



# Psychosocial Wellbeing of ‘Vulnerable’ Refugee Groups in (Post-)Conflict Contexts: An Intriguing Juxtaposition of Vulnerability and Resilience

Ilse Derluyn, Elisa van Ee, and Sofie Vindevogel

## Abstract

Refugees often find themselves in a precarious situation, characterised by multiple vulnerabilities. The label ‘vulnerable’, as specifically applied to certain categories of refugees like unaccompanied minors, child soldiers or elderly, may ensure due attention to their specific needs at various stages of conflict and in post-conflict situations, yet it risks masking specific support needs at the individual level. Therefore, the allocation of support should always be based on needs assessment at the individual level rather than the categorical level. A complex constellation of factors at the individual as well as contextual level appears to play a part in determining the impact of traumatic events and the post-traumatic reactions. At the contextual level, support oriented towards addressing vulnerability and fostering resilience can help individuals to gain control over their life and life context and to deal with psychological challenges in a way that reduces their impact. This chapter concludes that a systemic, strengths-based, culturally-sensitive, relational framework should guide the design and implementation of future interventions for refugees. This would ensure that they are context-sensitive, based on the capacities and strengths of the target population, and designed to enhance support that a given context offers to its most affected and vulnerable members.

---

I. Derluyn (✉)

Department of Social Work and Social Pedagogy, Ghent University, Ghent, Belgium

Centre for Children in Vulnerable Situations, Ghent University, Ghent, Belgium

e-mail: [Ilse.Derluyn@UGent.be](mailto:Ilse.Derluyn@UGent.be)

E. van Ee

Psychotraumacentrum, 's-Hertogenbosch, The Netherlands

The Radboud University, Nijmegen, The Netherlands

e-mail: [elisavanee@gmail.com](mailto:elisavanee@gmail.com)

S. Vindevogel

Department of Orthopedagogy, Expertise Centre on Quality of Life (E-QUAL),  
University College Ghent, Ghent, Belgium

e-mail: [sofie.vindevogel@hogent.be](mailto:sofie.vindevogel@hogent.be)

## 9.1 Introduction

James was born and raised in the eastern Ituri region of the Democratic Republic of Congo. He was only 12 years old when he was abducted and press-ganged into the Union of Congolese Patriots (UCP). As a child soldier, he was forced to kill his own parents and fight in a brutal Congolese militia. He remained captive for years, but managed to flee to a refugee camp in the border area. Despite his escape, he still feels trapped. He lives in constant fear both because he re-experiences his traumas night and day and because the UCP remains an active political force in Ituri. As a former child soldier, he feels stigmatised and rejected by the camp community. His greatest desire is to go to school and learn about new farming technology so that he can contribute to rebuilding of the community. At the same time, he does not dare to return to his community. He desperately wants to focus on the future, but is constantly reminded of the past.

In response to the unprecedented forced displacement of millions of people, the former High Commissioner for Refugees António Guterres said: ‘Forced displacement is now profoundly affecting our times. It touches the lives of millions of our fellow human beings—both those forced to flee and those who provide them with shelter and protection. Never has there been a greater need for tolerance, compassion and solidarity with people who have lost everything’ [1].

Refugees and internally displaced persons may have multiple vulnerabilities. It is accepted that certain groups, such as children (in particular unaccompanied minors), pregnant women, sexual minorities, individuals with disabilities and elderly persons, are ‘vulnerable’. Children face serious risks; children who are unaccompanied or separated from their families are especially at risk of neglect, abuse, violence and exploitation. Women and girls are at risk of experiencing discrimination, exploitation, violence (in particular sexual violence) and intimidation. People may also be subjected to violence or threats of violence because of their sexual orientation or gender identity. According to the United Nations (UN) Special Rapporteur on torture, members of sexual minorities are disproportionately likely to be subjected to torture [2]. People with disabilities (intellectual disability, psychosocial, sensory or physical impairments) are at risk of isolation, neglect, abuse and undignified treatment and are often excluded from participation in the community. Although, as a group, elderly people are usually defined in terms of age, their vulnerability is, as with most vulnerable groups, depending on the specific country context where they live and the living standards and life expectancy here. In elderly people psychological distress may occur against a background of pre-existing age-related neurological or psychiatric disorders, such as dementia, depression, and a general reduction in mental capacity. Frailty can create dependence and make access to support difficult [3, 4].

Quantitative data on different 'categories' of vulnerable people are very limited, but it is apparent that the size of the current population of vulnerable persons is unprecedented. For example, more than half of the refugee populations are children under 18 years of age, and a considerable proportion of them have been separated from their parents or previous caregivers [1]. The latest global report on child soldiering estimated that roughly a quarter of a million children worldwide are currently serving as conscripts in armed conflicts, in roles such as soldier, spy, cook, porter or sexual slave [5–7].

There is often a marked increase in gender-based violence in crisis situations [8]. In the Democratic Republic of Congo, for example, it has been estimated that 12% of women have experienced sexual violence and that 6–17% of survivors fall pregnant as a result of sexual violence [9, 10]. In 2000, the World Health Organisation (WHO) released a report [11] in which children born of rape were described as being at risk of neglect, stigmatisation and racism, abandonment and infanticide. Despite these concerns, little is known about the fate of children born of sexual violence and their mothers [12].

Although to some extent vulnerability of these groups can be defined in terms of personal factors—in particular age, gender, sexual orientation and disability, it involves several additional, interrelated dimensions, including contextual factors. Contextual vulnerability is based on societal factors such as living environment, social and economic status, neighbourhood and community resources and intimate and instrumental support [13, 14]. For example, children can be forced to join an armed group or may join 'voluntarily', but in either case being inducted into an armed faction as a 'child soldier' places children at huge risk of experiencing a range of difficulties [15–18]. Children born of sexual violence are at heightened risk, because a pregnancy resulting from sexual violence is considered to add to the trauma of sexual violence itself, and the mother and/or her community may perceive a child born from such a pregnancy as a living reminder of rape and the rapist (enemy) [12, 19].

Vulnerabilities can be multiple and may intersect and change over time. Health and welfare problems such as destitution may multiply vulnerability, as they put individuals at risk of homelessness, inadequate nutrition, poor physical and mental health, isolation, exploitation, abuse and high-risk behaviour, thereby increasing the overall risk of harm. Victims of torture, other forms of trauma and human trafficking, may be in need of protection because of the trauma they have experienced and because of being at risk of further abuse. Adverse effects of early life difficulties may influence psychosocial development, enhance later vulnerabilities and substantially increase probability of poor outcomes [13]. Vulnerability is also depending from circumstances, for example, the availability of education, health services or food. In other words, vulnerability is shaped by both personal and environmental factors and changes over time and according to circumstances [3].

