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War in Côte d'Ivoire and Management of Child's Post Traumatic Stress Disorders

A. C. Bissouma¹, M. Anoumatakky A.P.N² and M. D. Te Bonle³

¹*Child Guidance Center-National Institute of Public Health and National Mental Health Programme Côte d'Ivoire,*

²*Psychiatric Hospital of Bingerville and National Mental Health Programme,*

³*Child Guidance Center-National Institute of Public Health, Côte d'Ivoire*

1. Introduction

For two decades, Cote d'Ivoire has gone through a number of crises that undermined the Ivoirian national cohesion. In September 2002, almost two years after the 1999 putsch and the stabilization of the social, military and political situation, with a president and a Government recognized by all and sundry, as everybody looked forward to leading a normal life, the suddenness of the war, which broke out in the night of 18th -19th, shook the foundation of the nation. Côte d'Ivoire was under attack, towns were besieged, populations were running up and down for dear lives...The death toll, the mass displacement of people both internally and externally, the medico-psychological trauma brought about by this situation provoked a real trauma among the populations with its consequences in terms of social disorganization.

The country was divided into three zones: the governmental zone, the trusted held by the French forces "Licorne" and the U.N forces "ONUCI", and another zone called CNW (Central, North and West) held by the rebels.

In December 2002, the conflict initially intensified in the western region, in the *Moyen Cavally* region, especially on the *Guiglo-Toulepleu* road where people witnessed the birth of the phenomenon of child soldiers. The conflict was deadly there and the fight lasted 3 years in that region. From 2006 to 2008, these child soldiers were attended to.

Psychiatrists were put in place. Unfortunately, the socio-psycho-medical interventions, which started in 2002, have not been supported by a formal organization to ensure sustainability.

Our objective is twofold: to describe on the one hand a unique experience in Côte d'Ivoire, that of a field care of child soldiers by an Ivoirian psychiatrist and on the other hand, analyze the intervention in order to better prepare for future interventions.

2. Background

What is the context of psycho trauma in Côte d'Ivoire? It is rather difficult to trace back the first actions on psycho trauma.

Although the country had previously passed through a number of situations and catastrophes with a number of traumatic experiences, no significant interventions to improve people's mental health in situations of mass trauma had been instituted.

2.1 Côte d'Ivoire geographic and sociodemographic context

Côte d'Ivoire is situated in West Africa in the sub-Saharan area. It covers an area of 322,462 square kilometers. It is bordered in the North by Burkina Faso and Mali, in the West by Liberia and Guinea, in the East by Ghana and in the South by the Gulf of Guinea.

The political capital of the country is Yamoussoukro, located in the heart of the country, some 248 km from Abidjan (in the South), and the economic capital. The official language is French. It is a country of immigrants, on account of being a crossroad of economic and cultural exchange. It has witnessed an urban growth since independence. The country probably has the best urban centers in Africa south of the Sahara.

On the sociopolitical level, Côte d'Ivoire is a democratic republic led by an executive President.

The population of Côte d'Ivoire was estimated in 2008 at 20,179,602 inhabitants. Forty three percent of the population is less than 15 year-old, and 49% are female among whom 51% are within the active reproductive age.

The Ivoirian population is characterized by its ethnic diversity. There are more than 60 ethnic groups divided into 4 main groups: the *Malinkés* in the northwest, the *Voltas* in the northeast, the *Krous* in the southwest, and the *Akan* in the southeast.

Ivoirians are essentially religious-minded people, and the freedom of worship is guaranteed by the Constitution. The main religions are Christian faith, Islam and Animism.

As a rule, the Ivoirian population is diversified, young, barely literate and highly fertile; which constitutes a strong pressure on health agents who are over worked most of the time, especially in the situations of crises.

2.2 The different wars

Since the death of the Founding Father, His Excellency Felix Houphouët-Boigny in 1993, the country has always been prey to many uprisings. The climax was reached on the eve of Christmas in December 1999. The country knows its first putsch and a transition military take-over that lasted around 11 months. At the end of the military confrontations linked to the putsch, people were traumatized and a few actions were taken against this traumatic experience. In 2000, a controversial election, urban confrontations and a military and political crisis, brought President Laurent Gbagbo to power. A number of initiatives, such as Reconciliation Days were organized in order to reunite the nation, as well as a few attempts of psychosocial actions. Despite this, on 19 September 2002, an armed rebellion cropped up that attempted to topple the Government. The failure of this attempt saw the partition of the country. The northern part fell in the hands of the rebels, while the Southern part remained under the control of government forces. A third zone, the trusted zone in the hands of the international forces (*Licorne* and *ONUCI*) representing the intervention forces separated the two warring forces.

