K4D | Knowledge, evidence and learning for development

Effects of violence in the home on children's mental health and psychosocial wellbeing during conflict

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Question

What effects does violence in the home (either towards children or between adults, such as intimate partner violence) have on affected children's mental health and psychosocial wellbeing during conflict? Identify the key evidence gaps on this topic. Where possible, analyse how the situation differs for boys and girls, as well as for children from different age groups.

Content

1. Overview

Being exposed to violence in the home during war increases children's risk of developing problems in mental health and psychosocial wellbeing (MHPSW), a small but robust evidence base shows. Conversely, this evidence shows that supportive parenting can be a protective factor against the demonstrated negative effects of war on children's MHPSW. Evidence from multiple sources increasingly shows that exposure to war alone cannot account for how children exposed to similar war events experience different mental and psychosocial states and trajectories. Other factors, including home life, provide complementary, at times even better, explanations for children's MHPSW. In fact, in many cases, factors that traumatise children stem not only from war events, but also from everyday hardships. Home life can be a moderator, and potentially a mediator, of the effects of war (see e.g. recent literature reviews by Cummings, Merrilees, Taylor, & Mondi, 2017; Miller & Jordans, 2016).

The issue is particularly significant because, by late 2016, nearly one in four children worldwide – 535 million children – lived in countries affected by conflict or disaster, according to estimates by UNICEF (2016). Violence in the home, and known risk factors for it, often increase in wartime, though the dynamics in this are complex and not automatic (Rubenstein & Stark, 2017). At the same time, some children exhibit resilience. The findings below, based on a rapid literature review, explore the role of home-based factors in this. The findings are most about children between 11 and 16 years old, and mention no strong gender differences in most cases.

Violence in the home negatively affects children's MHPSW in wartime, both as an independent factor and as a worsening influence on the effects of war exposure.

- Violence in the home has strong negative effects on children's MHPSW, distinct from war, as shown e.g. in a cross-sectional study in Afghanistan (Panter-Brick, Eggerman, Gonzalez, & Safdar, 2009).
- Exposure to family violence worsened the aggression of children exposed to political violence (longitudinal study on Palestine by (Boxer et al., 2013). Further, children exposed to intense political violence who experienced little positive parenting were more likely to report post-traumatic stress disorder (PTSD) two years after baseline (Dubow et al., 2012).
- Inconsistent parenting, and high psychological control by parents, were linked to higher rates of psychological symptoms in several cross-sectional studies on Palestine (cited by Cummings et al., 2017, p. 51). Punitive parenting was significantly associated with aggressive behaviours among boys and girls exposed to military violence, a cross-sectional study in Palestine found (Qouta, Punamäki, Miller, & El-Sarraj, 2008).
- Negative parent-child interactions resulted in poor mental health even among children who had otherwise shown resilience to substantial stressors from socio-economic hardships and war (longitudinal study in Uganda by Klasen, Oettingen, Daniels, Post, et al., 2010). Among child soldiers who had experienced traumatising war events and community violence, lifetime domestic violence had distinct detrimental effects on mental health (cross-sectional study in Uganda by Klasen, Oettingen, Daniels, & Adam, 2010).
- Stigmatisation by family and community largely explained the impact of wartime sexual violence on affected girls' mental health (cross-sectional study in eastern Democratic Republic of Congo, by Verelst, De Schryver, De Haene, Broekaert, & Derluyn, 2014).

- Children with relations of rivalry with their siblings had worse symptoms from military trauma (cross-sectional study on Palestine by Peltonen, Qouta, El Sarraj, & Punamäki, 2010).
- Higher levels of family violence and family conflict significantly predicted a worsening of several mental health symptoms, in a longitudinal study in Afghanistan (Panter-Brick, Goodman, Tol, & Eggerman, 2011).
- Over two generations in the same families, both war and child maltreatment led to poor mental health (cross-sectional study on Uganda by Olema, Catani, Ertl, Saile, & Neuner, 2014).

Conversely, **children going through war fare better when they have supportive home lives**.

- Parental support in wartime had significant positive effects in its own right on children's MHPSW (cross-sectional study on Palestine by Harel-Fisch et al., 2010).
- Further, positive parenting, such as warm, supportive, and non-punitive practices, buffered the negative effects of war exposure on a range of outcomes in children's MHPSW, and enabled children to better adjust. This was found in several cross-sectional studies on Palestine (Cummings et al., 2017; Harel-Fisch et al., 2010; Qouta et al., 2008), and in longitudinal studies (on Palestine, Dubow et al., 2012); and Uganda, Klasen, Oettingen, Daniels, Post, et al., 2010).
- Children's connectedness to their families significantly protected displaced Chechen adolescents – especially boys – against internalising symptoms such as depression and anxiety. This is most robust for boys (cross-sectional study by Betancourt et al., 2012).
- Following intense war violence, children who kept having the lowest psychological trauma were those with higher secure attachment to their father, compared to children in trajectories of recovery and of worsening trauma, one longitudinal study in Palestine found (Punamäki, Palosaari, Diab, Peltonen, & Qouta, 2015).
- Positive and non-competitive relationships to siblings protected children against the harm caused by military trauma (Peltonen et al., 2010).
- Decreases in violence and conflict within the family over a year was associated with better outcomes in children's mental health (Panter-Brick et al., 2011).
- Promotive and protective factors that supported children's resilience and good mental health, including family factors, had effects that were specific to gender, symptom, and phases of armed conflicts, according to qualitative and quantitative evidence identified by a systematic review (Tol, Song, & Jordans, 2013).

Among the references examined, **only one study identified no mediating effects – positive or negative – from maternal attachment or family atmosphere**, taken as factors between an intervention and children's resilience (Diab, Peltonen, Qouta, Palosaari, & Punamäki, 2015).

Lastly, there is a consensus in the literature that "**risk and protective processes interplay at multiple social-ecological levels** to shape youth development", from children's immediate environment to society at large (Cummings et al., 2017, p. 49; also see Miller & Jordans, 2016). Consequently, children's functioning may vary in different settings (e.g. home vs. school), depending on how severely war has affected each setting, and on the unique supports and challenges for children within each setting (Ungar, cited in Cummings et al., 2017, p. 49).