Further, we will elaborate specific psychosocial and mental health risks that have been documented in various groups of 'vulnerable refugees', in particular in conflict and post-conflict contexts. We will also look in detail at the 'resilience' that many

refugees demonstrate. In addition we will explore factors at various levels of the socioecological system that may be associated with increased risk of mental health problems. Finally, we will discuss approaches to support and intervention for vulnerable groups of refugees. But first, we would like to reflect on the meaning of the ‘vulnerability’ label.

---

## 9.2 Labelled as ‘Vulnerable’

Although being labelled as ‘vulnerable’ may ensure that a group receives particular attention or that its specific needs are met at different times and stages of conflict and post-conflict situations, using this label also carries important caveats. First, designations of ‘vulnerability’ are often based on the so-called ‘objective’ characteristics, such as age (e.g. children, elderly), gender (women) or a presence of clearly identifiable physical problems (e.g. disability, illness). Although it is clear that these ‘objective’ characteristics may indicate greater vulnerability to detrimental effects of war, displacement, armed conflict and collective violence, there is no absolute or direct causal relationship between such characteristics and risk or need for support and protection at individual level. Individual members of ‘vulnerable’ groups may not be in need of additional support and/or protection, and, even more importantly, individuals who are not belonging to a designated ‘vulnerable group’ may be in need of extra support and/or protection. Labelling certain groups as ‘vulnerable’ may thus mask the fact that individuals who are not members of a recognised vulnerable group may have huge needs and therefore need to be supported accordingly.

A related point is that governments are increasingly using group-level vulnerability classifications to determine allocation of resources. Furthermore, based on ‘objective characteristics’ and the related ‘vulnerability’ label, they create subcategories within categories or groups that are already entitled to receive extra support. A good example of this strategy can be seen in what happens to the group of ‘unaccompanied minors’: whilst this group as a whole is recognised as ‘vulnerable’, government increasingly indicates ‘extra-vulnerable groups’ within this group, such as those under the age of 14 or girls. This ‘additional’ label is then used to allocate ‘scarce’ resources to the ‘extra-vulnerable’ groups. This process can mean that individuals who are not members of an ‘extra-vulnerable’ group do not receive the support to which they are entitled, as per definition a 17-year-old Afghan boy would be in less need of support than a 14-year-old Angolan girl.

This attempt to make allocation of resources and support more ‘objective’ contrasts with the approach used in most care and support systems. In these systems support is ‘needs-based’ and an ‘individualised care trajectory’ is put forward: needs assessment is then always carried out at individual level (not at group level), and support is allocated according to specific, context-dependent needs of an individual, *not* assumptions about the needs of a group or category which he or she belongs to. Although it is important to pay particular attention to the needs of certain groups, it is thus equally important that attention is paid to possible side-effects

of creating categories and subcategories based on an 'objective' approach to vulnerability.

---

### 9.3 Mental Health, Culture and Vulnerability

Poor mental health can be both a cause and a consequence of vulnerability [14]. There is evidence for a strong association between multiple and chronic extreme experiences in refugees and the diagnosis of post-traumatic stress disorder (PTSD), which has been defined as the presence of intrusive memories, avoidance, negative alterations in cognitions and mood and alterations in arousal and reactivity as a consequence of a single or a series of traumatic experiences. PTSD often co-occurs with other mental health conditions such as depression, anxiety disorders [20–22], complicated, persistent grief following violent loss [23–25] and other forms of psychological distress [26].

Deleterious effects of traumatic events on mental health and functioning in refugee populations have been well documented. Almost all systematic studies in conflict and post-conflict regions and across diverse cultural settings have reported rates of PTSD and depression that by far exceed those found in communities not affected by conflict. Reported prevalence of PTSD varies widely, ranging from 0% in a conflict-affected region of Iran [27] to 99% in Sierra Leone [28]. Weighted prevalence estimates from a subset of methodologically robust surveys included in a systematic review of Steel and colleagues [29] range between 13% and 25% and may be the most accurate indicator of PTSD rates, which is considerably higher than the prevalence rates found in Western countries.

In post-conflict populations, poor general psychological health has been associated with female gender, young or old age, low social status, bad living conditions and insecurity and violent and traumatic events, including forced displacement and child soldiering [30]. It has been consistently reported that the prevalence of PTSD, depression and anxiety in post-conflict populations is higher in females than in males [31–33]. In Sri Lanka, the prevalence of depression and associated factors increases with age in adult primary care patients, ranging from 0.3% in the youngest group to 11.6% in the oldest group [33]. Prevalence of depression reached 31% in a sample of elderly people in a Palestinian refugee camp [34]. There is, however, a dearth of studies on the impact of forced migration on mental health of elderly people. Equally, in post-conflict settings, deficits in mobility, cognition, self-care, seeing and hearing are associated with poor mental health, with a higher prevalence of PTSD and depression symptoms and worse social functioning [31, 33, 35]. A study of adolescents in the conflict regions of eastern Democratic Republic of Congo showed that displacement has placed them at increased risk for developing several mental health problems [36]. Furthermore, unaccompanied minor refugees are clearly at much greater risk than children fleeing with their parents; studies in resettlement contexts indicate that they are at up to a fivefold higher risk of developing symptoms of anxiety, depression and PTSD [37–39]. Psychological distress is also prevalent in former child soldiers [16, 40–43], although the reported prevalence

varies between contexts and according to the specific measurement methods and study timeframes [44]. Symptoms of psychological distress that may occur in the aftermath of child soldiering include a range of internalising and externalising problems, such as stress, flashbacks and nightmares, feelings of guilt and shame, sleep disturbances, social isolation, aggressive behaviour and hyper-arousal, as well as a range of psychosomatic complaints such as headache, stomach ache and decreased appetite [7, 45, 46]. War-affected populations, particularly groups of adolescents, may exhibit ‘internalising problems’ such as symptoms of depression, anxiety and post-traumatic stress, as well as ‘externalising behaviours’, such as conduct disorders, substance use and high-risk sexual behaviour. Often several symptoms co-occur, for example, externalising behaviours may be associated with or even mediated by internalising problems, such as depressive symptoms [47].