In November 2004, the French army based in Abidjan, the economic capital in the South, attacked the Ivoirian army. People took to the streets and many casualties were recorded.

In August 2006, people were, once again, shaken by the problem of toxic waste dumped into a number of sites in Abidjan. People concluded that, after the failure of the military coup, it was the time of chemical and bacteriological war.

On the political level, union governments came into existence, but their operations were once again hampered by internecine, partisan and political war. The country remained divided into two, even though on 31 July 2007, the reunification was announced. Despite of all these difficulties, the country lived on.

2.3 The 2002 war

In the night of 18 to 19 September 2002, a number of towns were attacked simultaneously: Korhogo in the North, Man in the West, Bouake in the central region, and Abidjan in the South.

The military and political crisis, facing Côte d'Ivoire at that moment would give birth to a humanitarian catastrophe, without precedent in the history of the country, and that would result in loss of human life among the civilian population affecting mainly women and children. Around 1,500,000 persons were forced to leave the theater of war, (OCHA, 2004) either to seek refuge in areas under government control, or to seek shelter in neighboring countries (400,000 Ivoirian refugees).

More than 2,600 teachers and 704,800 students were displaced, including about 59,000 who were able to resume classes in the institutions labeled as relay schools in the free zone. But, only few of those displaced children did enjoy psychological health.

This mass movement of traumatized people and the disorganization of the social structure yielded dramatic health, social and psychic consequences yet to be investigated and addressed.

All these displaced persons had many difficulties to readapt because few of them received psychological support as part of handling war trauma. The absence of medico-psychological and social intervention due to lack of qualified health personnel was visible.

The phenomenon of child soldiers actually appeared in December 2002, on the occasion of the outbreak of a new tension source in the western region. The interethnic conflicts took around three years, in an area where many factions, including those from Liberia, a neighboring country fought the battles. This tension source developed in a region that has been receiving traditionally a number of Ivoirians and foreigners for years, and also, since the Liberian war, some refugee camps.

2.4 Actions on behalf of traumatized people

Few documents have reported the intervention undertaken since 1999, and few research works have explored this issue. No one can deny that some activity reports did exist, but they are yet to be known by the public. It is only in the course of the 2002 war that we discovered traces of the humanitarian interventions undertaken. Theses and dissertations carried out at National Institute of Public Health (INSP). Unit Taking over an Integrated of Abidjan (UPECI), at the psychiatric hospital of Bingerville (in the district of Abidjan) as well as at the *Centre Mîe N'Gou of Yamoussoukro* (Bissouma& al, 2005; Kouadio, 2004; Kouakou, 2003), documented the psychopathological facts and disorders and confirmed the data of the international literature on the social, economic, psychological and medical consequences of the Ivorian war. These consequences may be categorized mainly into an increase in unemployment rate of 87.73% in Yamoussoukro after the war versus 21.82% before the war; an increase in psychological disturbances in the form mainly of anxiety, depressive and psychotic disorders; an increase insomnia, aggressive behavior and psychosomatic disorders, such as high blood pressure and diabetes mellitus; and the non-adaptation of the civilian populations to their host environments manifested by loss of interest in productive activities.

The consequences of this war have been dominated by post-traumatic stress and co-morbid signs with 93% of the victims experiencing sleeplessness and loss of appetite, depression, and an increase in consumption of toxic products (alcohol, tobacco, drug), and a certain degree of loss of social values for most of the population.

3. Situation analysis

In 2004, we took interest in the issues of psycho-trauma. At that time, despite the importance of the problem, there was insufficient interest in the issue and inadequate research had been carried out on it Cote d' Ivoire. The few studies that had come out were done in preparation for a doctorate of medicine dissertation and these studies were conducted among adults. Researches were about psychiatric disorders (depression, anxiety, and psychosis), but the issue of psycho trauma was not tackled. The situation of children was ignored.

