Applying the ADAPT Psychosocial Model to War-Affected Children and Adolescents

Sophie Yohani

Abstract

Multiple individual, social, and environmental factors have long been recognized as influencing a child’s response to traumatic experiences. However, there remain few socio-ecological frameworks to guide researchers and practitioners working with war-affected children. This article examines Silove's psychosocial model of adaptation and development after trauma and persecution (ADAPT model) in relation to war-affected children. The utility of the model is explored by examining whether the systems of safety, attachment, identity, justice, and existential meaning described in the ADAPT model are represented in a narrative review of research from the last 20 years on the experiences of war-affected children and adolescents. Results suggest that research with war-affected children has covered all five psychosocial pillars in the model, but with overemphasis on the safety, followed by the attachment, domains. This review highlights that need for research and psychosocial interventions that focus on adaptation of war-affected children’s identity development, sense of justice, and meaning systems.

Keywords

refugees, trauma, war, children, adolescents, adaptation

Introduction

In her seminal study for the United Nations, “The Impact of Armed Conflict on Children,” Graça Machel (United Nations, 1996) drew international attention to the devastating physical, psychological, social, and cultural effects of war on the lives of children. In the same year, United Nations Children’s Fund’s (UNICEF; 1996) “State of the World’s Children” report estimated that two million children were killed and six million children were injured or disabled in conflicts in the decade previous to its publication. Although we have since advanced our understanding of the experiences of children affected by war, they continue to face significant trauma during and after war. Both a10-year strategic review of the Machel study (UNICEF, 2009) and the recent 2013 “Annual Report on Children and Armed Conflict” (United Nations, 2014) identify ongoing abuses of children in armed conflict, including sexual assault, abduction, forced participation in conflict, attacks on schools, and deprivation of food, basic health care and education. Such experiences fall within current understandings of traumatizing events which include actual or threatened events, including death, serious injury, or sexual violence though direct experience, witnessing, hearing about a loved one, or repeated extreme exposure to details (American Psychiatric Association [APA], 2013). These reports underscore the fact that, globally, almost two decades later, many children continue to experience massive physical and psychological threats to their well-being.

Despite this dismal picture, not all children exposed to mass violence and trauma develop psychopathology. Multiple individual, social, and contextual factors are recognized as influencing a child’s psychosocial response to traumatic experiences. These include the nature and timing of the experience, social preparation, personality, coping skills, social and familial support, and secondary stressors. This recognition has resulted in calls to examine trauma and psychosocial adaptation of war-affected children from ecological perspectives, that is, from the vantage of children’s developmental level and life contexts (Boothby, 2008; Gabriano & Kostenly, 1996; Walton, Nuttall, & Nuttall., 1997), larger socio-cultural context (Rousseau, Drapeau, & Corin, 1997; Wessells, 1999), individual and social risk and protective factors (Betancourt & Khan, 2008), and time and context-dependent variables (Attanayake et al., 2009; Tol, Song, & Jordans, 2013). However, currently, we do not have...
a unifying ecological framework to guide psychosocial research and practice with children in conflict, post-conflict, and resettlement settings. Although some studies refer to Bronfenbrenner's (1979) socio-ecological framework (e.g., see Betancourt & Khan, 2008; Saile, Ertl, Neuner, & Catani, 2014; Yohani & Larsen, 2009), it was not developed for childhood trauma. Similarly, research that utilizes developmental psychopathology models (e.g., see Pynoos, Steinberg, & Piacentini, 1999) and Diagnostic and Statistical Manual of Mental Disorders (DSM)/International Classification of Diseases (ICD) classification systems do not adequately address collective or mass trauma.

One model that shows promise as a general guide or meta-model in the field of refugee mental health is the adaptation and development after trauma and persecution (ADAPT) model. With its focus on how individuals and society adjust to new information and experiences (i.e., adaptation), this psychosocial model provides an explanation for both resilient and psychopathological responses to traumatic events. It is built on the idea that stability at the individual psychic and social levels interact and reflect each other through supports from key psychosocial pillars represented in institutions, practices, and culture (Silove, 1999, 2000, 2005, 2006). In the aftermath of war trauma, individuals and communities actively defend and maintain these systems of psychosocial stability, which include safety, bonds and attachment, justice, identity and roles, and existential meaning. Individual and collective mental health disorders reflect a failure to adapt both individually (i.e. biologically) and in the psychosocial environment in the aftermath following trauma. Although this model has been presented with adults, it may have potential for application to children.

This review article examines whether the systems found in the ADAPT model (Silove, 2000) are represented in the body of knowledge on the psychosocial experiences and needs of war-affected children and adolescents through an analysis of research literature from the last 20 years. The goals are to explore whether this framework applies to a pediatric population and to identify patterns and gaps in the scientific literature as reflected in the five psychosocial domains of safety, attachment, identity, justice, and existential meaning. The model's broad perspective on psychotrauma has potential to inform psychosocial practice with children affected by mass violence. Using a narrative review approach, searches were conducted in major database (e.g., PubMed, medline, psycINFO, PILOTS) using key words covering the five domains in the model (i.e., safety, attachment, justice, identity, and meaning) and terms relating to war, conflict, trauma, resilience, and adaptation in children ages 5 to 18 years in conflict, post-conflict, and resettlement settings. A total of 118 representative journal articles and book chapters covering qualitative and quantitative studies were selected and a research assistant worked with the author to analyze and categorize information into the five domains described. A second research assistant served as an external auditor, and the final categories were determined through consensus. After a brief explanation of the model, each domain is illustrated by using a case incident, examples of major research findings relating to the domain, and, consistent with the model, an analysis of both adaptive and maladaptive responses to war-trauma. Finally, avenues for further research, practice, and policy implications are presented.

The ADAPT Psychosocial Model

The ADAPT model is an integrative psychosocial framework for connecting the multiple issues, stressors, and resources facing war-affected individuals (see Silove, 1999, 2000, 2005, 2006). Silove (1999) proposed five universal adaptive systems believed to subsume the functions of safety, bonds and attachment, identity and roles, justice, and existential meaning in all societies. Under normal circumstances, these systems are understood to have evolved to promote personal and social homeostasis between individuals and their community. Although these systems are described separately, they are believed to interact within and between individuals in a community in "a synergistic and mutually supportive way" (Silove, 2005, p. 41). As such, these systems evolve dynamically as different stressors face individuals and their community, creating differing needs and warranting different responses.

The hypothesis underpinning the ADAPT model is that extreme trauma fundamentally challenges one or more of these major adaptive systems which sustain "a state of psychosocial equilibrium in individuals and their communities" (Silove, 1999, p. 203). Focusing on adaptive mechanisms for individuals and communities is built upon several prior understandings. First, as a highly adaptable species, human beings likely share universal methods of survival in the face of adversity, even though cultural and contextual differences may shape the expression of these adaptive mechanisms (Silove, 2000). Second, these universal adaptive systems have reciprocal representations in both psychobiological and socio-cultural structures created to foster the group's survival and growth. Underlying Silove's model is the belief that human reactions to trauma are driven by an evolutionary need for survival and psychosocial development that mobilize "the inherent capacities of individuals and groups to repair their own institutions, given favourable support and judicious external assistance" (Silove, 2000, p. 341). Reemphasizing individual and community contributions to the adaptation process following trauma underscores the capacity communities have to actively adapt following adverse situations. In this sense, the ADAPT model can be situated within resilience literature (Rutter, 2003) but with more emphasis on individual and collective experiences after mass violence.

