
Fiona C. Thomas
Ryerson University

Anavarathan Vallipuram
Eastern University of Sri Lanka

Mark J. D. Jordans
War Child Holland, Amsterdam, Netherlands and King’s College London

Sambasivamoorthy Sivayokan
Jaffna Teaching Hospital, Jaffna, Sri Lanka and University of Jaffna

Ria Reis
Leiden University Medical Center and University of Amsterdam

Joop T. V. M de Jong
University of Amsterdam and Boston University

The impact of armed conflict on the mental health of children and youth has been well documented. However, examining emic perspectives (i.e., locally held insider views) on the mental health consequences of armed conflicts in diverse populations has received less attention. Qualitative data was collected in northern Sri Lanka, which included focus groups (FGs) with children, parents, and teachers (20 FGs), key informant interviews (18), and semistructured interviews with families particularly affected by the armed conflict (7). Thematic analyses showed a large range of impact on mental health conceptualized as spiritual problems (e.g., evil spirits and witchcraft), moral concerns (e.g., violence as...
a means to solve conflict), and perceived cultural decline. Most problems are addressed within the family, but eclectic care across the formal and informal sectors is sought when symptoms persist or worsen. Using a theoretical framework of ecological resilience, we identified examples of resources for children at the individual, family, and community levels. Mental health services in Sri Lanka could be improved by building on local mental health conceptualizations and available resources, especially with regard to rebuilding links between individual, family, and community structures.

**Keywords:** armed conflict, children, Sri Lanka, resilience

Despite the fact that children and adolescents often comprise 50% or more of the population in low- and middle-income countries, their mental health is frequently neglected, especially in areas of protracted conflict (Barenbaum, Ruchkin, & Schwab-Stone, 2004). Mental health may be broadly defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization, 2001, p. 1). Used in this way, the term overlaps in meaning with the term *psychosocial well-being* as it is has come to be applied by humanitarian practitioners (Psychosocial Working Group, 2003).

Most research on the psychological impact of armed conflict on children has emphasized psychiatric disorders and has commonly focused on correlating exposure to conflict-related events to symptoms of posttraumatic stress disorder and depression (Betancourt & Williams, 2008). Over the years there has been a shift from trauma-focused psychiatric epidemiology to research into broader mental health and psychosocial issues emerging in conflict settings (De Jong et al., 2001; Miller & Rasmussen, 2010; Tol, Rees, & Silove, 2013). This expanded perspective acknowledges that concepts of mental health and illness are variable across sociocultural settings and based on cultural philosophies, local medical discourse, and the lived experiences of those suffering from the illness (Kokanovic, 2011). The impact of contextual variables on mental health, such as effects of chronic stress situations, gender relations, and type of conflict situation, is also increasingly being recognized (Boothby, Strang, & Wessells, 2006; De Jong, 2002; Miller & Rascio, 2004). Resilience, which may be defined as "good outcomes in spite of serious threats to adaptation or development", has also gained increasing attention (Masten, 2001, p. 228).

Following Bronfenbrenner's (1979) work that acknowledges the interplay between multiple levels that influence individual development, ecological resilience theory also focuses on resilience processes operating at diverse contextual levels, rather than on individual traits (Tol, Jordans, Kohrt, Betancourt, & Koomproe, 2013a, 2013b). In particular, Bronfenbrenner (1979, 1989, 1993) distinguished among the micro-, meso-, exo-, and macrosystems, all of which influence the developing individual. Microsystems are considered environments in which the individual spends substantial time interacting with others (e.g., home, school), whereas the mesosystem is the interaction between these microsystems (Reijer, 2013). The mesosystem influences the capacity of children to thrive based on supportive resources resulting from this interaction (e.g., the interaction between teachers and parents). The exosystem consists of actors and institutions not directly interacting with the child but indirectly influencing its development through effects on the child's significant others (e.g., parents' workplaces, extended family, neighbors). The macrosystem consists of overarching laws, customs, ideologies and cultural practices that can influence an individual's development (Reijer, 2013; Ungar, 2011). In other words, researchers have argued that resilience is not a feature of the individual alone, but of this individual within multiple levels of the social ecology (Fernando & Ferrari, 2013; Hobfoll & De Jong, 2014).