2. Report scope, and state of knowledge

Scope of report

This report focuses on low- and middle-income countries (LMICs) where war takes places, and LMICs where people displaced by war live. This excludes high-quality literature on: children experiencing cumulative adverse conditions in high-income countries (HICs); war contexts in HICs (e.g. Bosnia-Herzegovina, Croatia, Israel, Northern Ireland); and LMICs with high levels of public violence (e.g. Brazil, Haiti, Mexico, South Africa). At the request of the commissioning body, Latin America was also excluded, although there is high-quality literature[1].

At the commissioning body's request, the report focused on academic evidence rather than practitioner and policy sources, and looked at references published in the past ten years, prioritising those from the last five years. In the allocated time, the report could not research the complex issue of isolated children (e.g. refugee minors), homeless children, and children living in the streets without or outside their families. However, all the literature on these groups of children notes that they frequently suffer significant interpersonal violence from other children and from adults, including some who are in positions akin to those of caregivers. Similarly, this report could not cover the case of children living (forcibly or not) with armed groups, although references on the functioning of child soldiers groups might offer relevant insights too.

Body of knowledge

There is a **dearth of evidence** on the specific report issue, in academic, practitioner, and policy literature. This was observed in the rapid searches conducted by the report author, and confirmed by several recent reviews of English-language literature (e.g. Cummings et al., 2017) and by multiple subject experts who contributed comments for this report. Compared to adults, youth affected by armed conflict "have historically received minimal sustained attention" in academia and public policy, despite constituting "large proportions of the affected populations" (Cummings et al., 2017, p. 3).

Most research so far has focused on questions that are related to, but distinct from, the one examined in this report. One major area of investigation has been the impact of family violence on children, but research on this has not been specifically on war-affected settings (expert comment). Another major object of investigation has been the impact of war and violence on children, where one effect being an increase in family violence, i.e. an ecological impact of war (expert comment). As a result, there is limited data on the specific question considered in this report (expert comment).

Commenting on the scant literature in this area, one expert observed that "recognition of the impacts on children's mental health of domestic violence, including [inter-personal violence (IPV)], in conflict settings is a neglected area" (expert comment). Research on this stands where research on IPV in gender-based violence (GBV) in conflict settings stood some years ago, the expert added. Children's mental health in conflicts still focuses on trauma external to the family".

[1] e.g. Flink, I. J. E., Restrepo, M. H., Blanco, D. P., Ortegon, M. M., Enriquez, C. L., Beirens, T. M. J., & Raat, H. (2013). Mental health of internally displaced preschool children: a cross-sectional study conducted in Bogotá, Colombia. *Social Psychiatry and Psychiatric Epidemiology*, 48(6), 917–926. https://doi.org/10.1007/s00127-012-0611-9

In fact, a recent narrative review of evidence highlighted numerous intersections between violence against women and violence against children in LMICs, including in contexts of war (Guedes, Bott, Garcia-Moreno, & Colombini, 2016). The dearth of research on the effects of violence in the home on children's MHPSW appears to go beyond war contexts, and to be a larger problem across high-, middle-, and low-income countries (Bunston, Franich-Ray, & Tatlow, 2017).

The small size of the evidence base on the report topic thus leaves "**significant gaps in knowledge**" (Cummings et al., 2017, p. 1). Even some of the recently undertaken research does not focus on the report topic. For example, research is currently underway, co-led by UNICEF and the CPC Learning Network at Columbia University, to better understand the relationship between violence against children and violence against women in war settings[2]. However, it does not focus on the effects on children (expert comment).

Reasons for, and ways to address, dearth of literature

Research on this issue poses **considerable "methodological, practical, financial, and statistical challenges"** (Cummings et al., 2017, pp. vi, 1), **as well as serious ethical issues**. This is emphasised throughout the literature, and was also raised by some contributing experts.

Addressing violence against children in the home during war poses "added complexity and challenges", especially compared to non-war settings (expert comment). The limited research on the effects of IPV on women and children in humanitarian settings is therefore rooted in safety, ethics, and other considerations. This includes, among others, "the requirement to have services in place before conducting research on violence, sensitivities and risks associated with doing research with women and children living with violence, even in stable and well-researched settings etc." (expert comment).

All references used for this report, and several of the contributing experts, **call for more research** into the issue, as well as into interventions[3]. However, several references and contributing experts emphasise that such research must always be tied to the provision of services. It is thus argued that researchers must not only measure violence in the home and its effects on children, but must also "help identify and evaluate interventions that address these impacts", such as studies of interventions to improve parental skills and family environments in support of children's mental health in conflict and post-conflict settings (expert comment).

In fact, another expert warned that, "[w]hile increasing the evidence base on the effects of violence against children is an important goal, it must not precedence over the delivery of support services for those experiencing violence […]". The safety of affected persons "must always be the priority", especially for those subjected to ongoing violence. For these reasons, the expert advocates that research "only be undertaken as a component of service delivery". Similarly, "[w]hile identifying evidence gaps is helpful, [the expert cautions] against generating new information without the capacity to respond to this new information in an ethical and sustained

[2] CPC Learning Network (n.d.). *Transforming Households: Reducing Incidence of Violence in Emergencies (THRIVE)*. http://www.cpcnetwork.org/resource/transforming-households-reducing-incidence-violence-emergencies/

[3] For sets detailed recommendations, including specifics on cross-sectional, longitudinal, and translational research, see: (Cummings, Merrilees, Taylor, & Mondi, 2017).

manner […]". Working with children affected by IPV can be a long-term process, where the primary goal is always to first secure safety. "[T]here are no brief interventions that help children recover from exposure to violence", as far as the expert could tell from both knowledge and experience in child protection (expert comment).

Academics and practitioners are currently gathering new data and/or conducting new research into the report topic, as indicated by several contributing experts.