Silove's five adaptive systems are outlined below. Each of the five sections begins with a case incident illustrating the pertinent issues related to that system. These cases are drawn from the author's clinical experience and critical incidents.
collected during research examining cultural brokers and mental health practitioners’ roles in facilitating refugee children’s adaptation in resettlement countries (Brar-Josan & Yohani, 2014; Yohani, 2013). It should be noted that case incidents sometimes involve issues related to more than one system, as an individual’s experience might involve a threat to multiple systems simultaneously.

Safety

Unbridled attacks on civilians and rural communities have provoked mass exoduses and the displacement of entire populations who flee conflict in search of elusive sanctuaries within and outside their national borders. Among these uprooted millions, it is estimated that 80 per cent are children and women. (United Nations (Machel Report), 1996, p. 10)

While living in Afghanistan during the civil war, 14-year old twins brothers witnessed the murder of their sister and her husband. One boy was also stabbed during the altercation. After resettling in Canada, both children saw a psychologist to address symptoms of trauma. Initially, both children were doing well, but then the boy who had been stabbed began using drugs and engaging in criminal activity. It was later discovered that he was being bullied while in school. Although he appeared adjusted to most people, he had developed a strong sense of paranoia and was coping by using substances. The boy started to respond to treatment after the bullying was addressed in school.

Description. Defining the absence of safety, Silove (2000) described events that threaten the survival or integrity of an individual or those close to the victim. In war, infringement on the safety system often involves experiencing traumatic events. Examining threat-based definitions, safety can be broadly outlined as the relative assurance of the physical, psychological, and spiritual integrity of individuals and their community. Attending to issues of safety and security is paramount for adaptation and survival (Silove, 2005).

Examining the research literature on war-affected children and adolescents, the safety system appears to draw the most interest from researchers. As seen in the case vignette, both directly witnessing violence (e.g., see Dyregrov, Gjestad, & Raundalen, 2002; Henley & Robinson, 2011; Heptinstall, Sethna, & Taylor, 2004; Husain et al., 1998; Pacione, Measham, & Rousseau, 2013; Thabet & Vostanis, 2000) and personally experiencing violence (e.g., see Allwood, Bell-Dolan, & Husain, 2002; Derluyn, Broekaert, Schuyten, & Temmerman, 2004; Goldstein, Wampfler, & Wise, 1997; Mirza, 2006; Pacione et al., 2013; Papageorgiou et al., 1999; Qouta, Punamäki, & El-Sarraj, 2003; Schaal & Elbert, 2006; Servan-Schreiber, Le Lin, & Birmaher, 1998) are common occurrences reported by war-affected children and their parents. Violence includes events like physical or sexual assault, shootings, and bombings. Indirect exposure to violence, through television or radio broadcasts, is another source of trauma (e.g., see Hadi & Llabre, 1998; Macksoud & Aber, 1996; Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009). Children and adolescents are also involved in the hostilities (e.g., see Amone-P’Olak, 2005; Bayer, Klase, & Adam, 2007; Betancourt, Borisova, et al., 2013; Derluyn et al., 2004; Macksoud & Aber, 1996; Robinson, 2013; Sack, Him, & Dickason, 1999), either training with armed forces, patrolling, or being forced to commit acts of violence or subterfuge. In some conflicts, girls are abducted by rebel forces and forced into marriage or other types of sexual abuse as reported among girls abducted in Northern Uganda (Amone-P’Olak, 2005). Resulting from these experiences, many children in these studies described fearing further acts of violence (e.g., see Allwood et al., 2002; Al-Mashat, Amundson, Buchanan, & Westwood, 2006; Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000; Goldstein et al., 1997; Hadi & Llabre, 1998; McFarlane, Kaplan, & Lawrence, 2011; Servan-Schreiber et al., 1998; Thabet, Abed, & Vostanis, 2002; Thabet & Vostanis, 2000).

To escape the dangers of war, children and their families may leave their homes, either becoming internally displaced within their own countries or by moving to other, safer countries (e.g., see Adam & van Essen, 2004; Gupta & Zimmer, 2008; Kuterovac-Jagodic, 2003; Robinson, 2013; Sack et al., 1999). However, relocation poses its own dangers, including starvation, assault, and exposure to further violence. In a study of Tibetan refugees living in India (Servan-Schreiber et al., 1998), one child lost half of her traveling companions in an avalanche, while another was captured and imprisoned for a month. In another study by Bates, Luster, Johnson, and Rana (2013), Sudanese youth who were forced to relocate to Ethiopia witnessed the death of more than half of their peers. Displacement has been found to have a negative impact on children’s well-being, with mothers of displaced Croatian children indicating a substantial increase in a variety of physical, behavioral, and emotional symptoms, as well as more concentration difficulties (Ajdukovic & Ajdukovic, 1998). Even for children who have relocated to a safe country, post-migration experiences have been linked with children’s psychological symptoms as noted in the case vignette (Heptinstall et al., 2004; Pacione et al., 2013). In a longitudinal study of adolescent Middle Eastern refugees residing in Denmark, post-migration adaptation and stressors (such as discrimination) were stronger predictors of psychological problems than pre-migration trauma (Montgomery, 2008). This demonstrates the significance of the refugee experience post-migration.

Adaptive responses. Responses to trauma need to be viewed in the context of their circumstances. After experiencing war violence, a period of arousal, hyper-vigilance, and avoidance of stimuli associated with the trauma can be considered adaptive behavior, especially if danger may reoccur (Silove, 1998). For example, the previous case illustrated how hypervigilant behavior in a youth alerted the presence of new threats to safety in his resettlement environment. Similarly,
in a study of internally displaced Bosnians living in the midst of war (Goldstein et al., 1997), an increased startle reflex and fears of going outside, common indicators of post-traumatic stress disorder (PTSD), were actually considered protective for children.

Responding adaptively to war experiences may also involve children remaining at or returning to their previous level of functioning before the trauma. Standardized measures of intelligence are one potential way to assess changes in children’s cognitive functioning, over time. In a study of Kuwaiti children using a translated version of the Wechsler Intelligence Scales for Children-Revised (WISC-R; Hadi & Llabre, 1998), mean changes in children’s WISC–R scores from pre-crisis to post-crisis were actually positive. While this change was partially attributed to practice effects, it may also be a sign of resiliency following trauma. Likewise, a decrease in psychological symptoms of trauma among young Middle Eastern refugees resettled in Denmark (Montgomery, 2010) may be viewed as an indicator of resiliency.

By managing day-to-day stressors and tasks, children can also show how they can adapt following trauma. For a group of Cambodian refugees living in America (Sack et al., 1999), almost all were able to carry out daily responsibilities, such as employment or schooling, despite their previous traumatic experiences.

In a study of Iraqi children following war, children displayed a tough bravado and detached emotionality, which appeared to increase the children’s sense of strength when feeling vulnerable (Al-Mashat et al., 2006). Toughness was seen as a good characteristic in this context.

**Maladaptive responses.** Intense emotions of anger, grief, sadness, and fear are expected in the face of the tragedy and destruction caused by war. However, when these feelings and behaviors persist, they can interfere with daily functioning. Reported feelings of sadness or depression (e.g., see Ajdukovic & Ajdukovic, 1998; Betancourt, Newnham, et al., 2012; Dyregrov et al., 2002; Heptinstall et al., 2004; McFarlane et al., 2011; Paardekooper, de Jong, & Hermans, 1999; Sezibera, Van Broeck, & Philippot, 2009; Thabet, Abed, & Vostanis, 2004) and anxiety (e.g., see Allwood et al., 2002; Goldstein et al., 1997; Hadi & Llabre, 1998; Mollica, Poole, Son, Murray, & Tor, 1997; Papageorgiou et al., 1999; Punamäki, 1996; Thabet, Tawahina, El-Sarraj, & Vostanis, 2008; Werner, 2012) are common in studies of children exposed to war. While these feelings are understandable, their strength and perversiveness may interfere with children’s ability to heal and develop following trauma.