Mental disorders such as PTSD are by definition characterised by a specific combination of symptoms affecting thinking, mood and behaviour and are associated with personal distress and/or impaired functioning. It is generally agreed, however, that good mental health amounts to more than a lack of symptoms of mental disorder. According to the WHO [48], ‘concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualisation of one’s intellectual and emotional potential, among others’. Mental illness is mainly defined in terms of symptoms, whereas mental health is mainly defined in terms of successful functioning manifested in productive activities, fulfilling relationships and resilience, i.e. the ability to adapt to change and cope with adversity [49]. Vulnerability in particular can limit the potential to function successfully. Trauma can severely disrupt child development, in particular psychosocial development which includes development of the ability to form fulfilling relationships. Relational aspects of adjustment after war and violence may be particularly salient in young children, because of their relatively greater dependence on caregivers [50]. In addition, caregivers who have been submitted to torture may present with parenting and family relationship problems [51, 52].

There is an ongoing debate, however, about whether Western psychological concepts of traumatic stress are relevant to populations in culturally diverse conflict and post-conflict regions [53]. Culture has been described as ‘an acquired ‘lens’, through which individuals perceive and understand the world that they inhabit, and through which they learn how to live within it’ [54]. All persons are influenced by—and in turn influence—their context and culture they identify with. Conceptions of the self and the other are shaped by culture and influence perspectives on normal and psychopathological phenomena [55]. Thus trauma and post-traumatic reactions can be viewed as products of a continuous, dynamic interaction between an individual and his or her context. Silove [56] argued that in post-conflict regions, core individual and societal adaptation systems are disrupted. ‘In each society, historical and cultural factors will determine the specific way in which these adaptive systems are expressed, what constitutes a threat to each one and how the community reacts to repair the adaptive systems after periods of mass conflict and chaos’ [57]. Derluyn and colleagues [15] and Kevers and colleagues [58] have also emphasised social impact of collective violence, war and armed conflict: collective violence affects not

just individuals but also social fabric, destroying social relations and social networks, as well as social support structures. Individual trauma should, therefore, always be considered in a relational framework and its broader social context [58]. As such, although there is a large body of evidence showing that war, displacement and collective violence have a negative impact on mental health and psychosocial functioning of vulnerable groups, there are also accounts for high resilience and strength in these populations, and the resilience perspective is often emphasised by those who criticise over-pathologisation of vulnerable groups. We will further elaborate on this perspective in the next paragraph.

---

## 9.4 Resilience

The concept of resilience is critical to accounts of positive adaptation in the context of significant adversity. Resilience has been operationalised in various ways, but it is generally regarded as the capacity to withstand, adapt to or rebound from challenging or threatening circumstances. Demonstration of resilience is a dynamic process involving the interplay of multiple risk and protective processes over time and encompassing individual, family and wider sociocultural influences [59]. Multiple biological and psychological variables, internal and external to the person, inform and constrain other domains almost always bidirectionally. Resilience depends on continuously interacting and transforming complex adaptive systems [60, 61]. Ungar [62] drew attention to the role of culture and context in this process, specifically their role in facilitating culturally meaningful ways of coping, which necessitates reflections on the need for a stronger cultural conceptualisation of 'resilience' [63].

Turning once again to the example of children as a vulnerable group, systemic factors (e.g. the quality of a child's family, school or community) typically account for more of the variance in child outcomes than the cumulative impact of individual traits, particularly in highly adverse contexts [64]. Anna Freud's famous observations during World War II drew attention to the importance of the presence of parents and parental reactions as a buffer against the impact of war on children [65]. Parenting can not only mitigate effects of war and violence but can also enhance processes by which children become resilient despite an adverse context. It has been shown that during war loving and non-punitive parenting are associated with positive child outcomes, namely, high creativity and cognitive competence, which could in turn have a protective effect on mental health [66, 67].

Resilience can take diverse forms, and there are many ways of coping with adversity, war and collective violence embedded in different levels of the socioecological system [46, 68]. Neblett and colleagues [69], for example, found that amongst African American young adults, spirituality, positive affect and communalism are sources of resilience which promote adaptive outcomes to stressful situations and other negative circumstances. However, certain experiences, such as child soldiering, may affect resources to which children have access or which they perceive as valuable in their search for a way of coping with difficult experiences and challenges they face [46, 70, 71].

Vulnerability and resilience can be seen as two sides of the same coin as their existence derives from the context of stress. Affirming one's resilience and addressing one's vulnerability help one to gain control over his/her life and deal with psychological challenges. In all populations forced to deal with challenging situations, high levels of psychological distress alongside remarkable agency and resilience are observed: people seem to continue with their lives and invest in life and relationships despite psychological suffering [72]. Alongside great suffering people may show great strength and agency, but equally, individuals who appear to function well may nevertheless be experiencing deep psychological pain and distress.

---

## 9.5 Risk Factors for Psychosocial Wellbeing

High prevalence of mental health problems in refugee populations encompasses considerable variation, and therefore scholars have tried to identify factors that increase a risk for development of psychological problems in refugees. The most important risk factors will be further presented and discussed.

### 9.5.1 War-Related Traumatic Events

There is a large body of evidence that in all categories of refugees, including the 'vulnerable' groups discussed in this chapter, exposure to war-related traumatic events has a very high impact on the presence and persistence of mental health problems [73, 74], even years after a conflict has ended or upon resettlement [72].

Several studies, for example, have documented a high impact of past traumatic events on child soldiers [16, 18, 46]. Some studies have compared the prevalence of psychological problems in former child soldiers and their peers who were not recruited and have shown that child soldiering has a detrimental impact on mental health, beyond to that of exposure to war only [41, 75]. Although comparative studies are scarce and inconsistent, there is strong support for the added role of aversive child soldiering events, as studies indicate that child soldiers who experience the greatest quantity and severity of war events are often the ones who experience the most severe psychological distress afterwards [41, 76]. In other words, there seems to be a 'dose-effect' relationship between adversity-related factors and psychological wellbeing in this population [77].

There is also evidence that sexual violence has a large impact on victims' mental health, both in adult refugee populations [78, 79] and in adolescent war-affected groups [80]. Various studies have documented fairly high levels of symptoms across a wide range of problem areas in victims of sexual violence. Breslau and colleagues [81] estimated the lifetime prevalence of exposure to rape at 5.4% and the probability of PTSD after rape at 49%.

