Recent Views on the Protection of Children's Mental Health

Anica Mikuš Kos

Zusammenfassung:
Der Artikel beschreibt den Wandel von Theorien über die psychische Gesundheit von Kindern, die von Krieg und Flucht betroffen sind, sowie deren Implikationen für die Praxis – bzw. vice versa. Ein Schwerpunkt wird auf die Bedeutung *protektiver Faktoren* für die betroffenen Kindern gelegt. Diese Sichtweise führt zu der Notwendigkeit, klinische Interventionen im engeren Sinne durch soziales Engagement zu erweitern. Das *Schulsystem* spielt dabei eine besondere Rolle, da mit diesem viele Kinder erreicht werden können. Die Prinzipien der *"Mental Health for All"-Strategie* im Rahmen schulischer Versorgung werden beschrieben.

The aim of this paper is to describe the process of change in theories on child mental health and the implications of the changing paradigm for the practice of mental health protection in childhood. We should, in fact, speak of reciprocal interactions between practice and theory. Many new models of child mental health protection were developed before the conceptual frame of the official theory was modified in accordance with new practical approaches.

Lessons learned from children affected by war and refugee children are important pillars of new views in the child mental health field. The activities of the psychological and psychosocial aid provided for those children will serve to illustrate of new practices.

Changing explanatory models, changing models of practice

In the past decade a vast amount of knowledge on resiliency and protective factors has been accumulated. Again, as so often before in the field of psychological and allied sciences, the obvious has been confirmed by

Zeitschrift für Politische Psychologie, Jg. 8, 2000, Nr. 4, und Jg. 9, 2001, Nr. 1, S. 497 - 504

research – namely the existence and influence of protective factors and processes which counteract the effects of potentially harmful and risk factors. It took a long time for the profession to recognize that not all children exposed to negative life experiences and adversity will be psychologically damaged. In the linear causal mode of thinking that prevailed in the past we were interested in the environmental causes of psychosocial disorders. And it was, of course, always possible to find conclusive relationships between the past traumatic events and unpleasant experiences of our clients and their current psychological or psychosocial disorders. The question as to why a child had some kind of psychosocial disorder, whether emotional, behavioral, or other could always be very convincingly answered.

For a long time the profession failed to pay attention to the large numbers of children having experienced chronic adversity or traumatic events whose development remained healthy. The question "Why not?", as to why so many children exposed to similar or even the same kinds of adversity and risk factors were not psychologically disturbed, has only become a frequently discussed issue in the professional literature in the last ten years.

The reverse way of thinking, the "Why no disturbances?" instead of "Why disturbances?" opened up new perspectives and created new explanatory models for complex interactions among different threatening and protective internal and external influences.

Rutter defined protective factors as "those factors and processes that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome". These can be within the child (for instance his / her temperamental features or social intelligence), within the family (for instance a supportive family relationship, good coping strategies of the parents) and / or within the community (for instance solidarity, acknowledgement of the moral value of suffering for a common cause).

The simple linear causal connections linking adversity, risk factors and psychosocial disorders derived from clinical work and sometimes resulted in unjustified simplifications or even harmful generalizations, for instance, that all children from broken families are disturbed. A frequent implicit or even explicit derivative of such thinking was also the assumption in the fifties and sixties that children exposed to adversity could (only) be saved by professional psychological help. Clinical workers did not, of course, encounter in their services children or adult persons who had been exposed to traumatic events or chronic adversities and remained healthy in the psychosocial sense.

The concept of protective factors is associated with the eco-social paradigm that focuses on the totality of the child's life space and its

subsystems and their influence on child's mental health, psychosocial functioning and development.

The eco-social paradigm takes into consideration the multitude of external and internal influences that have an impact on the child's development, psychological status and psychosocial functioning. Recognizing the determining importance of the current social reality for the child's mental health and widening the focus from psychological processes to social processes, relationship and functioning in extrafamilial contexts such as school, peer groups, organized activities, were important developmental steps for our profession.

The change in the theoretical paradigm was strongly influenced by the findings of epidemiological research. Longitudinal follow-up research on non-clinical samples of children has taught us that many children exposed to adversity or traumatic events will emerge without long lasting psychosocial disorders or otherwise harmed in terms of psychiatric diagnosis. Epidemiology has also shown us that the majority of children with psychological or psychosocial disorders, even many of those with very serious ones, are not our clients.

After recognizing that clinical psychology and child psychiatry contribute to improving the mental health of only a small number of children who present to us as clients, some of us started to question what could be done for the huge number of children with psychological distress and disorders who are not and will not become our clients and moreover to improve the psychosocial quality of life of all children in the community. How could we use our professional knowledge in the best interests of all children or of more children in need of some mental health support?