A number of factors account for the relative lack of research on psycho-trauma among children and adolescents.

As a rule, in African societies, the child and adolescent mental disorders are completely neglected. Instead, people are more concerned with the mental well being of parents and guardians. Some reform to improve the mental health of adults has occurred though more needs to be done. In African societies, to resort to psychiatric care means madness. Psychiatry is still stigmatized and a number of people refuse to accept the value of psychiatric care. The Brazzaville WHO conference held in 2005 came up with solutions for a better follow-up of mental health issues among children and adolescents.

When, finally, the issue of child soldiers emerges, it was more or less unwelcome, more or less unrecognized and not readily accepted by the Government. People working within a national non-governmental organization (NGO) to rehabilitate former child soldiers expressed their desire to be backed up in rehabilitation efforts by qualified mental health specialists. Convinced that these children were at risk of the traumatic effects of war and were at risk of developing post-traumatic stress disorders, it became urgent, for this NGO, to evaluate the mental health of the former child soldiers in preparation to help the children.

In June 2006, an assessment mission went to the western region of the country to assess the real needs in the field of psychosocial reform program for former child soldiers. The terms of reference of this consultancy were to assess the mental health situation of 400 child soldiers and their families living in five (5) villages on the *Guiglo-Toulepleu* road (*Kaade, Behoue, Ke-Bouebo, Pehe and Pantrokin*) and to assist them psychologically.

This activity ran from June 2006 to August 2008. In that period, a number of working sessions in *Guiglo*, a western region city, were conducted in order to work with the NGO staff in assisting the former child soldiers, but secondarily with Liberian young refugees (we will not discuss here). Our additional task was to support psychologically the personnel and to help them in their psychosocial activities.

In Côte d'Ivoire, that experience was unheard of because children's psycho traumatic experiences were not well appreciated and were ranked as second-class activity. Ivoirian psychiatrists did not invest in this area, leaving the field to humanitarian agencies. Similarly, Jézéquel (2006) underlines that, in the case of conflicts in Africa, the issue of child soldiers has been initially the prerogative of aid agencies. For him, child soldiers have become the symbols of an African continent on the decline, a "heart of darkness" alien to European culture. It becomes the object of a new "aid agency crusade", a western neo-interventionism paralleling the civilizing missions of the past.

At the beginning, this mission proved difficult on account of the nonexistent consensus national structure to provide various forms of assistance for victims of traumatic stress in Côte d'Ivoire, including the availability of competent human resource and material means, difficulties to access the area to carry out research (distances, situation and insecurity on the

road), the impossibility to undertake a regular follow-up, and the persistent instability and insecurity in the zone

My initial survey carried out during the draft of my specialization in psychiatry dissertation entitled: *"The war and the medico-psychology situations of children received at CGI and colliged case in the community"* formed the background literature for our intervention in the region.



This map shows the division of Cote d'Ivoire after the outbreak of the War of 2002. The country was divided into three zones (government, CNW zone under the control of the rebels and trusted zone). Cote d'Ivoire has been reunited July 30, 2007. The red line materializes the axis Guiglo-Toulepleu.

Fig. 1. Map of Côte d'Ivoire

As a young psychiatrist leading the team, we were doomed to venture on the slippery field of psycho-trauma without reference or theory.

We had to cross the country from South to West (around 600km) under difficult conditions. We used to leave Abidjan at sunrise to reach Guiglo at sunset, most of the time after an endless journey on a car or on a "gbaka" (a dilapidated 18-20 seat mini-car). We had to go there at our own expenses. On site, the NGO personnel organized both activities and sojourn.

At that time, there were instances of insecurity in the area and armed bands were still operating in spite of the program of disarmament set up by the Government.

At the same time, in these villages, there was no health center, and the people's somatic problems were difficult to solve (people had to go either to *Guiglo* or to *Toulepleu*); finally the NGO had to hire a male nurse. Schools were closed down and teachers had not come back. Some villages had no electricity and no telephone.

The traces of the war were visible everywhere: houses destroyed, walls riddled with bullet impacts, faces mirroring unspeakable suffering; misery and poverty seemed to be the daily companion of the population.