From the perspective of the ADAPT model, PTSD-related symptoms of arousal and hyper-vigilance can be protective in dangerous environments (Silove, 1998) but can significantly interfere with normal functioning once children enter a safer environment. Symptoms of PTSD are common in studies of war-affected children and adolescents (e.g., see Attanayake et al., 2009; Betancourt, Newnham, et al., 2012; Elklit, Østergård Kjær, Lasgaard, & Palic, 2012; Husain et al., 1998; Kia-Keating & Ellis, 2007; Laor et al., 1997; Macksoud & Aber, 1996; McMullen, O’Callaghan, Richards, Eakin, & Rafferty, 2012; Mirza, 2006; Neugebauer et al., 2009; Schaal & Elbert, 2006; Sezibera et al., 2009; Werner, 2012), with severity of post-traumatic symptoms ranging from mild to severe. Several studies report that the severity of children’s post-traumatic symptoms is linked to the amount of violent exposure children experienced (Heptinstall et al., 2004; Lavi, Green, & Dekel, 2013; Neugebauer et al., 2009; Schaal & Elbert, 2006; Solomon & Lavi, 2005). Among refugee children living in London with their families, a correlation was also found between the number of post-migration stressors (e.g., financial difficulties, insecure asylum status, language problems) and children’s PTSD and depression scores (Heptinstall et al., 2004). In particular, Heptinstall et al. found that experiencing the violent death of a family member and insecure asylum status were associated with higher PTSD scores. Insecure asylum status and severe financial difficulties were associated with higher depression scores (Heptinstall et al., 2004).

Retaining post-traumatic symptoms in a safe environment is a maladaptive, yet common, response for children exposed to war (Almqvist & Brandell-Forsberg, 1997; Sack et al., 1999). Prevalence and severity of PTSD and depression were measured in a 12-year longitudinal study of Cambodian refugee adolescents living in America (Kinzie, Ack, Angell, Manson, & Rath, 1986; Sak, Clarke, & Him, 1993; Sack et al., 1999). Four years after leaving Cambodia, 50% of 46 students exhibited PTSD (Kinzie et al., 1986) and twelve years later, 35% of 31 students met criteria for PTSD (Sack et al., 1999). In a study by Betancourt, Newnham, et al. (2012), 30.36% of a sample of 60 refugee children showed PTSD symptoms even after resettlement. Bronstein, Montogmery, and Dobrowolski (2012) found similar results in a case of Afghan unaccompanied refugee minors with 34% reporting PTSD symptoms, post-resettlement. According to the ADAPT model, these symptoms are maladaptive because they persisted for a long period of time and disrupted the regular functioning of these individuals. In a study of Iraqi children following the Gulf War, children’s post-traumatic symptoms had reduced 2 years after the war (Dyregrov et al., 2002). However, the overall scores remained high leading to conclusions that children’s post-traumatic “symptoms persist, with somewhat diminished intensity over time” (Dyregrov et al., 2002, p. 59). Ten years after the 1994 genocide against the Tutsi in Rwanda, many Rwandan youth living in orphanages and youth-headed households who had been exposed to extreme levels of violence were still significantly distressed, with 44% meeting criteria for PTSD (Schaal & Elbert, 2006). Conversely, Punamäki, Qouta, and El-Sarraj (2001) reported a significant decrease in Palestinian children’s neurotic symptoms 3 years following political violence, especially among those children exposed to the most traumatic events, indicating that some symptoms may decline over time.
The safety system and its relationship to PTSD tend to attract the majority of researcher attention. However, several other maladaptive responses are potentially linked with safety violations. Psychosomatic complaints (McFarlane et al., 2011; Paardekooper et al., 1999; Sezibera et al., 2009), guilt (Goldstein et al., 1997; McFarlane et al., 2011), neuroticism (Punamäki et al., 2001), underreporting of post-traumatic symptoms due to fear of stigma (Anstiss & Ziaian, 2010; Colucci, Minas, Szwarc, Paxton, & Guerra, 2012; Servan-Schreiber et al., 1998; Thabet & Vostanis, 2000), and developing an external locus of control (Kuterovac-Jagodic, 2003) are also described in groups of children following war-trauma. In total, these maladaptive responses likely contribute to adjustment difficulties for children and adolescents as they seek to begin new lives following war.

**Bonds and Attachment**

Children seek protection in networks of social support, but these have been undermined by new political and economic realities. Conflict and violent social change have affected social welfare networks between families and communities. Rapid urbanization and the spread of market-based values have also helped erode systems of support that were once based on the extended family. (United Nations (Machel Report), 1996, p. 9)

A 15-year old Somali girl was having relationship problems with her father while living in Canada. Before migrating, the girl and her family lived in a refugee camp in Kenya. To support the family, the girl’s father travelled to an urban area to make some money, during which time the girl’s mother died. The girl had difficulty coping with her mother’s death and considered it her father’s fault. She felt that if her father had done more and remained close to the family, her mother would still be alive. Over time, the relationship between the girl and her father deteriorated, and she left home and moved in with a group of peers. The girl’s attendance at school was poor so a community cultural broker arranged a meeting with the girl and her father. While initially challenging, the relationship between father and daughter improved slowly with the assistance of community cultural supports and grief counseling for both father and daughter.

**Description.** Attachment is a bond based on the need for safety, protection, and comfort (Prior & Glaser, 2006) that begins in infancy between a child and their caregiver(s) (Bowlby, 1969). This attachment need is paramount in childhood, when individuals are the most vulnerable. For children and adolescents facing war-trauma, this need for protection and comfort is highly salient. Research in Uganda (Bowlby, 1969), Kenya (Kermoian & Leiderman, 1986), Mali (True, Pisani, & Oumar, 2001), Israel (Fox, 1977), Nigeria (Marvin, Van Devender, Iwanaga, LeVine, & LeVine, 1977), Botswana (van Ijzendoorn & Sagi, 1999), and Zambia (Morelli & Tronick, 1991) supports the premise that attachment theory is applicable across cultures (Prior & Glaser, 2006).

As illustrated in the case vignette, one of the most devastating disruptions caused by violence, displacement, and other war-related traumas is the impact on the survivors’ interpersonal bonds (Silove, 1999). Separations and losses can be either actual or symbolic. For example, a child may be separated from a parent while fleeing a war-ravaged area or lose a favorite toy which represents her comforting feelings of home. As a symbol of familiarity and intimacy, the loss of a home has a deeply personal impact on children (Klingman, 2002a). In the surveyed literature, war-affected children and adolescents frequently reported attachment-related threats, including witnessing violence against family or friends (e.g., see Almqvist & Brandell-Forsberg, 1997; Ellis, MacDonald, Lincoln, & Cabral, 2008; Macksoud & Aber, 1996; McBrien & Day, 2012; Qouta et al., 2003; Schaal & Elbert, 2006), separations from caregivers (Amone-P’Olak, 2005; Bates et al., 2013; Derluyn et al., 2004; Durá-Vilà, Klasen, Makatini, Rahimi, & Hodes, 2013; Heptinstall et al., 2004; Hilker, 2009; Kia-Keating & Ellis, 2007; Kuterovac-Jagodic, 2003; Mirza, 2006; Papageorgiou et al., 1999), damaged community supports (Dyregrov et al., 2000), loss of close friends (Dyregrov et al., 2002), and a lack of social support (Bates et al., 2005; Paardekooper et al., 1999; Punamäki, 1996). Even after conflict has ceased, children may continue to worry about attachment-related threats. For example, 2 years after the Gulf War, more than 80% of Iraqi children reported fear of losing their family sometimes or always (Dyregrov et al., 2002). Examining the impact of separation from caregivers, Klingman (2002a, 2002b) found that children experienced greater distress from separations than from witnessing death, destruction, injury, or bombings.