Characteristics and limitations of available evidence

The quality of literature "is highly variable, ranging from well-intentioned but relatively weakly designed works […] to other studies that meet relatively high […] standards of methodological rigor, analysis, and interpretation", as noted in a review of quantitative literature on the issue (Cummings et al., 2017, p. v). However, the studies selected in the present report typically rely on robust methodology and academic peer-review. Taken together, they offer a balanced mix of cross-sectional and longitudinal studies, alongside a couple of translational studies from interventions. As a body of references, they draw on diverse methods.

However, their **approaches are largely quantitative, with very few qualitative perspectives**. This risks leading to oversights and simplifications. For example, one paper about violence against women and girls in humanitarian and development contexts warns that much recent research into this topic has taken a medical or epidemiological approach, with too little accounting for structural factors such as history and power (Lehmann & Read-Hamilton, n.d.).

In addition, the **number of researchers working on the report topic is quite small**, even as the publication sources are quite diverse. As a result, several references are authored by the same experts. Similarly, and related to this, there is **limited diversity in the countries and crises covered** – most cases are about Afghanistan, Palestine, and Uganda.

There are also **gaps about specific groups affected by structures of inequalities**. Certainly, most references examine some disaggregated measures of socio-economic class, ethnicity, family, war experiences, and MHSPW. Studies also typically mention the proportion of girls and boys in their sample, and many report findings by gender. However, some studies do not disaggregate results by gender on the effects of violence in the home (sometimes due to sizes of sub-samples that would then be too small). In addition, this rapid review found gaps based on age. Most articles used here seem to focus on children between 11 and 17 years old. Very few are about children between 6 and 11, and none on children younger than 6 or older than 18.

Further, there is a lack of research on some major structures of inequalities. One striking example is that, within the time of this rapid review, no references on the report topic could be found on children with disabilities. This is a major gap, because worldwide persons with disabilities face a distinctly higher risk of violence, including in the home, than persons without disabilities (Barrett & Marshall, 2017; experts' comments). A literature review on sexual and gender-based violence (SGBV) against adult and child refugees with a communication disability found that "a lack of evidence of the prevalence of SGBV for people with disabilities in humanitarian contexts" (Barrett & Marshall, 2017, p. 5). Those who are indentified are usually those with visible impairments. Yet, persons with intellectual impairments, or with communication needs, are particularly at risk of SGBV (Barrett & Marshall, 2017, p. 5).

Many findings are conclusive and precise in answering their research question. Taking all the references together, conclusions are also largely consistent. However, a few references do not

clarify what dynamics of violence in the home they consider, i.e. whether violence is directed towards children themselves, or between adults in the household. Similarly, references do not always specify what forms the violence takes, leaving it unclear if the issues considered are physical, sexual, or psychological violence, severe conflict (e.g. with shouting), or neglect. In addition, due to methodological choices in some studies, part of the evidence can only show correlation, not causality, between violence in the home and children's MHPSW (Cummings et al., 2017).

Lastly, a structural weakness of the literature found is that the **time frames considered are short**. In contrast to some references about post-conflict settings, findings concerning wartime are usually about situations at one point in time (i.e. cross-sectional), or at best about short-term longitudinal effects. The paucity of longitudinal data limits knowledge to children's acute reactions, leaving a gap about impacts on their ongoing development (expert comment).

3. Effects observed at one point in time (cross-sectional)

Cross-sectional studies look at the effects on children's MHPSW produced by microsystems, i.e. the individuals and organisations closest physically and psychologically to them, such as family, school, and neighbourhood (Cummings et al., 2017, pp. 49). Among these publications, family variables are one of the most commonly studied, covering the "quality of perceived parenting, parental mental health, perceived family support, and family conflict" (Cummings et al., 2017, p. 51).

Considering quantitative findings from cross-sectional studies all together, Cummings et al. (2017, p. 51) suggest that positive relationships between parents and children "may serve as secure, protective bases" for children exposed to war. Conversely, they suggest that "negative or unstable family relationships may further exacerbate [children's] risk of maladjustment" (Cummings et al., 2017, p. 51). In addition, significant positive relationships have emerged between parents' mental health and their children's (Cummings et al., 2017, p. 51).

Afghanistan

A large survey of Afghan children shows that **trauma in wartime must be understood "in the context of everyday forms of suffering, violence, and adversity"**, and that the persistent violence they suffer from is not confined to acts of war (Panter-Brick et al., 2009, p. 807)[4]. Young Afghans' most distressing lifetime trauma was related to violence. This encompassed not only exposure to war-related events, but also exposure to serious accidents, frightening medical treatment, and domestic and community violence, such as severe beatings by relatives (Panter-Brick et al., 2009, pp. 807, 812). Several variables independently predicted children's mental health problems, especially: being a girl, residence in Kabul, and most of all exposure to multiple traumatic events, and caregiver's poor mental health (Panter-Brick et al., 2009, p. 812).

[4] The 2006 survey consisted of questionnaire-based interviews with 1,011 children aged 11-16, 1,011 caregivers, and 358 teachers, with equal sex representation. Children's mean age was 13.5 years. They were all "randomly sampled in 25 government-operated schools" in the municipalities of Kabul, Bamyan, and Mazar-e-Sharif, which were purposively chosen (Panter-Brick, Eggerman, Gonzalez, & Safdar, 2009, p. 807). The survey assessed several measures in children: exposure to traumatic experiences and the impacts of these; as well as mental health and social functioning (depression, and behavioural, emotional, and social problems). The survey also assessed caregivers' exposure to traumatic events and their mental health (Panter-Brick et al., 2009).

The results suggest that children assign significance to traumatic events (be they related to war, community, or family) based on their current life circumstances and needs. For example, some children identified as their most severe trauma "severe domestic beatings, a severe accident, or a frightening medical treatment", rather than witnessing parents and grandparents being killed in rocket attacks, while others named the death of a relative killed in the past rather than recurrent severe domestic beatings. The selective prioritisation of one event does not mean that it caused of mental distress by itself (Panter-Brick et al., 2009, p. 814).

