leads naturally into discussions of how they felt and of their current emotional reactions. In this way, children share the various reactions they have experienced and usually learn that others feel similarly. The leader labels their responses as normal (understandable) reactions to an abnormal situation. Many children are relieved to learn they are not the only ones experiencing strange feelings and so are relieved that there is an explanation and that they are not going mad. The leader summarises the information arising in the group, and educates the children into what simple steps they can take to control some of their reactions. They are also told of other help available should their distress persist.

There is evidence that this structured crisis intervention is helpful in preventing later distress in adults (Duckworth, 1986; Dyregrov, 1988; Robinson & Mitchell, 1993; Smith & Yule, 1999). However, recent criticisms have been raised about the lack of proper randomised control trials. Some studies which have not used the CISD model but have rather used individualised crisis interventions have not only failed to find evidence in favour of early intervention with adults, but even claim that some people are made worse by early intervention (Rose & Bisson, 1998; Wessely, Rose, & Bisson, 1997).

Fortunately, the situation with children is a little more optimistic. Yule and Udwin (1991) describe their use of critical incident stress debriefing with girls who survived the sinking of the *Jupiter*. Self-report data 5 months after the incident suggest that this reduced levels of stress, particularly those manifested in intrusive thoughts (Yule, 1992). Stallard and Law (1993) show more convincing evidence that debriefing greatly reduced the distress of girls who survived a school bus crash. However, we still do not know when best to offer such debriefing to survivors of a disaster, nor indeed whether all survivors benefit.

Group treatment. Where natural groupings exist in communities and schools, it makes sense to direct some therapeutic support through such groups (Ayalon, 1988; Farberow & Gordon, 1981; Galante & Foa, 1986; Yule & Udwin, 1991; Yule & Williams, 1990). The aims of such therapeutic groups should include the sharing of feelings, boosting children's sense of coping and mastery, and sharing ways of solving common problems. Although no examples have been published to date, it would seem appropriate to offer group treatment to refugees who have experienced broadly similar events.

Gillis (1993) suggests that it is optimal to work with groups of six to eight children. His experience following a school sniper attack was that it was better to run separate groups for boys and girls because of the different reactions they had to the attack. Boys showed more externalising problems and girls showed more internalising ones.

Different authors have imposed varying degrees of structure on their groups, with Galante and Foa (1986) adopting a fairly structured approach, where different topics were tackled at each meeting, while Yule and Williams (1990) described not only a very unstructured, problem-solving approach but also ran a parallel group for the parents. Different incidents will require different approaches.

Group approaches seem to be very therapeutic for many children but not all problems can be solved in the group. Gillis (1993) suggests that high-risk children—those whose lives were directly threatened, who directly witnessed death, who were physically injured, who had pre-existing problems, or who lack family support—should be offered individual help. More generally, children whose problems persist despite group help should be treated individually.

Individual treatment. To date, there is little evidence that drug treatments have a central role, so the focus has been mainly on cognitive behavioural treatments that aim both to help the survivor make sense of what happened and to master their feelings of anxiety and helplessness.

Asking children to draw their experience often assists recall of both the event and the emotions (Blom, 1982; Galante & Foa, 1986; Newman, 1976; Pynoos & Eth, 1986). Drawings were not used as "projective" techniques, but as ways of assisting talking about the experience. However, there is evidence from a large study of 600 primary school children in Bosnia that structured art therapy does not help reduce the symptoms of distress (Bunjevac & Kuterovac, 1994).

Most survivors recognise that sooner or later they must

"face up to the traumatic event". The problem for the therapist is how to help the survivor re-experience the event and the emotions that it engenders in such a way that the distress can be mastered rather than magnified. Therapeutic exposure sessions that are too brief may sensitise rather than desensitise (Rachman, 1980), so therapists may need to use much longer exposure sessions than normal (Saigh, 1986). Fuller suggestions of useful techniques to promote emotional processing are given elsewhere (Rachman, 1980; Richards & Lovell, 1999; Saigh, 1992; Yule, 1991).

Exposure under supportive circumstances seems to deal well with both intrusive thoughts and behavioural avoidance. The other major symptom of child PTSD that requires attention is sleep disorder. A careful analysis will reveal whether the problem is mainly one of getting off to sleep or in waking because of intrusive nightmares related to the disaster. In the former case, implementing relaxing routines before bed and masking thoughts with music may help. In the latter, there are now some promising cognitive behavioural techniques for alleviating nightmares (Halliday, 1987; Marks, 1978; Palace & Johnston, 1989; Seligman & Yellen, 1987).