A study by Okello and colleagues [82] in Uganda documented the high impact of both war-related traumatic experiences and childhood adversities, whilst Mels

and colleagues [36] noted that displaced, war-affected adolescents in eastern Democratic Republic of Congo report more mental health problems than their non-displaced, war-affected peers. A recent study by Shehadeh and colleagues [83] in the Palestinian occupied territories documented that imprisonment of a family member, especially the father, is associated with an increase in children's mental health problems. This evidence is in line with the considerable impact of past traumatic experiences in populations of child refugees separated from their parents [84, 85]. Similarly, elderly people having experienced a greater number of adverse events carry a higher risk of developing mental health problems [86]. Indeed, both the type of trauma and the number of difficult experiences are of high relevance to their meaning and the likelihood of vulnerabilities.

### 9.5.2 Current Daily Stressors in Conflict and Post-Conflict Contexts

Large attention that has been paid for long to the impact of war-related traumatic events has been submitted to critique [87]. In particular, an influential study by Miller and Rasmussen [77] highlighted the massive impact of 'daily stressors' on the psychological wellbeing of war-affected populations, and the role 'daily stressors' play in *mediating* the impact of traumatic events on mental health. This study led to increased interest in how post-conflict living conditions—daily material and social stressors—influence refugees' psychological wellbeing.

In the specific case of refugee children, a range of factors that may affect mental health have been identified, including daily material stressors (e.g. poor housing, lack of financial resources), daily social stressors (e.g. limited social network, exposure to racism and discrimination, acculturation) and lack of access to professional support, in particular psychological care [74, 88].

In the case of unaccompanied minor refugees, quantitative studies in resettlement contexts have illustrated a huge emotional impact of several daily (material and social) stressors [74, 85, 89], whilst qualitative research has highlighted the psychological burden imposed by certain stressors, including lack of (permanent) residence documents, poor housing and limited access to schooling [72, 78, 90].

It has also been reported that in adolescent victims of war-related sexual violence and in former child soldiers, social stressors, particularly stigma and social exclusion, are one of the main risk variables for development of mental health problems [80, 91]. Former child soldiers tend to have a very ambiguous position in society, oscillating between being seen as a victim and as a perpetrator [45, 76, 92]. Children born of sexual violence are perceived as objects of shame and humiliation [51]. For example, the Acholi culture (northern Uganda) condemns illegitimacy, with some tribes discriminating against illegitimate children [93]. This means that children born to mothers captured by the Lord's Resistance Army have the lowest possible social status as they are double stigmatised by association with the rebels and by

illegitimacy [93]. It has been extensively documented that former child soldiers who are victims of (war-related) sexual violence and their children are both subjected to stigmatisation, discrimination, hostility and ostracism and that this is often a source of psychological distress [42, 51, 94–96]. Collective violence destroys social bonds and social networks, thus removing one of the most important protections against mental health risks associated with adversity and adding to other risks which war-affected populations face [15, 97].

The protracted refugee conditions of many refugee populations worldwide, whereby most of them live in very detrimental circumstances, clearly add to a mental health burden they already face as a result of past traumatic experiences, being uprooted and dealing with multiple losses. One could argue that these refugees experience the so-called *condición migrante* [98], a combination of post-migration stressors such as loss of family relationships, loss of social support and a loss of identity. Yet, living in a protracted refugee situation is even more complicated because of, amongst other things, a total lack of control upon immediate and longer-term future and high level of uncertainty over whether needs will ever be met. The result is often a ‘life in limbo’ that may feel temporary, but can become permanent [51].

---

## 9.6 Interventions for Refugee Populations in Conflict and Post-Conflict Settings

From the material presented earlier in this chapter, it seems obvious that interventions to support vulnerable groups should focus on reducing the main causes of their suffering. Considerable political effort is required to put an end to collective violence and destitution that compels these groups to leave their homelands in search for safety and a better living. Additionally, stress of post-conflict contexts should be minimised by rebuilding every aspect of a society (economy, infrastructure, education, health services, etc.) as soon as possible. Furthermore, specific interventions should be applied to address psychosocial wellbeing. Rather than presenting an overview of a variety of possible interventions, here we aim at setting out a broader framework for interventions in line with our argument that mental health problems should be considered in the broader context of problems an individual faces, strengths and resilience he or she presents with and relational and social context he/she is nested in. Although for a long time interventions focused on traumas which individuals had experienced stood central [7, 77], the increasing emphasis on the impact of daily material and social stressors on mental health and wellbeing is producing a gradual shift in focus. We therefore call for interventions to be based on a systemic, strengths-based, culturally sensitive, relational framework.

A *systemic approach* in interventions is necessary because psychological impact of collective violence is embedded in a spectrum of other factors that impinge individuals and their surroundings. This spectrum of challenges constitutes the context in which psychological wellbeing is shaped [45, 77]. This perspective implies that

healing psychological wounds of war and collective violence at individual level also entails repairing the damage done to all areas of people's lives and to the context in which they exist, as such damage tends to multiply problems caused by war and collective violence [99, 100].

James's family lost most of their belongings during the devastating war in Eastern Congo. His sudden abduction by the UCP compounded that loss, depriving him of what remained of his possessions and of his family and the ancestral land on which the family had built their homes. When he escaped from the UCP and arrived in the refugee camp, James found there was little left to return to. A consortium of humanitarian organisations for war-affected young people heard about his situation and intervened to support his transition to society. He now benefits from basic services (e.g. food programme, basic health care) provided to all people in the camp and is further assisted by a support team who is trying to trace his relatives, assess the state of affairs in his former community, negotiate the return of his family's ancestral land and prepare James and his former community for reunification and reconciliation. This will require lengthy, delicate and extensive mediation at community level, but it is likely to make a huge difference to individuals like James. For instance, if the complex land disputes are resolved and James is able to reclaim his ancestral land through community-supported mechanisms, he might be able to start farming, start building a new home and settle down.

Our plea for a more *strengths-based approach* follows from the evidence of high levels of resilience in vulnerable populations, together with problems stemming from the pathologisation of the refugee experience and the objectivation of refugees' vulnerability. We need to look at interventions that support a range of intra- and interpersonal factors and processes and can strengthen capacities of individuals, families and communities to deal with aversive situations [101]. Paying more attention to people's resources and support mechanisms does justice to a complex reality of refugees' adaptability and functionality and recognises complexity of the interplay between challenges and resources [15, 46].