Lacking a parent or caregiver may place children at greater risk for psychological difficulties. A study by Derluyn, Mels, and Broekaert (2009) found that separated refugee youth have an increased risk of facing multiple traumatic incidences, along with an increased risk for developing mental health problems. In a study of unaccompanied refugee minors seeking asylum in Norway (Batista Pinto Wiese & Burhorst, 2007), unaccompanied children were more likely to experience regulation difficulties, somatic complaints, depressed feelings, and hallucinations or delusions than children with family members. Similarly, in the United Kingdom, higher levels of psychological distress was observed in recently arrived young refugees, who had also experienced separation from immediate family (Durá-Vilà et al., 2013). As children’s ability to self-regulate draws greatly from their caretaker’s emotional state, it seems likely that unaccompanied minors run a greater risk of mental health problems following trauma exposure (Huemer et al., 2009; Loughry & Flouri, 2001; Lustig et al., 2004; Sourander, 1998). Similarly, psychiatric symptoms of PTSD and depression were more common and severe in groups of Cambodian refugees who did not live with a family member when they moved to America (Kinzie et al., 1986). Seglem, Oppdal, and Raeder (2011) found that unaccompanied refugee minors
have elevated levels of depressive symptoms even after resettlement. However, unaccompanied minors also experienced, on average, more traumatic events than children living with their families (Batista Pinto Wiese & Burhorst, 2007), highlighting the increased danger for children who are separated from their caregivers. A literature review by Huemer et al. (2009) concluded that being separated from family greatly increased refugee adolescents likelihood of experiencing traumatic events.

Youth-headed households are another outcome of war and the loss of caregivers. For example, many children lost their parents during the 1994 genocide against Tutsi of Rwanda and/or subsequently from AIDS. As a result, it was estimated that 10% of households in Rwanda were headed by children a decade after the war (Mirza, 2006). Children in youth-headed households were more “susceptible to disease, exploitation, poverty, inability to attend school, and displacement from their homes” (Mirza, 2006, p. 179). In addition, these youth often felt marginalized and unsupported by their community (Mirza, 2006). Another study found that Rwandan youth living in child-headed households were more likely to report PTSD symptoms than youth living in an orphanage (Schaal & Elbert, 2006). These studies give emphasis to the psychological and social sequel of threats to children’s attachment systems in the context of war.

In families, children are not the only members exposed to the effects of war. Caregivers may also be traumatized by violence, injustice, and instability (Klingman, 2006; Saile et al., 2014). Reports of traumatized and emotionally unavailable caregivers are found in studies of war-affected children (Al-Mashat et al., 2006; Almqvist & Brandell-Forsberg, 1997; Anstiss & Ziaian, 2010; Dyregrov et al., 2002; Hadi & Llabre, 1998; Henley & Robinson, 2011; Laor et al., 1997; Paardekooper et al., 1999; Quota et al., 2003; Saile et al., 2014; Thabet et al., 2008). Various studies have found that there is a higher rate of mental health problems within refugee parent populations as opposed to civilian populations (McFarlane et al., 2011). Psychological unavailability of caregivers, due to traumatization or physical absence, may contribute to long-term psychological challenges in children (Cicchetti, Toth, & Lynch, 1997). Studies have shown that the mental health of caregivers is a key predictor of the mental health of children (Betancourt & Khan, 2008). In a study of families living in the Gaza Strip during periods of violence, the emotional responses of children and their parents were found to be interrelated (Thabet et al., 2008). Parents’ PTSD scores predicted their children’s PTSD symptoms. Likewise, parents’ anxiety scores predicted their children’s anxiety symptoms. Similarly, Ajdukovic and Ajdukovic (1998) found that the number of children’s adjustment difficulties correlated with their mother’s post-traumatic stress reactions. More recently, Saile and colleagues (2014) shed light on the complex interaction between child and caregiver mental health in post-conflict settings. This study examined distal and proximal risk factors for child victimization by caregivers in Northern Uganda. Results indicate that aggressive parenting behaviors by caregivers was predicted by their own experiences of childhood maltreatment, female caregivers victimization in intimate partner relationships, and male caregivers symptoms of PTSD and alcohol use.

Caregivers also play an important role in accessing help for traumatized children, as caregivers usually possess the most intimate knowledge of their children’s well-being. Unfortunately, caregivers are sometimes unaware of their children’s mental health issues (Henley & Robinson, 2011; Miller, Mitchell, & Brown, 2005; Papageorgiou et al., 1999). This lack of awareness may be due to lack of attention from caregivers (Klingman, 2006), the caregiver’s own debilitation from trauma, or children’s attempts to shield or protect their caregivers. At other times, caregivers may fail to notice or even discourage children’s attempts to process traumatic events through re-experiencing play, hoping that children will simply forget the trauma (Almqvist & Brandell-Forsberg, 1997). For example, Dyregrov et al. (2002) reported that it was common practice in Iraq for parents to tell their children to forget what had happened. Furthermore, refugee parents may be unwilling to utilize mental health services for their children because of the stigma associated with mental health issues (Anstiss & Ziaian, 2010; Henley & Robinson, 2011).

Adaptive responses. Support is vital for children and adolescents to recover from traumatic experiences. Social (Barber, 2001; Bates et al., 2005; Hek, 2005; Kovacev & Shute, 2004; Kutervac-Jagodic, 2003; Stewart, Simich, Shizha, Makumbe, & Makwarimba, 2012; Werner, 2012), familial (Barber, 2001; Betancourt, Salhi, et al., 2012; Hadi & Llabre, 1998; Hek, 2005; Laor et al., 1997; Punamäki et al., 2001; Servan-Schreiber et al., 1998; Thabet et al., 2009; Werner, 2012; Yohani & Larsen, 2009), peer (Barber, 2001; Bates et al., 2013; Correa-Velez, Gifford, & Barnett, 2010; Dyregrov et al., 2000; Hek, 2005; Kovacev & Shute, 2004; Yohani & Larsen, 2009), and community supports (Yohani, 2008) are identified as significant resilience factors for the adaptation of war-affected children and adolescents. For children, the school environment is of major importance as they adjust. Schools can make a difference in refugee children’s ability to settle, build a sense of belonging, develop socially and emotionally, and regain a sense of structure and routine (Humphries & Mynott, 2001; Rana, Qin, Bates, Luster, & Saltarelli, 2011; Rousseau & Guzder, 2008; Rutter, 2003; Yohani, 2013).

Positive familial relationships and parental support appear to be particularly important for children to respond adaptively following war. In a qualitative study by Kanji and Cameron (2010), Afghani refugee children resettled in Canada frequently mentioned the importance of family and how being united with their family gave them strength, support, and a sense of security. Iraqi children reported maintaining physical closeness with their parents as a way of coping with their trauma (Al-Mashat et al., 2006). Similarly, Correa-Velez et al. (2010) found that there was a significant
correlation between living at home with parents and increased well-being within refugee children resettled in Melbourne, Australia. According to Thabet et al. (2009), greater parental support was related to lower levels of exposure to traumatic events among Palestinian children living in the Gaza Strip. Parental support was also found to be associated with lower post-traumatic symptoms scores (Thabet et al., 2009). Harmonious parenting, in which children felt loved and accepted by both parents, was linked to better adjustment among Palestinian children (Punamäki et al., 2001). Catani et al. (2010) conducted cross-sectional studies that focused on the impact of the Asian tsunami and domestic violence on youth living in Sri Lanka who had also experienced civil war in their country. Positive adaptation was measured by analyzing the sample’s post-traumatic stress symptoms, somatic complaints, psychosocial functioning, and reports of their schoolwork. It was found that family support was a predictor of positive adaptation. These findings indicate that it is imperative to protect parents after adversity to help their children recover. Conversely, discrepant parenting, where children perceived their mothers but not their fathers as loving and caring, was characteristic of children with higher levels of PTSD. Punamäki et al. (2001) also reported that Palestinian children who felt loved and accepted at home were more likely to fulfill their intellectual and creative potential.