In such a situation, the implementation of this far-reaching project that consisted in rebuilding human lives, in giving back a meaning to life and to raising children psychically by healing their invisible wounds named traumas, proved to be an arduous but inspiring task. We needed to face a huge undertaking, that of children requesting care, not always psychic, but often somatic, that of parents for whom we were all doctors and who were begging for assistance, that of participants who were most of the time overworked, psychically suffering sometimes from the burden of the task, under the tough conditions of the mission. The question was to bring answers, a little satisfying to everybody and to each one.

4. Methodology

The implementation of such a project required a methodology with a clear-cut description, feasible and doable but at the same time flexible enough to adapt to unforeseen field events in order to let us plan our actions on a daily basis.

4.1 Population

The population in this project comprised of two groups: child soldiers or those associated with the battle and the untrained field assistants to tackle the issues of psychological consequences of traumatic stress (10 NGO "Social workers" and 10 organizers from the village community).

The structure, which organized the field activities, had listed 500 children, but, finally 400 were recruited into the project. The sample retained for the study of psychopathological disorders was made up of 345 children broken down as follows: 93 children from *Kaadé*, 80 from *Béoué*, 118 from *Ké-Bouébo*, 67 from *Péhé* and 67 from *Pantrokin*.

Local NGO workers and workers from the village community, many of whom had no experience, assisted children with psychic suffering. Most local agents were either veterans or inhabitants of the village who had lived the events themselves and who had not been assisted psychologically. As for the local agents, they were condemned to live with permanent anguish, in the midst of the villagers under precarious sanitary and security conditions.

4.2 The project itself

The project, which took two years to complete, progressed through many phases: an initial assessment phase before intervention, with an initial assessment of the psychopathological situation of child soldiers and a definition of the intervention to be taken for social reintegration of those children;

an action phase with psycho medical consultations, educative assistance by the organizers of the structure (group therapy, literacy, re socialization), term assessment seminars.

Children's psychiatric consultation took place every three months. Thus, for a week, the organizers made an assessment of the situation of children and the stock of global assistance.

A final assessment phase of the children's psychopathological situation was conducted after intervention in the year 2008.

4.3 Means

We set up a data bank in order to study the psychopathological characteristics of the former child soldiers.

The collected data concerned the socio demographic (sex, age) and psychological characteristics (sexual activity, symptoms). This data gave us the opportunity to gather indicators to better plan our actions.

We asked for educational and playing equipment: balls, toys, pencils and felt-tip pens, building in games, paint and drugs: haloperidol, chlorpromazin, levomepromazin, and trihexyphenidyl (an antiparkinsonian) to palliate the side effects of neuroleptics.

4.4 Project implementation

The NGO project started at the end of the year 2005. Our fieldwork kicked off in June 2006 with a series of consultations with 400 former child combatants. The objectives of the initial consultations were to assess the mental health needs of the children, to train the community mobilizers to be attentive to the needs of the children, to initiate and supervise the administration of drugs as indicated, and finally to provide psychotherapeutic services. We received children either individually or in groups depending on their needs.

We planned and conducted field activities in series, and each activity lasted seven days; field activities began with an assessment of the psychological needs of the children followed by the training of the community mobilizers.

We conducted community awareness campaigns to convince parents on the harmful effects of war on the psychological health of individuals. The campaigns were conducted at market places, and an average of 100 persons per village (300 persons were present in *Kaadé*) attended the sessions.

At the end of the awareness campaigns, 177 persons asked for medical assistance though only 30 people eventually came for consultation.

Some major signs of psychic disorder were identified among parents including depression, psychosis and fear with a feeling of suspicion, demotivation with low performance at work and an accentuation of poverty situation.

Following our assessment of children's mental health needs, we engaged them in a variety of therapeutic activities such as drawing (draw your house and your family, before, during and after the war), and we engaged the older children in income generating activities to determine how the children would adapt to work situations. In the course of implementing our fieldwork we wanted to observe how the children behaved, how the village and family environment might be a limiting factor, how the weather changes and seasons influenced the engagement of children and how the children's social and cultural factors might influence the future of the children. Our fieldwork ended in August 2008, four months after the NGO project ended in April 2008. We now present the results of our medical assistance to the former child soldiers.