Ayalon (1983) suggests the use of stress-inoculation techniques (Meichenbaum, 1975; Meichenbaum & Cameron, 1983), among many others, to prepare Israeli children to cope with the effects of "terrorist" attacks. These ideas seem eminently sensible, but their implementation awaits systematic evaluation.

Prevention. Most would agree that prevention is better than cure and so more emphasis on preventing accidents (and war) would help put many of us out of business. In the meantime, we can at least help key institutions—notably schools—prepare for how they may respond to the sorts of crises that may hit them.

Anne Gold and I counsel schools to be *Wise before the event* (Yule & Gold, 1993). Head Teachers and senior staff should develop contingency plans to deal with the aftermath of possible disasters. I am proud to say that this booklet was presented to every school in the U.K. by the Calouste Gulbenkian Foundation and we have had very positive feedback on its usefulness.

Working with Children in War: Experiences in Bosnia

Since July 1993, I have been working with UNICEF and other agencies in Bosnia to alleviate the distress caused by the war to children and their families. With advice from Rune Stuvland, Psychosocial Advisor to UNICEF in former Yugoslavia, and together with my colleagues Patrick Smith, Sean Perrin, Berima Hacam, and David Schwartz, we developed a public health model for intervention using the school system as the vector for delivery. Our hierarchical model of service delivery was founded on providing all primary school teachers with some understanding of the needs of children affected by war and of first aid measures they could take to help. The syllabus of the Level I training was developed with local teaching staff and they delivered it first to all teachers in and around Mostar, and later, Sean Perrin took an elaborated version and delivered it to over 2000 teachers in Zenica and central Bosnia.

We provided some selected teachers with more advanced training and we also trained staff of some NGOs in basic counselling skills so they could work with adolescents presenting at youth clubs. Finally, we set up a resource and counselling centre attached to a mother and child outpatient clinic to which children could be referred for small group and individual work.

We surveyed nearly 3000 primary school children, aged 9 to 14 years, 2 years after the Dayton Peace Accord had brought an uneasy peace to Mostar. The children, who had lived through the siege and the fighting, reported high frequencies of frightening war experiences such as being sniped at, having shells explode near them, seeing dead bodies, and even witnessing killings. High levels of war experience were strongly related to high levels of post traumatic stress symptoms. Interestingly, levels of depression and anxiety were not elevated compared to British normative data (Smith, Perrin, Yule, Hacam, & Stuvland, 2000).

Particular Needs of Refugee Children

So far, the discussion has focused on stress reactions in children with only passing acknowledgement that refugees will probably have experienced an unusual number or degree of stressful experiences. Some people may well protest that it is "pathologising" or "medicalising" these experiences to be talking about stress reactions at all, let alone talking about PTSD. It has already been noted that there are wide individual differences in response to stress and by no means all children exposed to a life-threatening experience go on to develop PTSD. But many do show other stress reactions and, of course, children who have been uprooted from their homes and who may have lost a parent or other loved one during the turmoil may also have unresolved grief reactions. While recognising that most of these reactions are "normal" in the sense of being understandable, they still require that action be taken by those in authority to alleviate the children's distress. Diagnosis and labelling are but means to mobilise the needed resources.

It is also true that children can be resilient. As noted earlier, half the adolescents who survived the sinking of the cruise ship *Jupiter* went on to develop a full-blown PTSD. Among the others, many showed a number of stress symptoms that interfered with daily life but fell short of a diagnosable condition. While it is true that from the point of view of understanding development it is good to focus more on invulnerable and resilient children, it remains the case that vulnerable ones require help.

These stress reactions are not merely transient phenomena that settle down quickly once a child feels safe and secure. That may happen, but in the case of children exposed to war, the long-term effects can continue for many years (Elbedour, ten Bensel, & Bastien, 1993). Even in the case of civilian disasters, the effects can be long lasting, so that the 7-year follow-up of survivors of the *Jupiter* sinking is currently reporting that half those who had PTSD within the first year still have it 7 years later. Many others experienced other anxiety states and depression in the interim.

So what can and should we do? The first thing is to note that refugee children are at high risk of having mental health problems. It follows, therefore, that the school and other public health services should ensure that proper monitoring procedures are in force to ensure that help is given when required. This may mean having consultations and discussions with local child guidance, school psychological services, and other mental health services, as well as contact with appropriate refugee advocacy groups.