The quality and supportiveness of the recovery environment following trauma contributes to the outcome of early PTSD reactions (Steel, Silove, Bird, McGorry, & Mohan, 1999). In a study of children and adolescents living in a Rwandan unaccompanied center (Dyregrov et al., 2000), the psychosocial environment of the center, including camaraderie with other children, basic needs being met, education, and trained staff, was believed to have a healing effect on the children. Compared with children in the community, children living at the center actually exhibited lower levels of distress, even though “children living at centers initially experienced more losses and greater violence exposures than children in the community” (Dyregrov et al., 2000, p. 16). Similarly, refugee children and staff of an early intervention program in Canada both identified hope as a personal resource that was engendered when children felt supported by adult staff and other important caregivers (Yohani, 2008). According to Durà-Vilà and colleagues (2013), the delivery of mental health services in schools and being able to consult with teachers are highly beneficial for refugee children’s adjustment after trauma. Alternatively, loss of social connections and separation from family members appear to maintain symptoms of depression and PTSD (Bates et al., 2013; Gorst-Unsworth & Goldenberg, 1998; Hauff & Vaglum, 1995).

The needs of children and adolescents without families need to be handled sensitively in the aftermath of war. Dyregrov et al. (2000) cautioned that within-country adoptions of war-affected children need to be conducted with discretion, and Hek (2007) outlined the advantages and disadvantages of foster-care programs in resettlement countries. Although most societies have traditions to care for parentless children in the absence of blood relations (Mirza, 2006), communities may be less able to care for children in the immediate aftermath of widespread destruction, like the Rwandan genocide (Dyregrov et al., 2000; Mirza, 2006). Instead, group care may be an option while communities rebuild and recover, as it can foster social and cognitive development, as noted by research with Eritrean orphans (Wolff, Tefsi, Egasso, & Aradom, 1995), and meets basic needs, as noted in Rwanda (Dyregrov et al., 2000). For unaccompanied minors moving to settlement countries, caregiving arrangements vary depending on host country and can range from placement in group homes, shared apartments, to foster homes. In a study of asylum-seeking adolescents from Afghanistan in the United Kingdom (Bronstein et al., 2012), foster care was found to be negatively associated with PTSD. Highly committed foster parents are also crucial, as noted in studies of unaccompanied refugee youth in foster care in United Kingdom (Wade, Siritiye, Kohli, & Simmonds, 2012) and the United States (Luster, Qin, Bates, Johnson, & Rana, 2009). The relationship between caregivers and unaccompanied minors appears to be the crucial element in the success of these various care arrangements, providing evidence for the role of attachment/bonds domain of the ADAPT model. Bates and colleagues (2005) advocated specifically for the importance of open-minded and flexible foster-care placements that take into account the unique pre- and post-migration experiences and needs of the children in care.

Rebuilding community and social structures in the wake of conflict may offer avenues for children to restore their bonds with the larger community. In a study of Israeli preschoolers, “reconstitution of the socio-cultural layer of the protective matrix may have promoted adaptation of the children and facilitated a reduction in stress symptoms” (Laor et al., 1997, p. 354). Active community involvement was also identified by children and school officials as both protective and healing for Tibetan refugee minors (Servan-Schreiber et al., 1998). Afghan refugee children resettled in Canada expressed how support from their Ismaili community and their involvement in community-related activities greatly helped them to adjust (Kanji & Cameron, 2010). Conversely, neighborhood disorganization was linked to behavior problems among Palestinian youth (Barber, 2001).

**Maladaptive responses.** As previously identified in the safety system, symptoms of PTSD (e.g., see Attnayake et al., 2009), sadness or depression (e.g., see Thabet & Vostanis, 2000), anxiety (e.g., see Werner, 2012), guilt (e.g., see McFarlane et al., 2011), and shame (Al-Mashat et al., 2006), occur frequently in studies of war-affected children and adolescents. Clearly, traumatic events and responses to trauma are multifaceted. Viewed within the ADAPT model, these affective and behavioral responses likely arise from traumatic events that affect both children’s sense of safety and
attachment. Safety and attachment are highly salient, interconnected needs for children and do not function in isolation. For example, Schaal and Elbert (2006) reported that the two events most strongly related to PTSD symptoms in Rwandan youth were witnessing the murder of a parent and the belief that they themselves would die. However, theoretically, Silove notes that maladaptive responses to losses accumulated from threats to attachment systems involve grief and depressive reactions. In a study of Croatian refugee children, depression was correlated with deteriorating family relations, poorer relationships with mothers, and the child’s perceived rejection by the mother (Ajdukovic & Ajdukovic, 1998). It was also reported that children who lacked a supportive family environment had higher levels of stress-related symptoms and were at special risk for developing further psychological difficulties.

In the face of war-related trauma, families may lose their ability to function in a healthy and adaptive manner. When parents and children both experience trauma, family cohesion and parental capacity may be impacted (Almqvist & Brandell-Forsberg, 1997). In response to war-related stress, approaches to parenting may alter, evoking more authoritative parenting styles, less supervision of children, or less positive communication (Klingman, 2006). Similarly, the results of a study by van Ee, Kleber, and Mooren (2012) showed that asylum seeker and refugee mothers experiencing post-traumatic stress are at a higher risk for insensitive or unstructured interactions with their infants. Ajdukovic and Ajdukovic (1998) reported that as Croatian refugee children exhibited more stress reactions, maternal gentleness decreased. Difficulties in relationships with others may spread beyond the family, as well. In a group of internally displaced Bosnians, children reported being unwilling or unable to play with others (Goldstein et al., 1997).

Justice

War violates every right of a child—the right to life, the right to be with family and community, the right to health, the right to the development of the personality and the right to be nurtured and protected. (United Nations (Machel Report), 1996, p. 10)

During war in his country of Uganda, an 11-year old boy witnessed his mother being murdered. In addition, the boy and his family were unable to provide an appropriate burial for his mother’s body. These experiences troubled the boy for a long time. The boy believed he could never forgive the crimes he had witnessed and considered joining the army to seek revenge. However, over time he came to realize that he would be shooting and killing innocent people. Seeking revenge would have caused others to go through what he was going through. Recognizing this, the boy decided to break the chain of violence and walk away from it. At age 19, he decided to study law, with the hope of making a difference in his country’s judicial system.

Description. Common definitions of justice tend to include (a) the quality of being just, (b) fairness, (c) conforming to moral rightness in action or attitude, and (d) the upholding of fair treatment and due reward in accordance with honor, standards, or law (Houghton Mifflin, 2006). Experiences that threaten an individual’s sense of justice include torture, human rights violations, dehumanization, corruption, exploitation, and the presence of perpetrators living with impunity in the community (Silove, 2000). These experiences are psychologically traumatizing due to their propensity to humiliate and shame the individuals and communities. In response to these justice violations, Silove (2000) argued that “one pathway of adaptation to injustice is therefore to struggle for the creation of social structures that will prevent similar abuses in the future” (p. 344). In addition, Silove notes that “many great humanitarian leaders of this century themselves suffered persecution at some point in their careers” (p. 344), including Mahatma Gandhi and Nelson Mandela. Interestingly, the boy in the previous case followed a similar pathway to these great leaders.