5. Results

5.1 The socio demographic characteristics

More than half of the children were male (60.3%) against 39.7% female. Just below 1% (0.9%) of the children born during the war were aged less than 5 years. Figure 2 below shows the distribution of the children by age category.

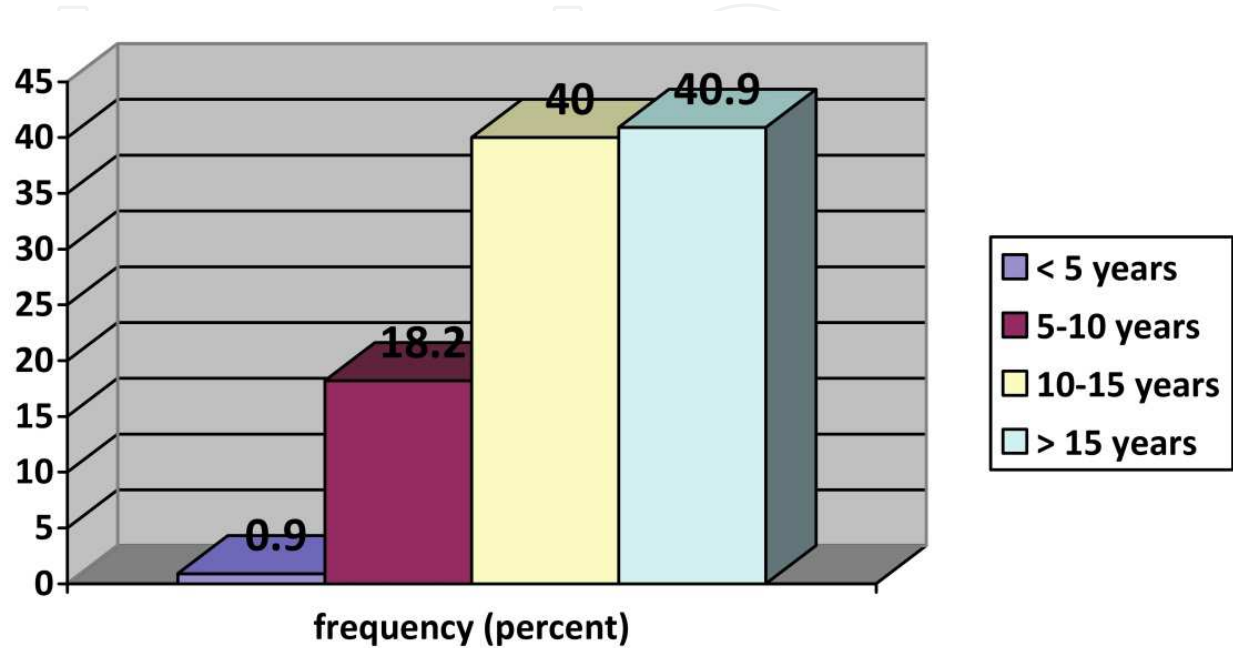


Fig. 2. Distribution of age

Ninety-two (92.2%) of the children did not go to school: Fifty-eight percent (57.7%) of them dropped out of school due to the war (0.3% at Kindergarten, 52.8% at primary school and 4.6% at secondary school) , 34.5% have never gone to school and only 7.8% attended school (4.6% at primary school and 3.2% at secondary school). Among these children, 86.8% had no activity while 13.2% were farmers, fishers or breeders.

5.2 The experience of the war

The consultations carried out and the reports made by the community mobilizers gave us the opportunity to trace the war experiences of those children. Eighteen percent (17.68%) of the children actually fought in the war and 61.74% worked either as cooks and cleaners in houses, or carried goods or worked as security guards. Information on the exact nature of involvement was available for 20.58% of the children.

A number of dramatic stories were told; like the one of this 17-years-old teenager from Kébouébo. He attended the 8th Grade in another town where he was sequestered for two weeks at the time the town was attacked by the rebels. In the course of his captivity, he was sodomized on a regular basis by a group of six armed men. Upon escaping, he returned to his village where he met a group of armed men from Liberia. He told that “ *when they asked me to come with them, it was to avenge my parents...but I thought of what these people did to me, I saw red and wanted to kill...they did not force me to take up arms.*”

We met in the same village a pregnant female teenager of 14. She had been captured in the bush. Her family had been massacred under her eyes, she was forced to cook the dead body

of her mother as food for her tormentors, and one of them desired to take her as his wife. At the time we met her, she had been living for over one year in another village without any link with her family and was pregnant with her second child.