This study sought to examine emic perspectives on psychological and social consequences of armed conflict on school-age children and to understand common help-seeking efforts that address these consequences at multiple levels. An "emic" perspective is a subjective description of beliefs, thoughts, and actions from the perspective of cultural insiders (Pike, 1967). "Etic" perspectives on the other hand, describe beliefs, thoughts, and actions from an external vantage point in constructs that can be applied cross-culturally (Morris, Leung, Ames, & Lickel, 1999).

This article focuses on qualitative findings that preceded a cluster-randomized trial of a school-based intervention in Sri Lanka (Tol et al., 2012). By capturing the lived experience of children and youth in this setting, this study examined the following research questions: (a) How do people in conflict-affected communities describe the psychosocial impact of armed conflict on children? and (b) From a social ecological framework of resilience, what are common sources of support for this population?

**Method**

**Setting**

Data were collected in northern Sri Lanka between July–October 2005 and March 2006. Sri Lanka currently ranks 73 out of 187 countries on the Human Development Index (United Nations Development Programme, 2014). Its population of 21.3 million is culturally, linguistically, and religiously diverse (United Nations Development Programme, 2012). The country has seen a cyclical pattern of conflict, with the most recent conflict starting in 1983 when the Liberation Tigers of Tamil Eelam (LTTE) initiated an armed struggle for an independent Tamil state. The civil conflict continued for more than two decades, with precarious peace agreements that were repeatedly broken. The conflict came to an end in 2009 when the Sri Lankan military defeated the LTTE. Data collection took place during a time of increased instability, before the eruption of large-scale armed conflict in 2006. Although Sri Lanka has been relatively stable since the end of the civil war, educational and health achievements have been significantly impacted, particularly in the northern and eastern provinces (United Nations Development Programme, 2012).
Participants and Site Selection

Project implementation regions were selected on the basis of their vulnerability to armed conflict, established relations with community stakeholders, and agreement from local authorities to conduct project activities. The selected communities were linguistically and socioeconomically similar to the communities with whom the evaluation studies were planned, as well as similarly exposed to violence. The cluster-randomized trial was planned in the Tellippalai and Uduvil divisions of the Jaffna district, and the qualitative study was conducted in the neighboring Karainagar and Velanai areas of the same region.

The study sought to learn the perspectives from three groups of participants: (a) key informants (KI) with community-identified experts in children’s mental health issues (e.g., religious and traditional healers, primary health care workers, staff of nongovernmental organizations); (b) focus groups (FGs) with general community members (e.g., children, parents, teachers); and (c) in-depth semistructured interviews with members of families particularly affected by the armed conflict. Data collection began at community meetings where village and religious leaders were asked to gather community members in a central space. At these meetings, we presented our research objectives and sought permission from local leaders to conduct the study. Attendees were asked to list KIs in response to the question of who takes care of children when they are not feeling well, as well as list names of schools and their principals in the area. We then approached those identified as community experts on children’s issues for KI interviews. During these community meetings, we also approached school principals, village leaders, people with extensive social networks (e.g., shopkeepers, health workers), and staff of nongovernmental organizations (NGOs) to inquire into whether children, parents, and teachers would be interested to participate in FGs. Through snowball sampling, we asked the KIs to identify other relevant KIs in their communities. Finally, at the sites where KIs worked (e.g., traditional and modern healing clinics, churches, temples), we introduced our research objectives to visitors and asked participants if they would be interested to participate in the study. For these latter interviews we were interested in the perspectives of families particularly affected by the armed conflict.