Various answers to these questions emerged. Among them were the concepts and practice of mental health promotion, of public health strategies for mental health protection, of the implementation of mental health attitudes and practices in such every day environments of children as schools, spreading mental health knowledge and know-how among different professions – e.g. health workers and educators – and volunteers. Such professional out-reach and social activities are often labeled as advocacy, promotion of mental health or prevention of psychosocial disorders. But, in fact, for many children with difficulties or disorders they also have an important therapeutic impact.

Obviously at the present time the role of the mental health professions and public expectations of them are changing. A new (unwritten) ethical code is appearing, which draws attention to the social responsibility and obligation of child mental health professionals to protect all children, especially those who are at special risk or specially vulnerable. The recently drawn up

standards for the quality of life of children, the Convention on Children's Rights, oblige us to use our knowledge and social power to reduce psychological suffering and to protect the development of children at risk on a large scale. In addition to our healing role, we are expected to assume the role of mental-health watchdogs for the population of children.
We have the knowledge and social power to influence the psychosocial quality of life of many children. In order to do this we must combine our healing function with public and social functions. This includes becoming professionally involved in social and political processes and in situations linked with armed conflicts. Our new social role includes advocacy and social activism aimed at creating psychosocially more favorable conditions for all children in communities and specially for those living in adversity or experiencing traumatic events and losses.

Linking knowledge used in clinical work, insights and practices acquired in clinical settings with social knowledge and awareness and at the same time being open to new truths, to the correction of old assumptions and widening of our theoretical positions is not a question of choice. It is a social and ethical obligation.

Mental health protection of children affected by war - lessons learned

The situation of war results in huge numbers of children having suffered traumatic experiences, losses and multiple and chronic forms of adversity. Armed conflicts represent a tragic natural experiment that provide us with the opportunity to learn about protective factors and resiliency.

Children affected by war or other mass disasters challenge the established models of therapeutic practices. Mental health professionals (at least those who are willing to see and recognize) soon become aware that only a negligible number of children can be treated. There are at least two reasons for this situation. The first is the lack of available professionals and services. The second, even more important reason is that people do not seek or do not want psychological treatment even when it is available. This has to do with priorities (priorities of economic survival), energy (physical and emotional), familiarity with psychological services and faith in their usefulness and other issues. The more the family is psychologically damaged or socially deprived, the fewer the chances are that the parents will bring the child to a mental health service.

When about 40 thousand refugees from Bosnia and Herzegovina, half of them children, arrived in Slovenia in 1992 the regular child mental health

services were available to them. However, very few of them presented as clients. Children in special need of psychological support were usually identified by teachers. The help they received was provided by (specially trained) teachers within the framework of school or by out-reach mental health workers visiting collective shelters or schools for refugee children.
With refugee children it became evident that if the mental health profession wants to reach a large number of children, it must develop out-reach and population-oriented models. The most important among them is the implementation of mental health activities in primary schools, which are the institutions that gather together all children of school age.

There are many other important lessons to be learned from war-related situations. Among them is the understanding and recognition of the importance of current life circumstances and quality of life. The social reality of the lives of children in refuge or in the post-war situation has a considerable influence on their mental health. For many children and young people at risk, successful enrolment in good schools with an empowering and supportive psychosocial climate assuring good achievement can have a healing impact and prevent psychosocial disorders.

The most important systemic mental health activities for refugee children in Slovenia were oriented towards improving and normalizing children's everyday lives. The philosophy and strategy adopted followed the WHO slogan "mental health for all children". Activities were designed to cater for all, or at least the great majority of children. The absolute priority was to implement mental health approaches and activities in primary schools. These covered all children aged 7 - 15 years and their teachers, and included the opportunity to contact parents, even on an everyday basis, where schools were located in collective accommodation for refugees.

Many activities and an enormous amount of energy and funds were invested in the 450 Bosnian teachers (themselves refugees) who worked in schools for refugee children during the 1992 - 1995 period, including their psychological and psychosocial support and training in child mental health topics.

The main objectives of the school program involving all Bosnian teachers in Slovenia were:

- to support teachers in coping with their own losses, traumatic experiences, humiliation and the adversities of their present situation;
- to provide knowledge and know-how in the field of mental health which would support them in their role of helpers for children and their endeavors to create an atmosphere in the classroom that was generally supportive and cheerful (as far as was possible under the given circumstances);

- to motivate and empower them in their teaching role and their function as psychosocial assistants to children

The psychosocial outcome of refugee children living in Slovenia measured on the basis of school achievement, the rate of behavioral disorders and police records showed surprising figures. There was only a very small difference between the school achievement of refugee children in Bosnian schools and later in Slovene schools and the school achievement of Slovene children. Inappropriate behavior was not more frequent in refugee children than in Slovene children. Young refugees were not mentioned in police records as often as expected. We suppose that the described strategy- and population-oriented school- and community-based activities contributed to the good outcome of the large number of children having experienced losses, many of whom had witnessed atrocities and were otherwise affected by the war and life in refuge.