Many children told their war experiences, how they stood up to defend their villages and their region; many of them witnessed atrocities and some of them carried the physical marks of their contribution to the war.

According to these children, their involvement in the war was motivated by revenge (13.91%); defense of the country/village (4.35%); liberation of their farms (3.19%); solidarity (2.32%); imitation of others (0.8%); and no reason (75.36%).

Ten percent of the children (10.43%) joined the conflict in 2002; 29.27% in 2003; 4.06% in 2004; and 1.74% in 2005. Over fifty percent of the children (54.5%) of the children did not specify the period of their involvement in the war; 4.35% were engaged in the war below the age of 10 and 49.86% between 12 and 15.

Over fifty percent (56.81%) saw a man being killed but 20.87% did not witness such a scene. Eight percent (8.41%) of the children said they did not have any reaction to a person being killed, 25.51% were afraid, 9.27% were upset, 4.93% were delighted, 2.32% felt pity, 1.45% revolted, and 3.78% said they felt traumatized. Just under ten percent (9.86%) joined deliberately the armed group to make war and 36.52% were inspired by someone they knew and 26.38% followed a parent. A third (30.43%) had learned how to manipulate weapons and 27.64% were trained in a camp. Among those who had been trained in a camp, one could list 46.8% of children recruited by an armed Liberian group called *LIMA*, 33.0% were recruited by *ZAKPRO* (an Ivoirian militia), 12.8% were recruited by *FLGO* (an Ivoirian militia for the liberation of the western region), 3.2% were recruited by *APIWE* (the Alliance of Wê Patriots), and 2.1% were recruited by an unidentified special force. Forty percent (41.16%) said there were children in camps during the war. Their number varied from less than five to more than thirty. All of them talked about the presence of girls among the child soldiers whose size reached sometimes 20, according to the groups. They served as cooks, (20%), fighters (5.22%) cleaners and maids (3.19%), security guards (2.32%), and as porters (2.03%). The number of girls used for sexual purposes was not specified. Forty percent (38.26%) of the children reported to have an affective and physical proximity with someone among the rebels.

5.3 Evidence of psychopathology

Over two percent (2.61%) of the participants had already had problems with the law (arrests by the police for offence). None had a previous record of psychiatric illness; 52.17% were sexually active with, at times, several partners (63.33% had 1, and 36.67% had as many as 6 sexual partners). Fewer than ten percent of the children (9.57%) had been victims of sexual abuse and violence (70% for girls against 30% for boys); many of the girls had served, as sexual slaves for the rebels. Twenty seven percent of girls involved in the research were teenage mothers. The teenage mothers justified these early motherhoods on the basis that the traditional *Guéré* cosmogony (the ethnic group of the region) required girls to give birth to prove their capacity to give life, which similarly gives them the status of being woman. Just over fourteen percent (14.49%) of the children reported the use of cannabis, gunpowder; 37.39% the use of various brand of locally brewed alcohol (*distilled cane sugar* or *Koutoukou* (*distilled palm wine*, or some adulterated alcohol); 16.52% smoked tobacco; and 0.3% inhaled solvents (glue). All the children showed evidence of mental health problems among which insomnia ranked first. There were a group of traumatized children presented with clear

memories of war events: the war was still present in their mind and the eventuality of its resumption was not warded off; the children frequently formulated this eventuality. The children's personalities were characterized by narcissistic fragility and failures. They openly expressed their anger, their aggressiveness and their tendency to revolt. One could note, at times, a great pessimism associated with a feeling of a future blocked and a social disinvestment. The children moved about in the village in groups. For example, in August 2006, in the course of the parade of the children of *Ké-bouébo*, they arrived in battle order chanting war songs wielding tanks, rock launchers, Kalashnikovs, and pistols sculpted in bamboo fiber. An important fact is to be noted: in *Pantrokin*, the former child soldiers surveyed showed evidence of psychiatric disorders linked to the war. When we asked them about their mental condition, they reported that they had received some form of traditional treatment (plant-made medicine). However the nature of this treatment has not been revealed.