Instruments

Following a review of the literature and consultation with project staff, one author (Wietse A. Tol) developed the interview and FG guides. Interviews and FGs were semistructured and focused on obtaining a narrative about the war experience, current challenges as a result of the conflict, perspectives on how the conflict impacted on children, youth, and families, and resources available at the individual, family, and community levels to support the development of resilience.

Procedures and Ethics

Training in ethnographic interviewing techniques and ethical research procedures was provided to local interviewers (by Wietse A. Tol), initially in a 1-week classroom setting and subsequently through 2 weeks of supervised field practice in which trainees practiced the learned skills with participants visiting the NGOs. Training was provided in English, with translation into Tamil with the assistance of a translator. Ample time was provided for role-playing communication and probing skills. The research team was selected as a separate team from the intervention staff and they were not involved in implementation of project activities. The training stressed the importance of collecting data from the perspective of participants, regardless of the mandate of the NGOs. Informed consent was obtained from all participants (as well as parents, in the case of children). Trained counselors were available for participants in need of additional support during interviews. Participants were also given the option to pause or stop the interview at any time they were uncomfortable answering specific questions. The ethics review board of the Vrije Universiteit Amsterdam granted ethical permission for this study. Additionally, we presented research procedures and asked for permission from the provincial and district school boards and community leaders in research sites. A team of four research assistants collected data. Interviews were conducted in Tamil.

Analysis

Data analysis was conducted on translated, transcribed interviews and FGs that had been audio-recorded. Nvivo 10 for Mac (QSR International, 2014) was used to conduct thematic analysis (Attride-Stirling, 2001). The coding framework was developed by two of the authors—one involved in the data collection process (Wietse A. Tol) and one external to the process (Fiona C. Thomas). This consisted of several stages. First, Thomas read a selection of transcripts from the FGs, KI interviews, and illness narratives to gain familiarity with the data. Second, relevant text segments from the transcripts were condensed into brief words or phrases (codes). Third, basic themes were derived from exploring the various topics discussed within the coded segments. Finally, these basic themes were organized into an analytical framework based on an ecological approach, with coding for child-, family-, peer-, school-, and community-level impacts and resources. Tol then randomly selected a handful of transcripts from those Thomas had previously coded and independently coded these using the framework developed through the aforementioned process. Tol and Thomas then discussed how their coding aligned or diverged. Where codes did not achieve sufficient interrater reliability, Tol and Thomas discussed in-depth and came to an agreement about how to apply each code. Once the coding framework was finalized, Thomas coded all transcripts independently using this framework. The findings reflect an ecological model of resilience that is based on the micro-, meso-, and exosystems as delineated by Bronfenbrenner (1979, 1989, 1993).

Results

The Individual

Similar to findings from a recent qualitative study in northern Sri Lanka (Somusundaram & Sivayokan, 2013), it was initially challenging to bring out elements of resilience in interviews and FGs. Participants did not immediately speak of adaptive changes that had occurred until interviewers directly questioned about this. Thematic analysis evidenced a broad range of emotional problems in Sri Lanka, which participants linked to the experience of ex-
families usually received support from extended family members. (double orphans) parents (UNICEF/ISS, 2004). Single-orphan ages 0 to 18 years who have lost either one (single orphans) or both (double orphans) parents (UNICEF/ISS, 2004). Single-orphan families usually received support from extended family members.

Changes in family structure reported in our sample were often related to ongoing stressors, or came up in the context of reminders of adverse experiences in the past. Child- and youth mentioned the fears they experienced as a result of what they had witnessed, and a lack of justice for perpetrators of violence. Emotional problems and somatic experiences were commonly reported together. Although these experiences were described at the individual level, they were often resolved in the context of the individual interacting with their family, school, and broader community. As one participant noted,

If one is cured, I cannot say that this is only because of my treatment. I also consider that his family and school environments and his own coping would have helped him to cure that problem. (KI interview, male counselor for children)

Parents, caretakers, and teachers described an increase in socially unacceptable behavior since the conflict. These included an increase in drug consumption, early sexual behaviors, watching violent and pornographic films, the use of violence and aggressive language to solve conflicts, and imitation of soldiers. One interviewee mentioned that “war has also created the feeling that violence is something acceptable” (KI interview, traditional healer/Christian faith healer). Parents and educators attributed these problems to the proximity to armed violence and the negative influence of TV and movies. Parents and caretakers often dealt with these situations by advising youth on what to do. However, parents and caretakers expressed a need for support in dealing with these problems.