Chechnya, Russian Federation

A survey conducted among Chechen adolescents who were internally displaced during the second Chechen war showed that these **youths' connectedness to their families was an important protective factor against developing internalising problems in emotions and behaviours**, such as depression, anxiety, emotional withdrawal, and somatic complaints. Connectedness was defined as survey participants' perceptions "of social connection, caring, respect, understanding and communication in relationships with their family, peers and the larger community" (Betancourt et al., 2012, p. 640). Assessments of their connectedness to their family evaluated to what extent they felt close to family members, felt understood and cared for in their family, and felt respected as participants in family decisions (Betancourt et al., 2012, p. 641)[5].

Multivariate analysis confirmed that family connectedness was a protective factor for the mental health and adjustment of these war-affected youth, independent of the role of other forms of connection and social support, and independent of age, gender, socio-economic status (e.g. housing), and indicators of trauma (Betancourt et al., 2012, p. 647). Indeed, only family connectedness showed a protective role against internalising problems at a level of statistical significance. No other protective factors approached such statistical significance, although connectedness with peers and community were also associated with a reduction in internalising problems (Betancourt et al., 2012, p. 646).

Multivariate analyses by gender found that the **protective relationships between family connectedness and internalising problems were strong in boys** (Betancourt et al., 2012, p. 635). Each "unit increase in family connectedness was associated with a -0.37 average unit decrease in internalising symptoms" (Betancourt et al., 2012, p. 647). For girls, family support was also protective against internalising problems, but this did not maintain statistical significance in analyses stratified by gender (Betancourt et al., 2012, p. 647).

In this regard, the authors of the study note that stronger protective effects of social support have usually been observed more commonly in girls. They suggest that one explanation for their findings may be that their "connectedness scale also asked about respect, being listened to, and participating in decisions", in addition to items typical of emotional support, such as a sense that others care about you (Betancourt et al., 2012, p. 647). In the study environment, more adult-like responsibilities were being shifted to teenagers due to the many demands facing their caregivers. As a result, respect and shared decision-making may have been more relevant for young men (Betancourt et al., 2012, p. 649).

[5] The study, conducted in 2000, surveyed a sample of 183 displaced Chechen youth, aged 10-17 years, with an average age of 13.6 years. They resided across 11 so-called spontaneous settlements where the International Rescue Committee was engaged. The sample comprised 92 boys and 91 girls (Betancourt et al., 2012, p. 639). The study measured war-related stressors, children's emotional and behavioural problems, and connectedness with family, peers, and the larger community in the camp (Betancourt et al., 2012).

The study authors emphasise that **identifying family relationships solely as a source of protection overlooks gender inequality and its effects** on boys' and girls' mental health and wellbeing. For example, a complementary qualitative study that the authors conducted in the same settings found that adolescent girls had been taking on care-giving roles. In contrast, boys had taken on different responsibilities and enjoyed minimal supervision. Boys, like girls, did have family responsibilities, "but they also had much more freedom to move about the camps and to develop friendships and engage in work or social activities" (Betancourt et al., 2012, p. 649). This matters to girls' MHPSW, because extant research has shown that "taking on care-giving roles and other family responsibilities has been associated with increased stress in children, particularly girls" (Betancourt et al., 2012, p. 649).

The study authors conclude that the findings reinforce the need to **move discussions of resilience beyond a focus on individual children's qualities**, and instead to "consider the wider context of child development" (Betancourt et al., 2012, p. 648). They advocate a population-based perspective and support for children in their broader social ecology, including families and communities (Betancourt et al., 2012, p. 648).

Democratic Republic of Congo (DRC)

A large-scale population-based survey (Verelst et al., 2014) showed that **stigmatisation by family and community largely explained the impact of wartime sexual violence on affected girls' mental health**. Victims of sexual violence reported both more war-related traumatic events and more experiences of stigmatisation, which included discrimination, hostility, and social exclusion. For example, girls who were victims of sexual violence "faced far more experiences of stigmatization, including feelings of being treated worse than others, being insulted, and rejection by and exclusion from family and/or community" (Verelst et al., 2014, p. 1145)[6].

Even when controlling for socio-demographics (age, availability of parents, and socio-economic status) and for exposure to war trauma, stigmatisation mediated the impact of sexual violence on girls who were victims of rape. Stigmatisation even explained the mental health impact of sexual violence more than the direct impact of sexual violence itself (Verelst et al., 2014). Stigmatisation thus played "an important role in shaping the mental sequelae of sexual violence" (Verelst et al., 2014, p. 1139).

Stigmatisation particularly explained effects on girls' depression (full mediation by stigmatisation). It also largely explained the effects on their post-traumatic stress: there was full mediation on avoidance and total PTSD, and partial mediation at 40%on hyperarousal (Verelst et al., 2014, p. 1139). On the other hand, there was no evidence of mediation for symptoms of anxiety and intrusion. Interpreting these differences, the authors suggest that symptoms of intrusion and anxiety may be the direct emotional and psycho-physiological responses to reliving sexual abuse, while avoidance and depression may be markers of a stigmatised social position within family and community (Verelst et al., 2014, p. 1145).

[6] The study is based on a large-scale quantitative survey in the eastern DRC. "Twenty-two secondary schools were randomly selected out of a stratified sample in Bunia" (Verelst, De Schryver, De Haene, Broekaert, & Derluyn, 2014, p. 1139). The participants in the population-based survey were 1,305 school-going girls aged 11-23. They self-reported on war-related traumatic events, sexual violence, stigmatisation, and mental health. 38.2% of participants (n=499) reported experiences of sexual violence (Verelst et al., 2014).

Palestine

Several studies on Palestinian children establish that warm, supportive, and non-punitive **behaviours in parenting** has been linked to more positive adjustment by children in the face of war. Conversely, they establish that inconsistent parenting, and high levels of parental psychological control are linked to higher rates of psychological symptoms in children (Cummings et al., 2017, p. 51, citing among others: Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009).

One large-sample study found that **parental support had a significant positive effect** on Palestinian children's mental health, wellbeing, and behaviours. Further, parental support buffered the effects that children's fear of armed conflict had on a range of outcomes for children, i.e. PTSD symptoms, life satisfaction, positive perceptions of life, and smoking. This positive effect is established even though fear of armed conflict has negative effects on children's mental, psychosocial, and behavioural outcomes, as documented in the same study (Harel-Fisch et al., 2010)[7].