James's greatest desire is to go to school and learn about new farming technology. He believes that education will give him a better chance of finding a paid job and making a better future for himself. He also sees education and a paid job as the route to a better position in the community, because they would enable him to contribute to the development of the community development and thus earn him respect. James has missed several years of

schooling because he was press-ganged into the UCP and at the moment there is no school operating in the camp. However, a group of parents and former teachers have got together to educate the camp's young people, and this means James can gradually catch up on his secondary education. Moreover, one of the elders in the camp, who took care of James when he arrived, has used his network of connections in the camp to introduce James to someone who used to work with new farm technology and is willing to share his experience and the lessons he has learned, to give James some familiarity with the job. This makes James focus more on the future and bolsters his hope that there is a better life ahead of him, which is crucial to his ability to cope with the stress and other psychological sequelae of his experience as a child soldier and the restrictions which camp life imposes on his development.

*A culturally sensitive approach* to interventions should address criticisms based on the cultural specificity of responses to stressful events. Interventions should be designed and organised collaboratively, with external agencies drawing on local partners' knowledge of a community's main psychosocial needs and resources and their understanding of the local relevance of particular psychosocial wellbeing indicators and ways of promoting wellbeing [100]. This should ensure that interventions are sensitive to a local context and cultural particularities.

Like many young people in the camp, James receives counselling from an international NGO that provides psychosocial support to war-affected young people. During one of the sessions, James told the counsellor that he is haunted by spirits. He often wakes up at night and sees the people he killed during his time with UCP in his room. He tells the counsellor that the spirits of these people wander around his room and threaten him. James also discloses that this arouses strong emotions in him, that it takes a long time for the fear and anxiety to dissipate and that even in the daytime he is haunted by vivid memories of the night. The counsellor discussed James's case during a meeting of the international team, and it elicited a discussion about the framing and interpretation of mental health symptoms. In line with his Western biomedical training, James's counsellor clearly interpreted James's re-experiencing as a symptom of post-traumatic stress for which he would suggest psychological therapy. His Congolese colleagues were able to offer insight into James's understanding of the concept of spiritual possession and explain that in their cosmological frame of reference, spiritual possession can best be treated by performing cultural ceremonies. The open discussion of cultural differences in this meeting stimulated the team to work towards an approach that aligned with the cultural framework of James's experiences and guaranteed that he received the support needed to alleviate his suffering and improve his mental health. His counsellor was thereby empowered to explore nonlinguistic and ceremonial approaches to processing traumatic events.

Finally, we call for a *relational approach* to support and humanitarian interventions. Healing and support interventions should recognise the importance of social contexts. Emphasis should be placed on interventions designed to repair local social contexts and social support networks, for example, through community-oriented therapeutic groups. Furthermore, when individuals and groups return home, a lot of resources should be directed towards family- and community-oriented programmes to help returnees reintegrate. There needs to be an acknowledgement that displacement and separation inevitably lead to changes in both the displaced and those left behind and hence that rather than trying to recover the old way of living, being and interacting, a new equilibrium must be constructed [95, 102]. In case of former child soldiers, particular attention must be paid to reconciliation processes as many of them have caused great harm to their own communities. Calls for active 'reconciliation' are often set against the dominant view amongst humanitarian intervention organisations (not amongst the affected communities, however) that child soldiers should be seen as 'victims' rather than 'perpetrators' [92]. Last, given the prevalence of social stressors and stigma, particularly amongst victims of war-related sexual violence and former child soldiers, and their huge impact on individual wellbeing, we should be wary of humanitarian interventions based on assigning people to categories. Indeed, providing certain groups, such as former child soldiers, with extra support may exacerbate feelings of hatred and revenge in a community, especially when a community itself suffers from numerous problems. Categorical approaches to humanitarian interventions are often derived from policies (at government level and in non-governmental and funding agencies) which see targeting 'the most vulnerable groups' as more 'attractive' in many ways (prospect of helpful media coverage, accessibility of the group, attraction of funding, etc.). It is important to remember that categorical approaches are at the expense of the noncategorical, 'holistic' approach which is increasingly advocated. Continuous tension between policy-driven interventions and programmes based on an assessment of needs taking into account complex circumstances of people's lives calls for intensive cooperation and networking between all actors in the field, including governmental and non-governmental, local, national and international agencies [95]. This kind of noncategorical approach would not only acknowledge that armed conflict affects all children and adolescents living in a conflict area, directly or indirectly [75], but also avoid the risk of stigmatisation caused by singling out particular (and often already contested) groups. A noncategorical approach also addresses our concerns regarding possible side-effects of labelling particular groups as 'vulnerable' purely on a basis of 'objective' characteristics, such as age, gender, disability or past experiences.

James has been stigmatised and rejected by other people in the camp ever since he arrived there after serving as a child soldier in the UCP. Although he tries to fit in, both he and his community have changed considerably since he was recruited by the UCP. He grew up listening to stories around the communal campfire. These stories taught him cultural norms and practices. Because there is no storytelling of this kind in the camp, he is missing out on

an important source of guidance about how to behave respectfully towards fellow community members. Some of the things he does and some of his behaviour are frowned upon, feared and considered rebellious and result in his stigmatisation and rejection. To help tackle this kind of problem, a community-based organisation is trying to revive the storytelling tradition, by organising meetings amongst community members in the camp and encouraging them to discuss the everyday issues that bother them under the guidance of the community's leader. This leader is also being supported in the role of negotiator and in attempts to initiate dialogue between, for example, former child soldiers like James and fellow community members. Such meetings and attempts at conflict mediation may lead to an enhanced understanding of different frames of reference and shared expectations of community life, as well as to a more nuanced understanding of former child soldiers. Over time, these things are to reduce conflict, stigma and rejection within the community.

To conclude with, we call for holistic interventions and initiatives that address psychological distress as a part of a comprehensive package of support encompassing many life domains that have a bearing on psychosocial wellbeing rather than in isolation. Furthermore, interventions should not just be translated from one culture to another; they should be designed in a culturally sensitive manner, taking account local frames of reference and culturally specific responses to psychological distress. Interventions should not focus exclusively on psychopathology and difficulties, but acknowledge and make use of strengths and resources of survivors. The comprehensive approach we propose needs to consist of an integrated, multilayered pyramid of support, including basic services and security (e.g. basic health care), community and family support interventions (e.g. family tracing and reunification), focused non-specialist support (e.g. livelihood programmes) and specialist services (e.g. psychological counselling) [103]. Support should draw on and reinforce capacities and strengths available in a given context, with the aim of increasing the contextual and social support that is already present to all community members and in particular to those with specific needs [46].