Justice-related threats can happen to children in their country of origin or following the conflict in a settlement country. Children may experience persecution (Almqvist & Brandell-Forsberg, 1997) for religious beliefs or cultural identity. Being prevented from helping wounded individuals during conflict (Qouta et al., 2003) may also affect children’s beliefs about justice. Following war, perpetrators of violence and destruction sometimes remain in their community with impunity (Dyregrov et al., 2000), continually reminding children of the unpunished atrocities that were committed. In settlement countries, threats to justice can occur at an individual or societal level. For example, children may be discriminated against because of their refugee status (Bates et al., 2005; Ellis et al., 2010) or they may be marginalized by legislation regarding refugees (Hek, 2005). These experiences may leave children and adolescents feeling powerless to impact their environment (Paardekooper et al., 1999) leaving them with unresolved anger and shame. Acts of discrimination toward refugee students can also lead to PTSD and depressive symptoms (Correa-Velez et al., 2010).

Adaptive and maladaptive responses. Respect and empowerment are central to just responses to war violence. At the forefront, service delivery and interventions should be conveyed in a culturally sensitive and appropriate manner for children and their families (Thabet & Vostanis, 2000; Yohani, 2008). These practices involve consultation with community members and development of culturally sensitive practices (Bates et al., 2005). Measures used to evaluate intervention effects should also be culturally sensitive as symptoms can be expressed in a variety of ways depending on the social and cultural context (Betancourt, Meyers-Ohki, Charrow, & Tol, 2013).

Responses that encourage and empower children and adults to take a stand against injustice offer adaptive ways to
address war-related atrocities. Although it may seem counterintuitive, from the ADAPT model’s perspective, remaining distressed because perpetrators remain unpunished in the community (Dyregrov et al., 2000), is actually a healthy response for children and adolescents. Their distress suggests that children have not given up and accepted that these situations are inevitable. For Tibetan refugee children, participating in their nation’s struggle against oppression was identified as a healing and protective factor (Servan-Schreiber et al., 1998). Similarly, Iraqi children spoke about their resentment toward the occupying Americans and their desire to help remove the occupying army (Al-Mashat et al., 2006). Specifically, continuing engagement in political activities has been associated with a good prognosis of PTSD symptoms (Allden et al., 1996). Palestinian children who responded actively to political violence had fewer traumatic symptoms and less emotional disorders compared with passive children (Punamäki et al., 2001). Israeli children exposed to war with strong ideological commitment did not report as many psychological impacts as those with weak ideological commitment (Punamäki, 1996). Finally, adults can also advocate on behalf of the rights of children in conflict situations. Goldstein et al. (1997) encouraged professionals, like pediatricians, to publicize the effects of war on children and bring public attention to injustices and specific needs of children. There is a need to further examine the nature of children’s involvement in justice-related activities as such engagement can be dangerous or contribute to further distress, depending on context.

Promoting a sense of justice and fairness in schools can assist children and adolescents as they resettle during post-conflict. For example, in settlement countries, anti-bullying policies can contribute to students developing feelings of belonging in new schools (Hek, 2005). According to Montero, Ibrahim, Loomis, and Newmaster (2012), anti-bullying programs must address “anti-immigrant sentiments” that many refugee students face to further increase feelings of belonging. In the United Kingdom, Blackwell and Melzak (2000) encouraged students to understand and work with the behavior of refugee students in ways that cause children to feel neither disadvantaged nor specially privileged. However, this may be a difficult task, as noted in one study whereby some Sudanese students viewed educational assistance to address gaps in their education as “punishment” (Miller et al., 2005, p. 28). Likewise, educational researchers (Derwing, Decorby, Ichikawa, & Jamieson, 1999; Seat, 2003) have noted that some children report feeling marginalized and stigmatized by being placed in English as a Second Language (ESL) classes. Furthermore, teacher misunderstandings toward newcomer students because of lack of cultural awareness (McBrien & Day, 2012) and lowered expectations from teachers (Rana et al., 2011) can lead to increased feelings of marginalization. These perspectives can be understood in light of other studies that suggest newcomer children are often rejected by their peers and are discriminated against for not being able to speak English (Anisef & Kilbride, 2000; Rummens & Dei, 2010). In these contexts, children’s responses can be viewed as attempts to resist systems that threaten to contribute to isolation and marginalization.

Exposure to violence also seems to affect children’s beliefs regarding appropriate responses to war. Former child soldiers in Uganda and the Congo with more PTSD symptoms were less open to reconciliation and had more feelings of revenge than those with fewer PTSD symptoms (Bayer et al., 2007). In a study of Israeli youth, greater exposure to violence tended to be related to more negative attitudes toward peace (Solomon & Lavi, 2005).

Silove notes that unlike other affective responses, like depression or anxiety, the DSM classification system does not contain primary anger syndromes (Silove, 2000). He proposes that further research is necessary to examine the possibility of a traumatic anger disorder for survivors of human rights injustices. This may be particularly relevant for understanding the behaviors of older children and adolescents. Aggressive behavior is often found in children and adolescents who survive war-trauma (Belsky, 2008; Miller et al., 2005; Paardekooper et al., 1999; Quota et al., 2003). Although some might argue that aggression and anger should be placed as responses to safety violations, others may view them as responses to unfair and unjust treatment. The perceived source of the maladaptive response affects the interventions proposed to address the behavior. For example, if aggressive behavior is postulated to stem from fear, interventions may involve managing physiological hyper-arousal using cognitive and behavioral approaches. However, if aggressive behavior is thought to stem from justice violations, interventions may include social justice activities aimed at empowering youth to make positive changes.

Identity and Roles

All cultures recognize adolescence as a highly significant period in which young people learn future roles and incorporate the values and norms of their societies. The extreme and often prolonged circumstances of armed conflict interfere with identity development. (United Nations, 1996 (Machel Report), p. 40)

A 14-year-old Iraq-born boy, arrived in Canada with his single-parent mother and was placed in a junior high school after less that four years of formal schooling during the war in his home country. At school he struggled academically and socially. His attendance was poor and he had conflicts with his teachers and other school personnel. When the boy began high school the following year, his attendance continued to be sporadic. The boy’s neighbourhood had high rates of criminal and gang activity, and he started to move toward these activities. The school recommended that he enroll in a reform school, but the boy did not want to go. The boy’s mother tried to discipline him, but nothing seemed to work. The boy’s involvement with gangs made him appear “cool”
among his peers. Some youth in the community were impressed that he appeared to be providing for his family, even if he was doing so using illegal means. The boy became a role model for other vulnerable students, some who followed his example and joined gangs.

**Description.** A major developmental task for adolescents is identity formation (Erikson, 1959). As children grow and develop toward adulthood, they must cultivate “a firm and coherent sense of who they are, where they are heading, and where they fit into society” (Shaffer, Wood, & Willoughby, 2002, p. 460). War severely disrupts a child’s sense of continuity, where day-to-day routines and expectations like attending school or playing with friends are lost (Klingman, 2006). Children’s roles, and subsequently their identity, may be forced to alter drastically. Children may change roles from students to soldiers, being cared for by parents to caring for siblings after the loss of both caregivers, or citizens of their own country to outsiders in a new country. Because of the plasticity of the brain, adolescents forge new identities in relation to the experiences they encounter. This could explain how the young boy in the case vignette easily identified with a local gang and how children recruited by armed groups grow to view themselves as part of armed groups.