Another article reported that **supportive parenting moderated the effects of children's exposure to military violence on their aggressive behaviour**. Even when children had witnessed military violence or were severely victimised by it, "supportive and non-punitive parenting practices protected children from aggressive and antisocial behaviour" (Qouta et al., 2008, p. 240). The protective role of positive parenting was in evidence in aggression as reported by teachers and children, but not as reported by parents (Qouta et al., 2008, p. 240). Conversely, punitive parenting was significantly associated with aggressive behaviour, among both girls and boys (Qouta et al., 2008, p. 240)[8].

In a rare study about the role of family relations among siblings, researchers found that **relationships among siblings moderated the effects of military trauma** on children's psychological well-being. Only sibling relations had such a moderating effect, not peer relations. Specifically, children who enjoyed considerable intimacy and warmth with their siblings, and who did not have rivalry with siblings, did not have severe symptoms following military trauma. This being said, low rivalry was associated with low PTSD only for children exposed to a low level of military trauma, whereas a lack of rivalry could not protect children from PTSD in high trauma

[7] This study was based on a sample of 24,935 children, aged 11, 13, and 15. The sample comprised: 7,430 Palestinians from the West Bank, 7,217 Palestinians from Gaza, 6,033 Palestinian Israelis, and 5,255 Jewish Israeli. The study measured: children's exposure to and subjective threat from armed conflict; children's PTSD, life satisfaction, positive perceptions of health, smoking, and involvement in youth violence; and parental support (Harel-Fisch et al., 2010).

[8] The findings about parenting in the article were based on a sample of 640 pupils, aged 6-16 (with a mean age of 10.51), in Gaza. 54.7% were girls, 45.3% boys. The measures used were about children's exposure to military violence, their aggressive behaviour, and parenting practices in their homes. Parents and teachers provided reports on all children. In addition, children aged 12-16 provided self-reports[8] (Qouta, Punamäki, Miller, & El-Sarraj, 2008, p. 234). The context at the time of data collection was one of relatively limited direct military violence, compared to the other sample mentioned in the article which was surveyed at a time of intensive air raids, killings, and destruction (Qouta et al., 2008).

situations. Children who had relations of rivalry with their siblings had worse effects on their mental health from military trauma (Peltonen et al., 2010, pp. 559–561)[9].

Uganda

One study demonstrated the **detrimental effects of lifetime domestic violence in child soldiers,** distinct from war experiences (Klasen, Oettingen, Daniels, & Adam, 2010, p. 573). It found that exposure to domestic violence had negative effects on children's mental health in addition to the effects of traumatising war events and of community violence (Klasen, Oettingen, Daniels, & Adam, 2010, p. 580). Exposure to domestic violence was significantly associated with PTSD, depression, and behavioural and emotional problems. Higher exposure was associated with stronger psychopathology (Klasen, Oettingen, Daniels, & Adam, 2010, p. 578). Contrary to theories of cycles of violence, however, the resulting mental health problems were more of the internalising kind, such as anxiety and depression, than the externalising kind, such as aggression. Aggression was found to be relatively low. The study found no gender differences in mental health outcomes (Klasen, Oettingen, Daniels, & Adam, 2010, pp. 578–579).

The study sample consisted of 330 former Ugandan child soldiers, aged 11-17 years (mean age of 14.4 years). 49% were girls, 51% boys. All children had experienced at least one war-related event, and 78% had additionally been exposed to at least one incident of domestic violence. Participants were recruited from a governmental school for war affected children in late 2006, i.e. shortly after peace negotiations had started without peace being established yet (Klasen, Oettingen, Daniels, & Adam, 2010, p. 573). The measures, self-reported by children, were about: traumatic war experiences; exposure to lifetime domestic and community violence; PTSD, depression, and behavioral and emotional problems (Klasen, Oettingen, Daniels, & Adam, 2010).

Similarly, a study demonstrated that **two generations in the same families were severely affected by both war and child maltreatment**, in regions severely affected by war that was ongoing at the time in Northern Uganda. The survey engaged with 100 adolescents (12 to 17 years old), 50 with a history of abduction by the rebel army and 50 without, alongside both of their parents (100 mothers and 100 fathers). Interviewees lived in camps. Both war and child maltreatment traumas were independently correlated with psychological disorders among adolescents. However, only child maltreatment, not war violence, accounted for PTSD in parents. The authors conclude that, even during severe war, "the impact of child maltreatment on psychological disorders surpasses the damage of war trauma" (Olema et al., 2014, p. 35).

Characteristics of cross-sectional evidence

These studies present a number of strengths. They rely on often large sample sizes, even during ongoing conflict. Their measures of children's exposure to war are explicit and diverse. They examine a wide range of variables related to children's developmental processes. This body of research thus creates "a rich pool of hypotheses about developmental processes" (Cummings et al., 2017, p. 52).

[9] The study was based on a survey of 227 children in the Gaza Strip. 36 % were girls, 64% boys. Their ages ranged between 10 and 14 years, with a mean of 11.37 years. 60.9% "lived in urban areas, 20.9% in refugee camps, 9.3% in a village, and 8.9% in resettled areas" (Peltonen, Qouta, El Sarraj, & Punamäki, 2010, p. 556). The survey measured children's military trauma, their depression, and their psychological distress, as well as their relations with peers and siblings (Peltonen et al., 2010).

However, cross-sectional literature "is methodologically and statistically limited in its ability to advance knowledge about [children's] long-term adjustment in violent contexts" (Cummings et al., 2017, p. 52). Because it simultaneously measures exposure to violence and children's adjustment to it, it can only provide "a snapshot of these variables at one particular time-point and developmental stage". It "can shed light on the associations among variables, but not on their temporal relations or [on] the causal risk and protective processes that link them together" (Cummings et al., 2017, p. 52). It cannot provide reliable evidence for translation into intervention. Longitudinal, process-oriented research is therefore needed to test hypotheses (Cummings et al., 2017, p. 52).