---

## References

1. UNHCR. Press release; 2015. <http://www.unhcr.org/myt15/>.
2. United Nations General Assembly. Annual report of the UN high commissioner for human rights: discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity. Geneva: UN; 2011.
3. UNHCR. Vulnerability screening tool, identifying and addressing vulnerability: a tool for asylum and migration system. Geneva: UNHCR; 2016.
4. Virgincar A, Doherty S, Siriwardhana C. The impact of forced migration on the mental health of the elderly: a scoping review. *Int Psychogeriatr*. 2016;28:889–96.

5. Coalition to Stop the Use of Child Soldiers. *Child soldiers. Global Report 2008*. London: Coalition to Stop the Use of Child Soldiers; 2008.
6. Machel G. *The impact of war on children*. London: Hurst & Company; 2001.
7. Wessells M. *Child soldiers. From violence to protection*. Cambridge: Harvard University Press; 2006.
8. Stark L, Ager A. A systematic review of prevalence studies of gender-based violence in complex emergencies. *Trauma Violence Abuse*. 2011;12:127–34.
9. Peterman A, Palermo T, Bredenkamp C. Estimates and determinants of sexual violence against women in the Democratic Republic of Congo. *Am J Public Health*. 2011;101:1060–7.
10. Scott JS, Rouhani A, Greiner K, Allbutt P, Kuwert MR, Hacker M, van Rooouen P, Bartels S. Respondent-driven sampling to assess mental health outcomes, stigma, and acceptance among women raising children born from sexual violence-related pregnancies in eastern Democratic Republic of Congo. *BMJ Open*. 2015;5:e007057.
11. World Health Organisation. *Reproductive health during conflict and displacement: a guide for program managers*. Geneva: World Health Organisation; 2000.
12. Van Ee E, Kleber RJ. Growing up under a shadow, key issues in research on and treatment of children born of rape. *Child Abuse Rev*. 2013;22(6):386–97.
13. Mechanic D, Tanner J. Vulnerable people, groups, and populations: societal ties. *Health Aff*. 2007;26:1220–30.
14. World Health Organisation. *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva: World Health Organisation; 2010.
15. Derluyn I, Vindevogel S, De Haene L. Toward a relational understanding of rehabilitation and reintegration processes of former child soldiers. *J Aggress Maltreat Trauma*. 2013;22:869–86.
16. Vindevogel S, Coppens K, Derluyn I, Loots G, Broekaert E. Forced conscription of children during armed conflict: experiences of former child soldiers in northern Uganda. *Child Abuse Negl*. 2011;35:551–62.
17. Vindevogel S, De Schryver M, Broekaert E, Derluyn I. Challenges faced by former child soldiers in the aftermath of war in Uganda. *J Adolesc Health*. 2013;52:757–64.
18. Vindevogel S, De Schryver M, Broekaert E, Derluyn I. War-related experiences of former child soldiers in northern Uganda: comparison with non-recruited youths. *Paediatrics Int Child Health*. 2013;33:281–91.
19. Van Ee E, Kleber RJ. Child in the shadowlands. *Lancet*. 2012;380(9842):642–3.
20. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet*. 2005;365:1309–14.
21. Lindert J, Ehrenstein OS, Priebe S, Mielck A, Brähler E. Depression and anxiety in labor migrants and refugees—a systematic review and meta-analysis. *Soc Sci Med*. 2009;69:246–57.
22. Momartin S, Silove D, Manicavasagar V, Steel Z. Complicated grief in Bosnian refugees: associations with posttraumatic stress disorder and depression. *Compr Psychiatry*. 2004;45:475–82.
23. Craig CD, Sossou M, Schnak M, Essex H. Complicated grief and its relationship to mental health and wellbeing among Bosnian refugees after resettlement in the united states: implications for practice, policy, and research. *Traumatology*. 2008;14:103–15.
24. Schaal S, Jacob N, Dusingizemungu J, Elbert T. Rates and risks for prolonged grief disorder in a sample of orphaned and widowed genocide survivors. *BMC Psychiatry*. 2010;10:55.
25. Schaal S, Elbert T, Neuner F. Prolonged grief disorder and depression in widows due to the Rwandan genocide. *J Death Dying*. 2009;59:203–19.
26. Van Ommeren M, Saxena S, Saraceno B. Aid after disasters. *BMJ*. 2015;330:1160–1.
27. Hashemian F, Khoshnood K, Desai MM, et al. Anxiety, depression, and posttraumatic stress in Iranian survivors of chemical warfare. *JAMA*. 2006;296:560–6.
28. De Jong K, Mulhem M, Ford N, van der Kam S, Kleber R. The trauma of war in Sierra Leone. *Lancet*. 2000;355:2067–8.
29. Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations

- exposed to mass conflict and displacement, a systematic review and meta-analysis. *JAMA*. 2009;302:537–49.
30. Roberts B, Browne J. A systematic review of factors influencing the psychological health of conflict-affected populations in low-and middle-income countries. *Glob Public Health*. 2011;6:814–29.
  31. Cardozo BL, Bilukha OO, Crawford CAG. Mental health, social functioning, and disability in postwar Afghanistan. *JAMA*. 2004;292:575–84.
  32. Ghumman U, McCord CE, Chang JE. Posttraumatic stress disorder in Syrian refugees: a review. *Can Psychol*. 2016;57:246–53.
  33. Senarath U, Wickramage K, Peiris SL. Prevalence of depression and its associated factors among patients attending primary care settings in the post-conflict Northern Province in Sri Lanka: a cross-sectional study. *BMC Psychiatry*. 2015;14:85.
  34. Chaaya M, Sibai AM, Fayad R, El-Roueiheb Z. Religiosity and depression in older people: evidence from underprivileged refugee and non-refugee communities in Lebanon. *Aging Ment Health*. 2007;11:37–44.
  35. Rivera WH, Mari JDJ, Andreoli SB. Prevalence of mental disorder and associated factors in civilian Guatemalans with disabilities caused by the internal armed conflict. *Int J Soc Psychiatry*. 2008;54:414–24.
  36. Mels C, Derluyn I, Broekaert E, Rosseel Y. The psychological impact of forced displacement: comparing risk factors in internally displaced, returned and non-displaced eastern Congolese adolescents affected by war. *J Child Psychol Psychiatry*. 2010;51:1096–104.
  37. Bean T, Derluyn I, Eurelings-Bontekoe E, Broekaert E, Spinhoven P. Comparing psychological distress, traumatic stress reactions and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *J Nerv Ment Dis*. 2007;195:288–97.
  38. Derluyn I, Mels C, Broekaert E. Mental health problems in separated refugee adolescents. *J Adolesc Health*. 2009;44:291–7.
  39. Mels C, Derluyn I, Broekaert E. Screening for traumatic exposure and post-traumatic stress symptoms in adolescents in war-affected eastern Democratic Republic of Congo. *Arch Pediatr Adolesc Med*. 2009;63:525–30.
  40. Betancourt TS, Borisova I, Rubin-Smith J, Gingerich T, Williams T, Agnew-Blais J. Psychosocial adjustment and social reintegration of children associated with armed forces and armed groups: the state of the field and future directions. *Psychology Beyond Borders*: Austin; 2008.
  41. Betancourt TS, Brennan RT, Rubin-Smith J, Fitzmaurice GM, Gilman SE. Sierra Leone's former child soldiers: a longitudinal study of risk, protective factors, and mental health. *J Am Acad Child Adolesc Psychiatry*. 2010;49(6):606–15.
  42. Derluyn I, Broekaert E, Schuyten G, De Temmerman E. Post-traumatic stress in former Ugandan child soldiers. *Lancet*. 2004;363(9412):861–3.
  43. Klasen F, Oettingen G, Daniels J, Adam H. Multiple trauma and mental health in former Ugandan child soldiers. *J Trauma Stress*. 2010;23(5):573–81.
  44. Rodin D, van Ommeren M. Commentary: explaining enormous variations in rates of disorder in trauma-focused psychiatric epidemiology after major emergencies. *Int J Epidemiol*. 2009;38(4):1045–8.
  45. Derluyn I, Broekaert E. Child soldiers. In: Brown J, Campbell E, editors. *The Cambridge handbook of forensic psychology*. Cambridge: University Press; 2010.
  46. Vindevogel S, Broekaert E, Derluyn I. A global perspective on child soldiering. In: Conte JR, editor. *Child abuse & neglect worldwide, Global responses*, vol. 2. Santa Barbara: Praeger; 2014.
  47. Okello J, Nakimuli-Mpungu E, Klasen F, Voss C, Musisi S, Broekaert E, Derluyn I. The impact of attachment and depression symptoms on multiple risk behaviors in post-war adolescents in northern Uganda. *J Affect Disord*. 2015;180:62–7.
  48. World Health Organisation. *The world health report 2001: mental health: new understanding, new hope*. Geneva: World Health Organisation; 2001.

49. Surgeon General for Mental Health: A report of the Surgeon General; 1999. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.
50. Scheeringa MS, Zeanah CH. A relational perspective on PTSD in early childhood. *J Trauma Stress*. 2001;14:799–815.
51. Van Ee E. A new generation: how refugee trauma affects parenting and child development. Diemen: Arq; 2013.
52. Van Ee E, Kleber RJ, Jongmans MJ. Relational patterns between traumatized parents and their non-traumatized children, a review. *Trauma Violence Abuse*. 2015;17:186–203.
53. Summerfield D. The impact of war and atrocity on civilian populations: basic principles for NGO interventions and a critique of psychosocial trauma projects. London: Overseas Development Institute; 1996.
54. Kleber RJ, Figley CR, Gersons BPR. Introduction. In: Kleber RJ, Figley CR, Gersons BPR, editors. *Beyond trauma: cultural and societal dimensions*. New York: Plenum; 1995.
55. De Jong JT. Public mental health and culture: disasters as a challenge to western mental health care models, the self, and PTSD. In: Wilson JP, Drozdek B, editors. *Broken spirits, the treatment of traumatized asylum seekers, refugees, war and torture victims*. New York: Brunner-Routledge; 2004.
56. Silove D. The psychosocial effects of torture, mass human rights violations and refugee trauma: towards an integrated conceptual framework. *J Nerv Ment Dis*. 1999;187:200–7.
57. Silove D. The global challenge of asylum. In: Wilson JP, Drozdek B, editors. *Broken spirits, the treatment of traumatized asylum seekers, refugees, war and torture victims*. New York: Brunner-Routledge; 2004.
58. Kevers R, Rober P, Derluyn I, De Haene L. Remembering collective violence: broadening the notion of traumatic memory in post-conflict rehabilitation. *Cult Med Psychiatry*. 2016;40(4):620–40.
59. Walsh F. Family resilience: a framework for clinical practice. *Fam Process*. 2003;42:1–18.
60. Cicchetti D. Resilience under conditions of extreme stress: a multilevel perspective. *World Psychiatry*. 2010;9:145–54.
61. Masten AS. Global perspectives on resilience in children and youth. *Child Dev*. 2014;85:6–20.
62. Ungar M. Resilience, trauma, context and culture. *Trauma Violence Abuse*. 2013;14(3):255–66.
63. Vindevogel S, Ager A, Schiltz J, Broekaert E, Derluyn I. Toward a culturally sensitive conceptualization of resilience: participatory research with war-affected communities in northern Uganda. *Transcult Psychiatry*. 2015;52:396–416.
64. Ungar M. Practitioner review: diagnosing childhood resilience: a systemic approach to the diagnosis of adaptation in adverse social ecologies. *J Child Psychol Psychiatry*. 2015;56(1):4–17.
65. Freud A, Burlingham DT. *War and children*. New York: Medical War Books; 1943.
66. Punamäki RL. Resiliency in conditions of war and military violence: preconditions and developmental processes. In: Garralda ME, Flament M, editors. *Working with children and adolescents, an evidence-based approach to risk and resilience*. Oxford: Lanham; 2006.
67. Punamäki RL, Wouta S, El Sarraj E. Models of traumatic experiences and children's psychological adjustment: the role of perceived parenting, children's resources and activity. *Child Dev*. 1997;68:718–28.
68. Mels C, Derluyn I, Broekaert E, Garcia-Pérez C. Coping behaviours and post-traumatic stress in war-affected eastern Congolese adolescents. *Stress Health*. 2014;31:83–8.
69. Neblett EW Jr, Hammond WP, Seaton EK, Townsend TG. Underlying mechanisms in the relationship between Africentric worldview and depressive symptoms. *J Couns Psychol*. 2010;57(1):105.
70. Vindevogel S, Broekaert E, Derluyn I. "It helps me transform in my life from the past to the new". The meaning of resources for former child soldiers. *J Interpers Violence*. 2013;28:1–24.
71. Vindevogel S, Wessells M, Broekaert E, Derluyn I. Dealing with the consequences of war: resources of formerly recruited and non-recruited youth in northern Uganda. *J Adolesc Health*. 2014;55:134–40.