Additionally, alcohol dependency, often among fathers, was another concern: “mostly the father may be using alcohol and mother will be bearing the family burden” (KI interview, traditional healer/Christian faith healer). Parents and caretakers expressed a need for support in dealing with these problems.

At the same time, some educators and caretakers had differing views on the challenges in providing education. Some parents noted that their children were treated differently because they were from different castes than the teachers and the majority of students. Yet, educators reported a lack of support for education from parents: “Parents do not worry much about their children not going to school because their sole concern is earning money for their day to day existence” (KI interview, traditional healer/Christian faith healer).

Neighbors. Traditionally, neighbors played a role in the rearing and supporting of children in their communities. For example, in times of illness by helping to collect money for hospital fees, caring for orphan or abandoned children, and helping their neighbors’ children with school fees when the parents could not make payments. Neighbors also played a role in the healing process for individuals affected by the conflict: “Neighbors and relatives brought all meals for us for at least a month and stayed with us so we would not be alone during this time. This is our custom when someone close passes away” (semistructured interview, female, age unknown).

Many educators provided students who had limited means with school materials, uniforms, and occasionally paid their school fees. Parents, caretakers, and children also described this support provided by educators. Educators described working one on one with children, advising them, and providing emotional and psychological support as needed:

Since I have good experience in dance, drama, and music, I spent most of my time telling stories, dancing and singing with the children. They now anticipate my arrival. I wanted to make school enjoyable for them so they would be engaged. Slowly, they started to open up to me about their problems. (KI interview, male counselor for children)

Microsystem

The family. Participants described how the family’s function of caring was compromised due to experiences of armed conflict. Changes in family structure reported in our sample were often related to the loss of the father, with a small minority of single-father-headed households in cases where the mother passed away. Following UNICEF’s definition, we refer to orphans as children ages 0 to 18 years who have lost either one (single orphans) or both (double orphans) parents (UNICEF/ISS, 2004). Single-orphan families usually received support from extended family members.

A mother describes the challenges she faced with her 11-year-old daughter after her husband was found dead and the subsequent support she received from extended family members:

Sometimes she became very adamant and would repeatedly say, “I will go to school only with my father. One way or another, bring him to me.” During meals and before going to bed she would continue asking for her father. . . . My brothers comforted her. They used to take her around on their bicycles and buy her chocolate. . . . Gradually, her constant crying, refusal to take meals, problems in going to sleep, crying after a nightmare, and nagging subsided. . . . My younger sister’s husband is very much attached to her and this also makes her happy. My sister and her husband frequently take my daughter out with them when they go out shopping or on visits and buy her new dresses and sweets. (semistructured interview, mother)

School. Participants spoke of supports for children in school settings. In addition to traditional school systems, nontraditional school settings have been established to support children and youth. One participant spoke about a school she founded for the visually impaired: “I wanted the children who have lost their eyesight to feel acceptance in society. They must lead a normal life like others and they must enjoy all rights enjoyed by others” (KI interview, Director of Centre for Visually Impaired, female, age unknown).

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everyone” (KI interview, manager of boys’ home, male, 60 years old).