4. Effects observed over time (longitudinal)

Longitudinal studies explore if and how family-level factors before and during war mediate and moderate the effects of exposure to war on children's MHPSW. Family factors "have repeatedly been identified as salient predictors of youth outcomes" in longitudinal studies (Cummings et al., 2017, p. 73). The studies account for negative or positive outcomes by shedding light on the "cognitive, socio-emotional, physiological and other processes" that shape children's adaptive and maladaptive functioning over time in particular contexts (Cummings et al., 2017, p. 57; also see p. 76).

Afghanistan

A study in Afghanistan found that **higher levels of family violence such as traumatic beatings significantly predicted a worsening of mental health symptoms** other than PTSD in children one year after baseline (Panter-Brick et al., 2011). Similarly, higher levels of major conflict in the family significantly predicted a worsening of depressive symptoms in children one year on. Conversely, improvements in family life during the year were associated with better outcomes in children's mental health by the end of the year (Panter-Brick et al., 2011). PTSD scores, however, were solely contingent on lifetime trauma, especially from more than three events (Panter-Brick et al., 2011). The study demonstrates "the importance of identifying specific sources of adversity" in children's social ecology to predict specific outcomes (Cummings et al., 2017, p. 73)[10].

Palestine

One study found that **exposure to family violence worsened children's aggressive behaviour** (Boxer et al., 2013). The research examined the impact of multiple sources of violence on children's aggression, using three successive annual assessments of a sample of Jewish Israelis, Palestinian Israelis, and Palestinians. It compared dynamics between the baseline (T1) and the next two yearly assessments (T2 and T3). It found that, when children had been exposed to political violence at T1, increases in violence in family, school, and community between T1 and T2 were associated with increases in aggression between T2 and T3. Further,

[10] For this study, 234 pairs of children and caregiver completed a repeated assessment, one year apart. Children were aged 11 to 16 years old, with an average of 13.5 years at baseline, and a gender balance. The data were collected as part of a larger mental health survey in schools chosen by a stratified random sampling across several regions. The measures collected were about: children's exposure to traumatic events, psychological symptoms, and PTSD; caregivers' psychological symptoms; stressors; and protective factors (Panter-Brick, Goodman, Tol, & Eggerman, 2011).

exposure to violence in family, school, and community at T2 predicted increases in aggression across time points among the youngest age cohort. Lastly, exposure to political violence at T1 was associated with violence in family, school, and community at T2 for all age cohorts (Boxer et al., 2013)[11].

Based on the same sample as the research by Boxer et al. (2013), another study (Dubow et al., 2012) used slightly different variables. It measured children's exposure to political conflict and violence (as reported by parents for 8-year-olds, and by children for 11- and 14-year-olds); their PTSD (as reported by children); their self-esteem (*idem*); and their academic grades (as reported by parents). The measures about parents were on mental health, and positive parenting (as reported by parents in both cases).

That study found that **positive parenting** moderated the relationship between children's cumulative exposure to political conflict and violence on the one hand, and these children's PTSD symptoms on the other hand. Children who were exposed to high levels of political conflict and violence, and who also experienced little positive parenting, were more likely to report PTSD symptoms at T3 (Dubow et al., 2012).

Another study (Punamäki et al. 2015) found that **children who experienced greater secure attachment to their parents (especially their father) recovered better from war trauma**. The study thus confirmed that children did well if their parents were emotionally available and provided security, as predicted by attachment theory[12].

The study identified three trajectories in children's PTSD symptoms over time. 12% of children (n=29) experienced a resistant trajectory, where they had low amounts of symptoms which did not vary much over time. 76% of children (n=183) experienced a recovery trajectory, where they had a relatively high amount of symptoms that decreased over time. 12% of children (n=28) experienced a trajectory of increased post-traumatic stress symptoms (PTSS), with relatively high amounts of symptoms that increased over time (Punamäki et al., 2015, p. 137). Children's own war trauma had no impact on their PTSS, whereas their parents' war trauma did (Punamäki et al., 2015, p. 138).

Children in resistant trajectories had higher secure attachment to their father, compared to children in trajectories of recovery and increase (Punamäki et al., 2015, p. 137). The security of attachment to fathers was typical of children in this trajectory, whether secure attachment to mothers was not. The researchers suggest this may reflect fathers' and mothers' roles in the local culture. Children may take mothers' emotional availability and security as more self-evident,

[11] The study sampled 1,501 children from three age cohorts – 8, 11, and 14 years –, and their parents. Specifically, the sample of children comprised 600 Palestinians, 450 Palestinian Israelis, and 451 Jewish Israelis. Data were collected in three annual assessments. The questionnaires measure several aspects of children's lives: their exposure to political conflict and violence (as reported by parents for 8-year-olds, and by children for 11- and 14-year-olds); their exposure to conflict and violence at school (as reported by children); their exposure to conflict and violence in the family (*idem*); and their aggressive behaviour (as reported by both children and parents) (Boxer et al., 2013).

[12] The study assessed Palestinian children in the Gaza strip, 3, 5, and 11 months after the 2008-2009 war on Gaza, a period of intense military violence followed by continued military occupation and restrictions. The sample consisted of 240 Gazan children aged 10-12 (mean age of 11.35 years), and 170 parents. Among children, 49.4% were girls, 50.6% boys. Children self-reported their personal exposure to war trauma, cognitive trauma processing, emotion regulation, and attachment style. Their parents self-reported family war trauma, and attachment style (Punamäki, Palosaari, Diab, Peltonen, & Qouta, 2015).

while mothers may have increased their sensitive and caring behaviour at the time. As a result, there may be no record of the significance of this attachment for children's mental health. In contrast, fathers' protector role may have been particularly salient, explaining why the security of attachment to fathers was recorded as significant (Punamäki et al., 2015, p. 138).

Children in recovery trajectories had attachment that was more in the avoidant style (e.g. not telling parents about one's problems) than the preoccupied style (e.g. asking parents not to leave the house out of fear of being abandoned), compared to children in the trajectory of increase (Punamäki et al., 2015, p. 137). Study authors state this may reflect the fit between avoidant attachment and the demands of society and recovery after intense violence. Responses that avoid frightening thoughts and emotion can have short-time value for adaptation (Punamäki et al., 2015, p. 138).