Having one’s social position, roles, possessions, and school stripped away may seriously threaten a child’s “sense of empowerment, efficacy and individuality” (Silove, 2005, p. 345). As when children move to a new country, they are often faced with roles and expectations differing from those in their country of origin. Fantino and Colak (2001) explained, “the uprooting, disruption, and insecurity inherent in migration affect psychological and social development, making the process of identity formation a more difficult balancing act between two or more sets of cultural notions and values” (p. 591). Bates et al. (2005) examined resettlement experiences for unaccompanied Sudanese refugee youth placed in foster care in America. Differences in gender roles and behaviors caused confusion. In foster homes, cultural differences regarding household roles created difficulties when boys resisted cooking as “women’s work” and feared mockery for working in the kitchen. At school, boys also found female assertiveness very different in dating relationships. Similarly, two studies in Australia found Afghan (Iqbal, Joyce, Russo, & Earnest, 2012) and Burmese (Koh, Liamputtong, & Walker, 2013) female refugee youth faced difficulties in negotiating their identity because of differing gender roles and expectations between their culture of origin and mainstream Australian culture.

In some wars, individuals are targeted on the basis of their ethnic identity. For example, during the 1994 genocide against the Tusti in Rwanda, approximately 800,000 Tutsis were killed by Hutus (Mirza, 2006). Hilker (2009) studied Rwandan youth about 10 years after the genocide. Although political attempts have been made to de-emphasize ethnicity, Hilker found that discussions about ethnicity had become a taboo and moved underground. Ethnic stereotyping was still pervasive among Rwandan youths who continuously categorized important others by perceived ethnic identity. This process of categorization is complex, uncertain, and often contradictory; it fails to capture the lived reality, which is more complex than the ethnic categories largely based on stereotypes. Hilker also explains that the war affected young Rwandans’ trust of others, especially those in other ethnic groups. For reconciliation to be most effective among Rwandans, Hilker argues for the need to challenge ideas about the “conceptual Tutsi” and “conceptual Hutu.” Hilker explains that,

a first step would be to encourage “concrete” Hutus, Tutsis and “mixed” Rwandans to discuss their views and experiences openly, to acknowledge the plurality of their identities and to foster affiliations with others based on other common experiences and interests. (p. 97)

**Adaptive and maladaptive responses.** As school occupies a central part in a child’s world, it makes sense that school experiences would strongly affect identity and role development for war-affected children and adolescents. However, discrimination is a reoccurring theme among refugee children in school settings (J. Stewart, 2012). Perceived discrimination and resulting stress have an impact on identity formation in children due to the internalization of negative messages (Derluyn & Broekaert, 2008), activation of pre-migration traumatic reminders (Derluyn & Broekaert, 2008), and correlation with depressive symptomology (Ellis et al., 2010; Ellis et al., 2008). Yet the literature also suggests children and adolescents actively resist such threats to their identity by concealing their ethnic identity (Khanlou, Koh, & Mill, 2008; Shakya et al., 2010), using humor, or confronting institutions such as schools play a key role in protecting children from ongoing threats to identity. Hek (2005) examined the role of education in the settlement experiences of adolescent refugees in the United Kingdom. Allowing refugee minors to bring pieces of their personal and cultural identity were important factors in school settlement, including creating links between home and school, employing teachers with similar cultural-linguistic backgrounds, and the promotion of first languages. In addition, being allowed to self-identify as refugees and feeling that their experiences and contributions were valued by staff and students instilled a sense of belonging in adolescent refugees.

Developing a sense of one’s own identity and establishing attitudes toward other groups are typical developmental activities in adolescence (Branch, 2001). Fantino and Colak (2001) explained that these normal developmental tasks are complicated for refugee children in Canada, who face the challenge of meaningfully integrating “their history with the present and future realities of Canada” (p. 595). As young refugees relocate to new countries, they are faced with the
tasks of navigating cultural differences and acculturation. Berry (1984) developed a four-part model of acculturation based on the level at which individuals participate in the host culture (high/low) and retain their previous cultural identity (high/low): assimilation, integration, separation, and marginalization. In a study of adolescents from the former Republic of Yugoslavia resettling in Australia (Kovacev & Shute, 2004), an integration approach to acculturation positively correlated with measures of psychosocial adjustment, including global self-worth and peer-social acceptance. Integration occurs when individuals’ maintain their native cultural identity and actively participate in the new country (Berry, 1984). As such, Kovacev and Shute suggested encouraging refugee youth to both build bridges with their host society and sustain connections with their culture of origin. Conversely, youth who rejected either their own culture of origin (assimilation) or the host culture (marginalization) had the lowest adjustment ratings. Both assimilation and marginalization seem to equally endanger adolescents’ ability to become group members and, consequently, their ability to develop a stable identity (Kovacev & Shute, 2004). In a study by Luster, Qin, Bates, Rana, and Lee (2010), interviews focusing on factors that contributed to successful adaptation among Sudanese unaccompanied refugees were conducted, 7 years after their settling in the United States. Participants cited their ability to have an integration approach to acculturation, by combining the best of their Sudanese culture with the best of American culture, as one of the reasons for their successful adjustment.

Existential Meaning

All sectors of society must come together to build “ethical frameworks,” integrating traditional values of cooperation through religious and community leaders with international legal standards. (United Nations (Machel Report), 1996, p. 58)

A 17-year-old girl from the Democratic Republic of Congo related that at age 13-years, she was separated for two years from her family during the war in her country. Her family were devout Christians and members of their local religious community. During the two years she lived alone in a displaced people’s camp and experienced sexual and physical abuse. These experiences caused her to question the existence of God and to denounce her religion—even after being reunited with some members of her family. At age 17-years she started to attend church and was slowly exploring her belief system again.

Description. In instances of war, entire populations and regions are disrupted on multiple levels, including personal, familial, and societal, through violence and the destruction of physical property and infrastructure (Klingman, 2006). Following war, children and adolescents are left striving to re-establish their basic human needs for equilibrium (Kahana, Kahana, Harel, & Rosner, 1998; Williams-Gray, 1999) and to find reasons for the pain and suffering they experienced. Warfare exposes children to information and experiences which may dispute their central beliefs that people are trustworthy; that the world is meaningful, predictable, and safe; and that the self is worthy (Janoff-Bulman, 1992). Silove (1999) wrote that “exposure to inexplicable evil and cruelty can shake the foundations of the survivor’s faith in the beneficence of life and humankind” (p. 204). In a study of Israeli youth, both objective and subjective measures of exposure were associated with PTSD symptoms (Solomon & Lavi, 2005), but subjective measures made a greater contribution to the variance of symptoms. This finding suggests that, in addition to actual exposure, how youth interpret violent exposure affects their psychological well-being. Examining the research literature on war-affected children and adolescents, little information exists on children’s meaning-making during and after exposure to mass violence.

Religion and spirituality are one significant source from which individuals draw and create meaning. This has been found to be a protective factor in moderating the effect of war trauma in youth (Werner, 2012). Seeing places of worship destroyed (Dyregrov et al., 2000) and being prevented from burying loved ones with dignity, according to religious traditions (Qouta et al., 2003), are two threats to existential meaning for children and adolescents. Religion and spirituality can offer children and adolescents support (Bates et al., 2005; Kanji & Cameron, 2010) through rituals, shared beliefs, and spiritual advisors or leaders. When these institutions and practices are threatened, it may strip away children’s ability to make sense of pain and suffering.