Fig. 3. Bamboo rifle made by a child-Ke-bouébo

The children were showing different psychic disorders (*one child could show one or more symptoms*).

Mental Health Problem (Symptom)	Frequency	Percent (%)
Behavior disorder (theft)	281	81.45
Insomnia	265	76.87
Anxiety	261	75.8
Disorder of character	249	72.24
Easily moved to tears	143	41.6
Sadness	114	33.0
Social isolation, withdrawn	98	28.4
Delirium or hallucinations	54	15.6
Memory disturbance	47	13.8
Suicidal gestures or behavior	40	11.6
Logorrhea	39	11.3

Table 1. Symptom patterns of mental health problems among former child soldiers

Psychiatric diagnosis was possible among 81.45% of the children with the following (CIM 10) diagnoses present in table 2 below.

probable psychiatric disorders among former child soldiers	Frequency	Percent (%)
Post-traumatic stress disorders (F43.1)	150	53.38%
Depressions (F32.11, F32.8	57	20.29%
Acute psychosis (F22.0, F23.31)	36	12.81%
Anxiety (F41.1, F41.2)	34	12.10%
Schizophrenia (F20.0, F20.1)	4	01.42%

Table 2. Frequencies of probable psychiatric disorders among former child soldiers

5.4 The somatic problems

A number of the children had various forms of health problems (hypo gastric pains among children who had been raped, dermatological diseases, sequelae of head injury, deafness, ear infections, and lumbar pains).

The somatic problems were dominated by74.75% headaches, 67.97%palpitations, 29.10% feeling of suffocation, 22.30% loss of appetite and 06.10% enuresis

5.5 The socio-cultural aspects

It is important to underline here some socio cultural characteristics observed in that region, as a minimum knowledge of the cultural environment in which one wants to act significantly influences one’s ways of life.

A latent conflict existed between children and adults. Precarious economic situation and poverty were important in the region. The involvement of the children in the project, financed by national and international structures was backed by a food donation (rice, oil). Parents had been complaining sometimes because they were willing to receive themselves the provisions or they claimed the provisions of their children, when the latter had given up their activities with the project. The children were used as foils by parents, but there existed between them a conflict of authority reflecting the reversal of social order from the war.

Income generative activities have been impaired by the way children perceived them. The activity which did not kick off well enough was truck farming. Boys were saying that “*cultivating okra, egg-plant was sauce*” meaning that they are ingredients to cook sauces, and that it is women who cook, therefore this activity could not be exercised by men. In a number of regions in Côte d’Ivoire, truck gardening, especially those destined to daily consumption are the prerogative of women.

Poultry also did not fare well. Chick distribution created jealousy in some villages, but children themselves had problems in adapting. Without wasting time, either they ate up the chickens or some children embezzled the products of the sale.

The activities, which were the most successful, were sewing and carpentry because the children were put in apprenticeship. The boss himself monitored their vocational project.

An important rate of early pregnancies was observed. Girls explained that to be considered as a woman, one has to prove one’s fertility. To be a mother is to achieve the status of a woman.

Excision of the young women was still carried out in this region; girls and boys put it that it is important to do it, if a woman was not excised this would bring bad luck to her husband.

6. Strategy of intervention

In order to develop a meaningful relief program we first took stock of existing interventions in the region. Next we trained the NGO staffs in the management of traumatic stress symptoms. In the course of fieldwork we constantly modified what information was useful to adopt in the management of psycho trauma symptoms.

Activity follow up was made through telephone calls with the field teams who used to call as soon as a need arose or whenever problems cropped up.

6.1 Activities already implemented

A number of humanitarian agencies had implemented a number of activities including songs, funny stories, code of living, and promotion of children’s rights, literacy campaigns and sports. Those activities, although useful, did not always meet the real needs of the children or led to the relief of required mental health problems of affected children. But those children were preys to anguish, psychic disorders and aggressiveness. Adults were not equipped to receive and accept such brutal and violent emotions.

6.2 Medical prescriptions

Psychotropic drugs prescription was dominated by antidepressants (amitryptilin). Generally speaking, these drugs were prescribed in small dose. Drugs prescribed appear in table 3 below.