Uganda

One study on the mental health of war-affected youth in Uganda (Klasen, Oettingen, Daniels, Post, et al., 2010) found that **negative interactions between parents and children resulted in poor mental health outcomes among children who had otherwise shown resilience** to substantial stressors from socio-economic hardships and war. In contrast, children experienced fewer symptoms of psychopathology when they had less exposure to domestic violence, better socio-economic situations of the family, and a perception of more spiritual support (Klasen, Oettingen, Daniels, Post, et al., 2010)[13].

Characteristics of longitudinal evidence

These studies present a number of strengths compared to cross-sectional studies. They investigate the interactions between many variables from multiple levels in children's social-ecological systems, and examine change at multiple levels too (Cummings et al., 2017, pp. 57–58, 76). They also identify predictors, mediators, and outcomes among them (Cummings et al., 2017, pp. 57–58, 76). In addition, many of these studies examine causalities in individual children's trajectories of development – "within-person" –, while also comparing children's trajectories with one another – "between-person" (Cummings et al., 2017, p. 58). As a result, longitudinal studies can isolate the role of different contextual influences, and bring out "both positive and negative influences, processes, and outcomes", e.g. maladaptation but also resilience (Cummings et al., 2017, p. 76). Further, they clarify the direction of relations over time between social ecologies of war violence, mediating psychological processes, and children's adjustment (Cummings et al., 2017, p. 76).

Despite the advantages of such research approaches, an 2017 in-depth review of quantitative literature "revealed a paucity of research laboratories engaged in [longitudinal] research […], reflecting the need for exploration of these issues by many more research groups in many more contexts", particularly to inform research for interventions (Cummings et al., 2017, p. 77).

[13] The research is based on a survey of 330 former Ugandan child soldiers, aged 11-17 (mean age of 14.44). 48.5% were girls. Children were all recruited for the survey from a boarding school in northern Uganda that had been established by the government of Uganda as a special-needs school to support war-traumatized children. The study measured post-traumatic resilience in children and adolescents who were extremely exposed to war violence (Klasen, Oettingen, Daniels, Post, et al., 2010).

5. Effects observed in interventions (translational studies)

Translational studies apply findings from basic research on the role of family in children's MHPSW to develop more effective treatment and prevention (Cummings et al., 2017, p. 81). Numerous programmes have sought to foster children's well-being and mental health in wartime.

Burundi

An evaluation of a school-based intervention in Burundi during political instability and violence (Tol et al., 2014) hints at the **importance of mediating factors such as family functioning**. It assessed children's functioning before the 15-session intervention, and then one week and three months after it[14].

While the study found no main effects from the intervention, children's trajectories over time revealed complex mediation by moderating factors, including family. For example, in the intervention group, children living in larger households experienced greater reductions in depressive symptoms and in functional impairment over the periods of assessment. Similarly, children in the intervention group who lived with both parents experienced greater reductions in depressive symptoms and in PTSD over the period (Tol et al., 2014).

The intervention had no significant effects as treatment, but appeared to have more consistent benefits for prevention. However, these effects were contingent upon individual variables (e.g. age, gender) and contextual variables, including family functioning, the state of the conflict, and displacement (Tol et al., 2014).

Palestine

In Gaza, Palestine, a study about a school-based intervention concluded that **maternal attachment or family atmosphere did not moderate** the impact of the classroom-based intervention, and that the intervention did not significantly increase participating children's resilience (Diab, Peltonen, Qouta, Palosaari, & Punamäki, 2015). This is one of the few translational studies identified by (Cummings et al., 2017, p. 92) as including measures on family.

The sample was made up of 482 children, aged 10-13 (mean age of 11.29 at baseline). Participants were assigned through cluster randomisation to either the intervention group (242 participants) or a waitlist as a control condition (240 participants). The researchers conducted three assessments for data, one pre-intervention, and two post-intervention, at 2 and 6 months respectively. They measured children's exposure to traumatic events, psychosocial wellbeing, prosocial behaviour, maternal attachment, and family atmosphere. Resilience was conceptualised as "the presence of good mental health despite exposure to war trauma" (Diab et al., 2015, p. 27).

[14] The sample was made up of 329 children (48% of them girls), aged 8 to 17, with a mean age of 12.29 years. All children had suffered exposure to at least one traumatic event, and exhibited significant mental health symptoms. Participants were assigned through cluster randomisation to either the intervention group (153 participants) or a waitlist as a control condition (176 participants). The study measured not only children's exposure to traumatic events, PTSD, hope, coping repertoire, and coping satisfaction, but also their social support and social capital (Tol et al., 2014).

Characteristics of translational evidence

A small subset of more rigorous translational studies present a number of strengths, as showcased for example in the quantitative studies selected by (Cummings et al., 2017, pp. 81–96). In these authors' selection, the research is diverse in several regards: geographic contexts, political conflicts, youth populations, assessment timing, and independent and dependent variables. It also involves multiple types of study groups, e.g. regarding control groups (Cummings et al., 2017, p. 93). Moreover, it often includes "relatively large sample sizes, stronger sampling procedures, designs with randomized control trials, appropriate statistical analyses, and other evidence of methodological rigor or complexity" (Cummings et al., 2017, p. 82).

Among these references however, relatively few have tested family-focused interventions. This is due to "the many practical and logistical challenges for constructing large-scale prevention and interventions studies", as family-focused interventions are quite expensive and time-consuming (Cummings et al., 2017, p. 90). Further, despite the evidence showing that family variables mediate the relationship between war and children's wellbeing, interventions to support war-affected children's wellbeing, both for prevention and treatment, have focused on direct work with children. They have paid only modest attention to ongoing risk factors in their families and broader environments (Miller & Jordans, 2016). In addition, research that looks only at the family level comes with its own limitations, including testing just one level of children's social ecology. Nonetheless, the low number of such robust interventions does leave many knowledge gaps (Cummings et al., 2017, p. 90).

Overall, the body of translational research has a number of major methodological weaknesses (Cummings et al., 2017; Jordans, Pigott, & Tol, 2016). These weaknesses leave important knowledge gaps on mediators and moderators of outcomes, including on family factors (Cummings et al., 2017, p. 94; Jordans et al., 2016). Many programmes on children's MHPSW in wartime have not been evaluated or do not rigorously present scientific evidence on efficacy[15].