Community organizations. Formal and informal community organizations were established in the absence of support from neighbors or to supplement this support when it was available. One participant spoke of the support she received from a widows’ society:

At present I am a member of the widow society that is in our area. I take my son along with me for gatherings. All members in that society move as members of one family. As there are children in those families my son has a good relationship with them. He is happy when he spends his free time playing with them. (semistructured interview, mother, 38 years old; son, 14 years old)

Health services. The professional health sector in study sites included specialized health care personnel, often located in the larger cities. Care from the professional sector was accessed only in more urgent cases and was not the first line of support sought out. Often, health care personnel treated conditions such as diarrhea, infections, gastrointestinal issues, and severe mental illnesses. Participants often resorted to different health seeking strategies simultaneously:

After 20 days we were discharged from the hospital and allowed to go home. . . We consulted a doctor of traditional medicine regarding the muscle pain. He gave us some oils, which we applied as instructed by him. . . . Exercises were also done. . . . My mother had taken a vow that she would give a hand made of silver to the Nainatheevu Amman temple. The following year in August, we went to the temple and fulfilled the vow. (semistructured interview, mother, age unknown; daughter, 18 years old)

Participants attributed illness to varied sources, including evil spirits and other supernatural forces. Care was sought in interconnected ways based on ideologies and interpretations of root causes. Additionally, participants reported challenges with paying for health care, which may help to explain why the formal health care system was not routinely accessed.

Religious and traditional healers. Religious and spiritual beliefs were foundational in facilitating coping. Parents and caretakers often approached religious and traditional healers for treatment of somatic complaints, behavioral issues, or issues believed to be connected with supernatural forces. As discussed above, participants often sought out a combination of resources from religious and traditional healers and the professional health system simultaneously. They would combine for instance, tying holy thread or sprinkling ashes on the child, offering food to the deities, lighting camphor, and drinking certain herbal mixtures. Some participants reported not going back to see religious and traditional healers because of limited financial resources or because the healing effects did not last long.

The Mesosystem

Despite the presence of various microstructures, participants reported limited interaction between these microstructures, indicating a reduced presence of mesostructures. For example, while participants described accessing care from religious and traditional healers and the professional health sector, caregivers in these sectors did not report interacting in their services. Additionally, participants from the education and health sectors did not discuss interacting in their care for children, except in more serious cases where a child required additional attention. At the same time, mesostructures were present in the occasional interaction between educators, parents and caretakers. When necessary, educators also involved peers and external organizations (e.g., NGOs, U.N. agencies) to provide support for children most in need. Some teachers partnered with different organizations to promote the value of education to parents: “With the help of fisherman’s societies we try to educate parents regarding the importance of education” (FG, teachers).

The Exosystem

Participants often described challenges with finding employment and noted that opportunities were restricted to certain areas for safety reasons. With limited employment opportunities, poverty and displacement increased. As a consequence, families often did not have sufficient income to pay school fees for their children. Ongoing displacement during the conflict also meant that children were unable to attend school regularly: “war has made many of them orphans, children have faced multiple displacements. Some have been displaced more than 10 times. Their education and the earnings of their parents all have been subjected to many changes” (KI interview, female child counselor). Teachers reported that classroom achievements were substantially impaired since the beginning of the conflict. They described high absenteeism and dropout rates, and inattentiveness of children when they were present at school. Additionally, there was often pressure on children and youth to support the family either by finding employment or working in the fields.

There were gender differences in the sources of absenteeism from school. With increased violence toward girls since the conflict, participants noted that some parents prevented their daughters from attending school. Educators described the pressure on boys to drop out of high school in order to find employment. Ultimately, the limited income placed stress on family relationships. Most parents and caretakers noted that they would resolve these tensions by explaining the current circumstances to their children, engaging them in cultivating land, and supporting their education when they could. While community members often described families in the context of the conflict as being less affectionate and more neglectful toward their children, they acknowledged the limited resources available to parents and caretakers to deal with the consequences of poverty and displacement.

Discussion

Research in the area of ecological resilience argues that resilience is not a feature of the individual alone, but of this individual within multiple ecologies and interpersonal relationships (Fernando & Ferrari, 2013; Hobfall & De Jong, 2014; Tol, Jordans, et al., 2013a, 2013b). Based on our analysis it is clear that at each of the multiple ecologies of micro-, meso-, and exosystems, negative impacts as well as resources need to be considered.