Putting the ideas of "mental health for all children" into practice

The new approach to the role and function of the mental health establishment can be defined in WHO terms: "Mental health for all children". The basic characteristics of activities and programs in line with "mental health for all children" strategies are:

Activities which will reach all or at least a large member of children: supporting and empowering all children at risk and providing some assistance to all children in need, so that the help will not be limited to the few who are clients of mental health professionals.

Programs integrated in the normal settings for children. Such programs are acceptable to all children and their parents. They do not require any special effort on the part of parents. They should not be stigmatizing. They contribute to the improvement of the psychosocial climate of the setting. For instance, implementing mental health attitudes, instructing teachers about mental health issues, about children at risk, encouraging and motivating teachers to act as psychosocial helpers.

Programs which improve the everyday quality of life of children. Developing activities in the community or a supportive psychosocial atmosphere in schools and kindergartens are good examples. Creating settings which provide children with positive experiences in interpersonal relationships and in work which will influence children's views of mankind and counteract the experience of deceit, humiliation, mistrust in people. This

is of special importance for children exposed to traumatic events and chronic adversity.

Special emphasis on the enhancement of children's self-esteem. Self esteem is an important healing component which gives the child the feeling that s / he can direct her / his own life, that s / he is not helpless. These processes promote coping capacities in children.

Persons of different professions and lay persons involved in institutional or other organized work with children could be engaged as helpers. In order to assume these roles, helpers should be provided with psychosocial support and training.

Bringing mental health professionals into settings where children and their families live. Mental health workers should be easily accessible. Their methods of work should be adapted to the needs and mentality of the target group and be acceptable to them. This involves such strategies as reducing as far as possible the distance, organizational barriers and cultural, social and psychological obstacles to the use of professional assistance.

Parents should be involved in mental health programs: However, we should be aware that only a limited number of parents will be interested, willing or capable to participate in programs. Often parents who are most in need of some professional mental health help will not use services or programs, e.g., severely depressed parents who lack the energy to participate or parents who for various reasons are not sensitive to the emotional needs and difficulties of their children. Thus, child-centered methods and direct work with children should be given priority.

Advocacy for the improvement of the psychosocial quality of children's lives and raising public awareness about children's needs are important pillars of child mental health protection.

The described strategies will only have a substantial impact on the mental health of the population of children if a critical mass of participating persons (mental health workers, primary health workers, teachers, volunteers ...), institutions and organizations are involved.

Population-oriented mental health care of children requires not only professional efforts but also considerable social and managerial efforts.

Conclusions. The "mental health for all" strategy is aimed at improving the psychosocial conditions of life of all children and enhancing their coping capacities and mental health. These prerequisites are indispensable for the protection of the huge number of at-risk children from marginal environments – immigrants, poor children, children of unemployed parents and other families living in poverty, even many children from families that are not socially disadvantaged, but whose parents fail to turn to the available professional services when their children have psychosocial disorders.

Literatur:

Evaluation of the Projects of Psychosocial Help to Refugee Children in Slovenia (1996). Financed by UNICEF. Ljubljana (Slovenia): Center for Psychosocial Help to Refugees, The Slovene Foundation.

Grant, N. I. Rae (1991). Primary Prevention. In: Child and Adolescent Psychiatry. A Comprehensive Textbook. Edited by M. Lewis. Baltimore: William & Wilkins, 918-929.

Mikuš Kos A. (1996), They Talk, We Listen. Ljubljana: Slovenska filantropija.

Mikuš Kos A. (1998), Derviškadić Jovanović S. What can we do to support children who have been through war? In: Forced Migration Review, Oxford, December 1998: 4-7.

Mikuš Kos A. (1999), Healing and recovery of children affected by war. The role of the mental health profession. In: Lebenstatsachen und psychoanalytischer Prozess. Deutsche Psychoanalytische Vereinigung, Herbsttagung 1999: 365-372.

Remschmidt H., Schmidt M.H., Walter R. (1998), Survey of the Utilization of Psychiatric Services and Systems for Children and Adolescents in Germany. In: Designing Mental Health Services and Systems for Children and Adolescents. Ed. by Young JG, Ferrari P. The Book Series of the International Association for Child and Adolescent Psychiatry and Allied Professions. Philadelphia: Brunner-Mazel, 83-94.

Slodnjak V. (1998), Psihosocialne značilnosti mladostnikov beguncev. In: Begunci v Sloveniji. Pregled dosedanjih aktivnosti. Uredila M. Pagon, A. Mikuš Kos. Visoka policijsko-varnostna šola, Ljubljana 1998: 85-104.