For example, assessing quantitative studies, Cummings et al. (2017, p. 93) note that few studies are truly translational: most do not explicitly test a theoretical model, and/or "state how they are grounded in longitudinal, process-oriented research" (also see Jordans et al., 2016). In addition, many evaluations do not use random assignment or control groups, despite recent advances. Nor do they assess the fidelity of implementation or the sustainability of effects (Cummings et al., 2017, pp. 81, 93).

In addition, a systematic review of evidence found that parenting interventions often fail to engage with fathers, despite robust evidence that fathers have a strong impact on children's and mothers' MHPSW (Panter-Brick et al., 2014). Few interventions disaggregate effects by referring to couples as such or father. Instead, most focus on the mother-child dyad. Robust evaluations of participation and father from fathers on outcomes in children or families are stymied by how parenting interventions have been designed, delivered, and evaluated (Panter-Brick et al., 2014).

The prevalent alternative approach has been for programmes to rely on 'consensus-based guidelines', i.e. broad principles of services to address needs in mental health and psychosocial

[15] Cummings et al., 2017, p. 81; Jordans et al., 2016; Jordans, Tol, Komproe, & Jong, 2009; Peltonen & Punamäki, 2010.

support (e.g. IASC Guidelines on Mental Health and Social Support in Emergency Settings[16]). Yet, there is little rigorous evidence on the effictiveness of the programmes advocated – in isolation and together. In addition, effects are highly heterogeneous across programmes (Tol et al., 2014).

6. Findings from other settings relevant to wartime

Relevant findings from non-war settings in LMICs

Importantly, one expert notes there seems to be "**little reason to assume that findings from non-conflict settings would not generalize**; that is, it would be expected that IPV represents at least as great a threat to children's wellbeing in conflict and refugee settings as it does in other contexts". It is "well established that family violence of all kinds endangers children's mental health and psychosocial development" (expert comment). The expert observes that the evidence base for this is solid, regarding:

- Witnessing inter-parental violence, typically committed by men or boys against women or girls. This generates high levels of fear in children, repeatedly activating their stress responses. In turn, this adversely affects their brain development and their capacity to regulate emotions. It "also teaches children that conflict escalates quickly, is dangerous, and is acceptably resolved through physical violence and emotional abuse. For boys and girls alike, witnessing repeated IPV increases the risk of their ending up in an abusive intimate relationship and of perpetrating abuse themselves" (expert comment).
- Directly "experiencing frightening parenting, which may range from harsh emotional responses to actual physical violence". Physical and emotional violence against children "generates chronically high levels of stress and distress among children". For infants and very young children, "harsh parenting and child abuse increase the risk of disorganized attachment, which is negatively associated with nearly every indicator of child wellbeing". There is insufficient data to generalise about the relative risks to boys vs. girls, or about gendered psychological impact of violence in conflict and refugee settings (expert comment).

Lastly, the expert adds that research from diverse high-stress contexts "has shown that persistent stress adversely affects parenting". Armed conflict and forced migration clearly place powerful and persistent stress on parents.

Similarly, another expert stated that, "based on evidence from non-conflict settings, positive family/parental functioning must have a strong ameliorating impact on modifying the mental health impacts of external trauma on children, including in conflict settings. And conversely, […] violence within the household would exacerbate the impacts of conflict" (expert comment).

[16] See: Inter-Agency Standing Committee [IASC] (n.d.). *IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings*. https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings

Another expert listed further established evidence from non-war settings that has relevance to, and implications for, children's MHPSW in wartime:

- "Infant and child survival and well-being are directly correlated with the safety, health and well-being of their mothers" (expert comment).
- "Children's behaviour, ability to learn and core biology are all influenced by exposure to adverse and traumatic experiences, such as IPV. Children may even be more deeply affected by stress and trauma than adults, depending on their age and developmental stage" (expert comment).
- "Recovering from trauma requires safety, something that is almost impossible to guarantee in situations of ongoing IPV in the home" (expert comment).
- "Mothers whose physical and/or mental health is compromised by violence may be less able to care for their children or support their families financially, affecting children's emotional and social development, nutrition, health and school attendance" (expert comment).
- "Children are resilient, yet some children are more resilient than others, and […] brain development and associated emotional well-being and behavioural regulation, memory, concentration etc can be impacted by exposure to trauma" (expert comment).

For now, considerations of safety, ethics and other research aspects have led researchers and practitioners to **rely on data from contexts other than armed conflicts** in order to understand the effects of violence on women and children, and survivors' needs (expert comment). For instance, to work from data akin to a baseline, researchers and practitioners have used both population-based research by the World Health Organisation (WHO) and service-based data on violence against women from non-conflict settings. This is done while "recognising the effects in conflict settings are likely to be significantly exacerbated due to an increase in exposure to violence, the experience of multiple ongoing trauma, [and] the breakdown in community support mechanisms and support services" (expert comment).

Findings from additional settings

An appendix to this report provides complementary references. The appendix lists references which contain points that are relevant to the report topic but that could not be used in the report, due to limited time. It also provides references on two further settings that are connected to wartime contexts in LMICs: post-conflict periods in LMICs; and children from LMICs who are refugees (in LMICs or in high-income countries) while war is ongoing in their home country.

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Key websites

- CPC Learning Network – Violence against children: http://www.cpcnetwork.org/resource/tag/violence-against-children/
- Development and Psychopathology – Special issue – Developmental and Social-Ecological Perspectives on Children, Political Violence, and Armed Conflict: https://www.cambridge.org/core/journals/development-and-psychopathology/issue/developmental-and-socialecological-perspectives-on-children-political-violence-and-armed-conflict/69E29E9DF64DD681E03850642CF54BB3
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About this report

This report is based on ten days of desk-based research. The K4D research helpdesk provides rapid syntheses of a selection of recent relevant literature and international expert thinking in response to specific questions relating to international development. For any enquiries, contact helpdesk@k4d.info.

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