Overall, the microsystems of children and youth were significantly altered as a result of the conflict. Changes in family structure were described as having the largest impact on the well-being of children and youth. The microstructure of the family became more isolated due to displacement and loss of community net-
works. This inherently impacted on the social fabric of villages and communities. Villages had once been secure and familiar environments with supportive social structures. These spaces either ceased to exist as a result of the conflict, or experienced significant loss of structures and institutions as well as the disentangling of networks of relationships due to displacement (Somasundaram, 2007).

Bronfenbrenner noted that a child’s development is generally enhanced if two or more of the microsystems within which they are actively involved are strongly linked (i.e., the mesosystem). What happens then when one or more microsystems of the developing child are dramatically altered or when links between microsystems disappear? As eloquently articulated by Somasundaram (2007),

in collectivist societies, the individual becomes embedded within the family and community so much so that traumatic events are experienced through the larger unit and the impact will also manifest at that level. The family and community are part of the self, their identity and consciousness. The demarcation or boundary between the individual self and the outside becomes blurred. (p. 2)

In this way, when the links between microsystems dissolve, the child’s social ecology of resilience is impacted.

Significant occurrences at the exosystem, such as increased financial upheaval, exerted indirect influences that impacted on children in various ways. For example, as a result of the conflict, families were often displaced resulting in loss of property and employment. This resulted in the inability of families to financially support their children’s education, subsequently limiting the child’s interaction with the important microstructure of school. As indicated by our findings however, alternative community-based organizations occasionally provided resources to address such impacts. In this way, the challenges as well as resources available at the community level need to be understood for designing meaningful interventions.

Programmatic Implications

The findings have numerous implications for mental health and psychosocial support interventions. First, common themes indicate that program developers and implementers can draw inspiration from programs in other settings while acknowledging the importance of designing these programs with great sensitivity to context. In particular, detailed pre-intervention assessments can help identify local resources available in a community. Additionally, as this study highlights, emic perspectives are important to examine as it shows how children, families, and communities experience the impacts of armed conflict and how they attempt to address these impacts. Such knowledge can be used to design external assistance that is considered relevant by affected populations and builds on existing resources. The emic perspectives captured in this study point to the integrated ways in which healing resources were accessed, the importance of rebuilding mesostructures, and the significant impact changes in the exosystem can have.

Research in multiple settings highlight the role of religion, religious leaders, and traditional healers in facilitating coping (Fernando & Ferrari, 2011; Linley & Joseph, 2004; Thomas, Roberts, Luitel, Upadhyaya, & Tol, 2011; Tol, Reis, Susanty, & De Jong, 2010). This, as well as the interplay of religion with the traditional and professional health sectors, is important to consider in interventions targeting resilience development and healing within communities. Our findings indicate that participants often accessed healing supports from religious leaders, traditional healers, and medical professionals simultaneously. Given the large majority of individuals who accessed care from traditional healers and religious leaders, interventions that build upon collaboration between these sectors may be important (De Jong, 2014).

Bearing in mind the dynamic nature of social environments, it is critical to consider both competing and complementary frameworks in designing and implementing interventions.

Second, interventions at multiple levels require coordination between different types of services in varying sectors. Following the social ecological model of resilience, this means rebuilding the mesostructures where they have been damaged. For example, a school-based intervention that incorporates educators, children, parents, caretakers, health care providers, and community members can implicitly facilitate the development of interpersonal bonds, and links between microsystems, where those of different castes or different socioeconomic status work together. Programming that connects families, schools, and communities can positively impact on social solidarity, reduce distrust, and increase linkages between the different microsystems of support (Ginzburg & Neria, 2011; Valliapan, 2011).