The best thing the school can then do is to provide a secure and predictable environment in which the child can settle and learn. (See examples of good practice in Rutter & Jones, 1998.) Education is even more highly prized among many refugees as that leads on to skills that can be taken with the child whatever the outcome of applications for citizenship. Within the pastoral care system, those teachers who will be caring for the refugee need to be alerted to some of the issues discussed above. They need to develop good, trusting relationships with the child in the hope that worries and concerns may be shared.

But this is where a particular problem in working with refugees comes to the fore. As van der Veer (1992) points out, many refugees will have gone to great lengths to escape the country where they felt threatened and may have been involved in illegal activities to get to their country of refuge. They may be suspicious of all people in authority and adults may have told children never to tell outsiders anything. They may have to conceal things they did while fleeing. Until decisions are taken about their future legal status, they will be reticent to share all the truth. Thus, teachers and other adults should not expect children to be totally frank about what happened to them, and this may hinder the process of helping children come to terms with their experiences.

A further complication arises when the fate of those left behind is unclear. Adults try to protect children from the worst, and this may be counterproductive. Discussing the needs of refugee children in Slovenia, a number of teachers told me that the worst thing they had to deal with was when they knew that a child's father had been killed in the war in Bosnia, but the mother had forbidden them to tell the child. A brief discussion confirmed that the teachers agreed that it was by far the best policy to be honest and truthful with the children as otherwise when they did discover that the father was dead, they would be angry with mother and teacher and find it harder to trust adults in the future. In any case, the child surely had a right to grieve. In that instance, what started out as a series of crises could be resolved by developing a school policy of openness. Parents would be told that the school would help them to tell children any bad news and would be on hand to support them through the difficult time. Again, teachers helping refugee children need to be aware of any family left behind who are seen as being at risk from the authorities and need to allow children to share their worries as far as is possible.

In the early days when a child joins a school, the help of an interpreter may be necessary. Here, a further possible complication may have to be considered. Many modern conflagrations are civil wars, often of complex natures and divided along religious or ethnic lines. It is vital to check that any interpreter that one involves is acceptable to the child and family. Families are understandably nervous that emigres of different groupings may be spies or may feed information back to their original country. Considerable sensitivity is required. To say to a child, "Oh, you are from Iran (or Iraq, or Rwanda, or Bosnia). Come and meet another child from there…" without knowing that both children are from compatible subgroups, may be less than helpful! Issues to do with interpreters are fully discussed by van der Veer (1995).

Refugee children will probably have experienced stresses that most of us hope never to face. Many of them will cope reasonably well. Others will cope better if their mental health needs are recognised and appropriate help offered. Schools are in a vital position to ensure that such help is offered. Both in the provision of a good caring atmosphere and in seeking appropriate outside support, schools can make an enormous difference to the future adjustment of children who have been the unwitting victims of adults' failures to resolve differences other than by force.

Concluding Remarks

Most countries in the world—with the notable exceptions of Somalia and the United States of America—have endorsed the UN Convention on the Rights of the Child. And yet, until recently, UNICEF's charter proscribed it from working with boys aged over 14 years as they were deemed to be of fighting age.

There has been great concern raised about the effects of bearing arms and of killing people on "boy soldiers"—but where are the empirical studies on how best to re-educate and rehabilitate such victims of war?

And now we are faced with the disaster that is Kosovo. How can we best advise local agencies on how to intervene on a large enough scale to make a significant improvement to the lives of the displaced children?

I am still enough of an optimist to believe that mass interventions are possible. Together with my good colleagues Atle Dyregrov, Sean Perrin, Patrick Smith, Leila Gupta, and Rolf Gjestad (Smith et al., 1999)—and under the auspices of the Foundation for Research into the Effects of War on Children—we have developed a survival manual for teachers and nurses to use with 20–30 children at a time to educate them in self-help techniques to allay the worst effects—the scary, intrusive thoughts; the heightened arousal; the avoidance; and the grief. We are just about to field test it and so, using the improved measures we have been working on for the past decade, we will evaluate it before releasing it to the world.

It would be lovely to think that children's right to develop peacefully will be better respected in the new millennium. But if that is not immediately achievable, at least we are a lot closer than we were 10 years ago to making a significant contribution to improving their adjustment and their happiness.

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