72. Vervliet M, De Mol J, Broekaert E, Derluyn I. "That I live, that's because of her". Intersectionality as framework for unaccompanied refugee mothers' experiences. *Br J Soc Work*. 2014;44:2023–41.
73. Betancourt TS, Williams WT. Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention*. 2008;6:39–56.
74. Fazel M, Reed RV, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet*. 2012;379:266–82.
75. Annan J, Aryemo F, Blattman C, Green E, Brier M. Promoting recovery after war in northern Uganda: reducing daily stressors by building human capacity. *J Child Adolesc Trauma*. 2012;22:849–68.
76. Blattman C, Annan J. The consequences of child soldiering. *Rev Econ Stat*. 2010;92(4):882–98.
77. Miller KE, Rasmussen A. War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Soc Sci Med*. 2010;70(1):7–16.
78. Keygnaert I, Vettenburg N, Temmerman M. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Cult Health Sex*. 2012;14:505–20.
79. Keygnaert I, Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, Temmerman M. Sexual violence and sub-Saharan migrants in Morocco: a participatory assessment using respondent driven sampling. *Glob Health*. 2014;10:32.
80. Verelst A, De Schryver M, Broekaert E, Derluyn I. Mental health of victims of sexual violence in eastern Congo: associations with daily stressors, stigma, and labeling. *BMC Womens Health*. 2014;14:106.
81. Breslau N, Kessler RC, Chilcoat HD, Schultz LR, Davis GC, Andreski P. Trauma and post-traumatic stress disorder in the community. The 1996 Detroit area survey of trauma. *Arch Gen Psychiatry*. 1998;55:626–32.
82. Okello J, De Schryver M, Musisi S, Broekaert E, Derluyn I. Differential roles of childhood adversities and stressful war experiences in the development of mental health symptoms in post-war adolescents in northern Uganda. *BMC Psychiatry*. 2014;14:260.
83. Shehadeh AS, Vanderfaillie J, Loots G, Derluyn I. The impact of parental detention on the psychological wellbeing of Palestinian children. *PLoS One*. 2015;10(7):e0133347.
84. Hodes M, Jagdev D, Chandra N, Cunniff A. Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. *J Child Psychol Psychiatry*. 2008;49:723–32.
85. Vervliet M, Lammertyn J, Broekaert E, Derluyn I. Longitudinal follow-up of the mental health of unaccompanied refugee minors. *Eur Child Adolesc Psychiatry*. 2014;23:337–46.
86. Chee YK, Levkoff SE. Culture and dementia: accounts by family caregivers and health professionals for dementia-affected elders in South Korea. *J Cross Cult Gerontol*. 2011;16:111–25.
87. Wessells M, Monteiro C. Psychosocial assistance for youth: toward reconstruction for peace in Angola. *J Soc Issues*. 2006;62:121–39.
88. Montgomery E, Foldspang A. Discrimination, mental problems and social adaptation in young refugees. *Eur J Pub Health*. 2008;18:156–61.
89. Montgomery E. Trauma and resilience in young refugees: a 9-year follow-up study. *Dev Psychopathol*. 2010;22:477–89.
90. Thommessen SAO, Corcoran P, Todd BK. Experiences of arriving to Sweden as an unaccompanied asylum-seeking minor from Afghanistan: an interpretative phenomenological analysis. *Psychol Violence*. 2015;5:374–83.
91. Verelst A, De Schryver M, De Haene L, Broekaert E, Derluyn I. The mediating role of stigmatization in the mental health of adolescent victims of sexual violence in eastern Congo. *Child Abuse Negl*. 2014;38:1139–46.
92. Derluyn I, Vandenhoe W, Parmentier S, Mels C. Victims and/or perpetrators? Towards an interdisciplinary dialogue on child soldiers. *BMC Int Health Hum Rights*. 2015;15:a28.
93. Apio E. Bearing the burden of blame—the children of the Lord's resistance army, northern Uganda. *Coalit Stop Use Child Soldiers*. 2008;11:2–13.

94. Denov M. *Child soldiers: Sierra Leone's revolutionary united front*. Cambridge: Cambridge University Press; 2010.
95. Derluyn I. Towards a new agenda for rehabilitation and reintegration processes for child soldiers. *J Adolesc Health*. 2011;49(1):3–4.
96. Vindevogel S, Coppens K, De Schryver M, Loots G, Broekaert E, Derluyn I. Beyond child soldiering: the interference of daily living conditions in former child soldiers' longer term psychosocial well-being in northern Uganda. *Glob Public Health*. 2013;8:485–503.
97. Schiltz J, Vindevogel S, Derluyn I, Broekaert E. Dealing with relational and social challenges after child soldiering: perspectives of formerly recruited youth and their communities in northern Uganda. *J Community Appl Soc Psychol*. 2016;26:307–22.
98. Graafsma T, Tijken J. *Leven in een 'condición migrante'*. In: Lamers PA, editor. *Hulpverlening aan migranten: De confrontatie van culturen in de geestelijke gezondheidszorg*. Brussel: Samson Stafleu; 1987.
99. Ager A, Boothby N, Bremer M. Using the 'protective environment' framework to analyse children's protection needs in Darfur. *Disasters*. 2009;33(4):548–73.
100. Miller KE, Rasco LM. An ecological framework for addressing the mental health needs of refugee communities. In: Miller KE, Rasco LM, editors. *The mental health of refugees: ecological approaches to healing and adaptation*. Mahwah: Erlbaum; 2004.
101. Wessells M. Supporting the mental health and psychosocial well-being of former child soldiers. *J Am Acad Child Adolesc Psychiatry*. 2009;48(6):587–90.
102. Derluyn I, Mels C, Parmentier S, Vandenhole W. *Re-member. Rehabilitation, reintegration and reconciliation of war-affected children*, Series on transitional justice, vol. 11. Intersentia: Antwerp; 2012.
103. Inter-Agency Standing Committee. *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva: IASC; 2007.