Lastly, in designing and implementing interventions, there is a need for continuous scrutiny during implementation to take into account dynamic changes in the exosystem. In this study, increased poverty resulting from unemployment and displacement impacted on school attendance and high dropout rates. With many children and youth unable to attend school, school-based interventions may miss some of the most vulnerable youth, requiring the implementation of creative community-based interventions. Relatedly, participants spoke of the specific vulnerabilities of girls and how this impacted on their school attendance. Such information is important to consider in designing community-based interventions so as to not miss vulnerable populations. In addition, our findings highlight the presence of nontraditional school settings that have been established to support children and youth with differing needs. Similarly, the evolution of mutual help structures that developed (e.g., widows’ societies) point to the efforts to reestablish connections and links and build community solidarity and support. These unique needs require further consideration in designing interventions.

Research Implications

With regard to future directions for research, literature on traumatic stress in individuals in conflict-affected countries has focused on common psychopathologies and the investigation of risk and protective factors in these settings. What is additionally needed is an understanding of the variables that mediate and moderate the development and maintenance of resilience (Vente-vogel, Jordans, Eggerman, van Mierlo, & Panter-Brick, 2013). Which interventions across the developmental trajectory can support the growth and maintenance of resilience? What changes in the microsystems of the developing child, namely the familial, educational, and community settings, are needed to foster favorable psychosocial outcomes for children, youth, and adults (Panter-Brick, 2010)? Future studies can explore what protective factors are available to children immediately before, during, and
after an event to further understand how these components are crucial in improving developmental outcomes (Magid & Boothby, 2013). Our study provides one possible model for how to combine emic and etic perspectives when conducting evaluation of psychosocial interventions. While cross-sectional data point to associations between variables, longitudinal studies in this area can assess the relative causal mechanisms involved in resilience processes.

Limitations

Limitations include that the fieldwork took place in Sri Lanka in 2005 and 2006. As such, a substantial amount of time has elapsed since the data collection period. As resilience is context-dependent and influenced by time, it would be important to collect recent data to verify if these themes still resonate with the youth and families in these communities. Additionally, ceasefire agreements and recent peace building efforts may have influenced how the impact of the conflict is perceived and what resources are available to support healing. At the same time, findings from this study overlap with findings from recent research in the region (see Somasundaram & Sivayokan, 2013).

Third, our research was conducted in partnership with service providing organizations. While we emphasized throughout the fieldwork that participants would not receive any benefits in services (with both interviewers and participants), there is the possibility that participants may have stressed their vulnerability in their narratives in expectation of services.

Conclusion

Despite the above-mentioned limitations, this study indicates the value of a social ecological model of resilience. While the challenges individuals face in conflict settings cannot be neglected, we suggest that interventions based on a social ecological model of resilience can strengthen links between microsystems, thereby contributing to positive outcomes in children. Although such improvements are important in their own right, we feel it will be important to assess if improvements in linkages between microsystems (i.e., addressing the impacts of armed conflicts on the “social fabric” of children’s communities) is subsequently associated with improvements in individual children’s mental health.

As stated by Krell (1997) and elaborated on by Silove (1999), individuals and communities generally have little choice other than to adjust in some way to the impact of armed conflicts on their lives. However, rather than the traditional perspective of resilience as an individual trait that is either present or absent, contemporary resilience researchers conceptualize resilience as a product of the child’s “social ecology,” that is, an interactional process between the individual and their social and physical environment (Luthar, Cicchetti, & Becker, 2000; Unnart, 2011). In their systematic review, Tol, Song, and Jordans (2013) found that current research findings support the view of resilience as a dynamic process that is heavily context dependent. Instead of the application of a universal model of resilience promoting intervention, they argued that such interventions will need to be tailored to specific contexts to have any significant positive impact on the mental health of the target populations. It is our hope that based on these findings we have highlighted the importance of not only strengthening microsystems for children and youth but also the value of the linkages between microsystems (i.e., the mesosystems) in establishing a comprehensive social ecological model of resilience. We recommend that interventionists carefully assess opportunities to build bridges between microsystems to ultimately weave stronger mesosystems for children and youth in postconflict settings.

References

EMIC PERSPECTIVES ON THE IMPACT OF ARMED CONFLICT

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