Adaptive and maladaptive responses. Adaptive responses to trauma offer ways for individuals to begin making sense and dealing with the atrocities of war. To cope effectively with prolonged traumatic situations, children need to be able to construct new metaphors and personal narratives to replace fragmented understandings shattered by war experiences (Punamäki, 2002). Symbolizing can help children diminish anxiety-driven behavior (Kaplan, 2006). Punamäki (1996) studied Israeli children’s ideological commitment, explaining that this is “psychologically important because people strive to find a meaning for traumatic events and incorporate them into their life experiences” (p. 55). She found that the more children were exposed to political violence, the more they expressed ideological commitment. Punamäki (1996) also reported that children with a strong ideological commitment had lower levels of psychological problems, as long as their exposure to war was not overwhelming, compared with those with a weak commitment. Children with a weak ideological commitment reported more anxiety and insecurity, depression and failure, lack of social support, and bad family relations. Punamäki concluded that “children’s responses are based, at least in part, on the interpretations and meanings they attribute to these events” (p. 67). Similarly, for Palestinian youth
involved in the Intifada movement, political violence was not associated with youth problems (Barber, 2001). Barber ascribes this to the meaning youth appeared to attribute to the conflict and their commitment to the social and political principles underlying it.

Dreaming and playing games may also play a role in helping children to process their traumatic experiences. In a study of Palestinian children who recorded their dreams, different characteristics of dreams were associated with the presence or absence of psychological symptoms (Punamäki, 1998). For example, children who reported more repetitious, unpleasant, and aggressive characteristics in their dreams also reported more psychological symptoms. Conversely, for children whose dreams were bizarre, vivid, active, and involved joyful feelings and happy endings, their traumatic exposure was not associated with psychological symptoms. These findings led Punamäki (1998) to conclude that “the protective role of dreaming means that traumatic events are not associated with mental health symptoms if children’s dreams incorporate beneficial and/or lack dysfunctional characteristics” (p. 580). Results from a study by Helminen and Punamäki (2008) also demonstrate how “high intensity and low negative, and high positive” images in dreams may protect the mental health of children exposed to trauma. Children who had been exposed to trauma had less post-traumatic symptoms when their dreams included images that were intensive and positive. Correlations between exposure to military trauma and anxiety and aggressiveness were not found in children who had low negative images in their dreams. A major theme in interviews with Iraqi children was their interest in war games (Al-Mashat et al., 2006). This may demonstrate a way children attempt to process and make sense of the trauma they have experienced.

Both Tibetan child-refugees and school officials spoke of strong religious beliefs as a protective and healing factor essential for recovery from stress-related, post-traumatic symptoms (Servan-Schreiber et al., 1998). Newcomer refugee youth resettled in Canada after escaping war in their home country of Afghanistan spoke of seeking strength from God in times of difficulty (Kanji & Cameron, 2010). South Sudanese children living in a refugee camp in Uganda identified praying as a coping behavior (Paardekooper et al., 1999). Likewise, Iraqi children identified prayer and reading the Koran as giving them a sense of comfort and strength, helping to minimize their fears (Al-Mashat et al., 2006). Even in the face of violence, poverty, and destruction, two thirds of internally displaced Bosnian children still believed life was worth living (Goldstein et al., 1997). This statistic suggests that these children were able to hold onto the belief that good things in life were still possible. Likewise, refugee children were able to articulate a sense of hope and sources of hope during early years of adjustment in Canada (Yohani & Larsen, 2009).

Sadly, not all war-affected children are able to maintain a positive outlook on life. Approximately half of surveyed internally displaced Bosnian children reported feeling pessimistic about the future after the civil war in former Yugoslavia (Goldstein et al., 1997). Some children develop a sense of foreshortened future (Al-Mashat et al., 2006), believing they would not survive until adulthood (Al-Mashat et al., 2006; Dyregrov et al., 2000; Dyregrov et al., 2002). Conversely, in a study of Israeli youth, future orientation was not found to be associated with exposure to terror (Solomon & Lavi, 2005). Interestingly, the most optimistic youth in this study had experienced the most intensive terror and reported the highest PTSD symptomatology. Feelings of fear and hopelessness are a paradoxical situation for war-affected children and adolescents. Although loss of hope is not a helpful response to trauma, it is also representative of a possible reality for children in war-torn areas. Even if children escape the initial violence of bombings, shootings, and assault, they must still contend with the lack of food, clean water, sanitation, shelter, and health services - which often follow war.

Summary
This article examined whether the psychosocial systems of safety, attachment, identity, justice, and existential meaning found in the ADAPT model (2006) are represented in a review of research from the last 20 years on the experiences and needs of war-affected children and adolescents. The intention was to explore whether this model has potential to serve as a guide for research and practice with war-affected children given its attention to adaptive and maladaptive responses to war-trauma. The review is limited by its “wide-net” approach incorporating literature on war-affected children in conflict, post-conflict, and resettlement settings. While this was chosen to capture studies addressing adaptive and maladaptive responses in all five domains, it resulted in an overemphasis of literature on refugees. Future reviews can utilize a more focused approach by conducting systematic reviews of one domain and sub-population of war-affected children.

Results suggest that research with war-affected children has covered all five psychosocial pillars in the model thereby showing promise as a meta-theory for conceptualizing the psychosocial experiences of war-affected children. However, the review highlighted the research community’s emphasis on the safety domain with most studies focusing on the identification of PTSD in children and adolescents. This mirrors the fact that much of the research on war-affected individuals is conducted by clinical psychologists or psychiatrists whose instruments rely on the respective clinical manuals (ICD or DSM). The focus on safety is followed by research within the attachment domain. Research in this area emphasizes the role of social supports and caregivers as protective factors and resources for children’s adaptation after mass violence and familial losses. Maladaptive responses to such losses are similar to those found within the safety domain and include PTSD, depression, and anxiety as the main outcomes of threats to attachment systems. Safety and attachment are
highly salient, interconnected needs for children that do not function in isolation, and it may be difficult to tease apart whether disorders such as PTSD are responses to safety violations, attachment violations, or both. However, from a theoretical point of view, the ADAPT model suggests that grief and depressive reactions are maladaptive responses to losses accumulated from threats to attachment systems. Future research with war-affected children may clarify this further with the recent expansion of criteria for PTSD and inclusion of other trauma-related disorders in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; APA, 2013).

This review shows that the least amount of research was found within the domains of identity, justice, and meaning. Given the significance of these areas in child and adolescent development, future research and interventions should examine adaptive and maladaptive responses in these three areas to expand our knowledge base of children’s experiences beyond the emphasis on safety and attachment. For example, are conduct and severe anger problems in war-affected adolescents a maladaptive response to threats to injustice? If so, what types of interventions can be implemented to ensure adolescents experience resolution and positive adaption in the aftermath of such threats? How do we address young people’s meaning-making systems in conflicts involving threats to religious ideologies and places of worship? Finally, it is worth noting that the areas covered in the ADAPT model and this review were equally covered in Machel’s (United Nations, 1996) Impact of Armed Conflict on Children report almost 20 years ago. Although children and adolescents continue to be adversely affected in war, the research community has now amassed substantial empirical evidence giving us insight into the nature and impact of trauma and mass violence on children. Going forward, there is also a need to place emphasis on researching interventions that build on such evidence. Research that explores institutional policies and practices that support interventions for children and families in post-conflict and resettlement environments should also consider socio-ecological frameworks. As such, as the ADAPT model can be a guide to ensure psychosocial domains of safety, attachment, human rights/justice, identity, and existential meaning are equally addressed.

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**Author Biography**

**Sophie Yohani** is a psychologist and associate professor in the Department of Educational Psychology at the University of Alberta, Canada. Her research and clinical interests are in multicultural issues in clinical/counselling psychology, gender-based violence, mental health of children and women in post-conflict and resettlement countries, and psychosocial adaptation, hope and resilience in the aftermath of trauma.