Number of Children	Medication	Daily Dosage
34	Amitriptilin	35-75 mg
18	Haloperidol	5-7.5 mg
14	Chlorpromazin	150-200 mg
7	Bromazepam	3-4.5 mg
30	Trihexyphenidyl	5 mg
5	Carbamazepin	400-1,200 mg

Table 3. Psychotropic medications prescribed in the management of mental health problems

The range of drugs used was voluntarily restricted in order to promote their rational use by the field agents who have no medical background. Dosage has been at their minimum to facilitate handling and limit the risk of side effects e.g. chlorpromazin, which is usually prescribed in dosages of 200 to 300 or 400 mg per day, was given in with maximum dosages ranging from 150 -200 mg in our sample . This permitted, in most cases, drug taking without difficulty.

The molecules recommended in international literature in the treatment of post-traumatic stress disorder and co-morbid states, such as paroxetin and hydroxyzin were not used, especially because of their high price and the difficulties involved in their availability in rural areas.

Once the first positive effects of the treatment were reported, the organizers discontinued further use of the drugs. Reports indicated that some parents even took the drugs with the view to enjoying their sedative effects. Thus, with one chlorpromazine tablet in the evening, they slept well and they could the next day return to their farms without effort.

We asked the organizers to take back the drugs to avoid drug misuse, and to administer the drugs to the children.

The NGO had a package of drugs available to field workers based on drug prescriptions. Living in the community, they distributed a sufficient quantity every week and ensured good treatment compliance.

6.3 Additional examinations

In order to provide comprehensive health care to the children, we referred some of them to other specialists as follows: the children who needed surgical consultation (2), gynecological consultation (1), general medicine consultation (2), ophthalmological consultation (1), ENT consultation (2), and urological consultation (2). It proved important to carry out electroencephalogram (EEG) for 3 children and an x-ray of the lumbar vertebrae for one child. Consultations required that children be sent down to *Guiglo*. As for the EEGs, (which were disrupted later), the children had to come down to Abidjan.

6.4 Psychotherapeutic action

Beside the activities implemented by the volunteers, such as literacy campaigns, animal breeding, agriculture, training of volunteers and the populations about post-traumatic disorder, a number of therapeutic activities were initiated: family drawing, game, and therapeutic workshops.

Concerning drawing, the instructions were "*draw your house and your family before, during and after the war*". All the children took up this activity, even those who had never gone to school. Their drawings were full of memories of their trauma. The lines were strong, violent testifying to an internal aggressiveness and violence. The dominant colors were black, red and orange. Few children were imagining a return to normal life after the war. They had drawn their house destroyed by the war and which remained the same after the war; not rebuilt but over grown with weeds.

It seemed important to initiate some psychotherapeutic activities. The children had come off, in this context, with objects from their environment, most of the time it was bamboo or raffia. Children with the most important psychic disorders had built objects recalling the war, while those who overcame their problem had drawn houses, churches and cars.

Working tools and activity comment cards were difficult to use because there were no specialized education officers among the field teams. Even if the officers showed interest,

their expected involvement in psychotherapeutic work represented an extra work, as they had other activities to attend to (identification of children in need of birth certificates, HIV/AIDS awareness activities). So that, psychotherapy was necessary for a number of children, an activity based on talking with the children, proved impossible for field workers.

7. Intervention results

We made two assessments of our intervention. In September 2007, 15 months after the beginning of our intervention the number of children showing disorders had decreased considerably. 74.20% of the children showed a positive mental health. By linking this rate to the 281 children suffering at the beginning, one noted an improvement rate of 89.32%. The children had a better health condition; they were dynamic and jovial. They carried with ease their activities despite would-be internal conflicts. Concerning this, they had implemented a system of justice relying on the oldest among them. Those who went back to school had good academic results.

The breakdown of the children in line with persistent symptoms after our intervention appears in table 4 below.

Behavioral disorder (theft, running away, aggressiveness, instability)	26	07.47%
Insomnia	13	03.91%
Anguish/ Fear	10	03.04%
Headaches	12	03.56%
Emotional disturbance	10	03.04%
Amnesiac disturbance	4	01.20%
Enuresis	5	01.52%
Sadness	1	00.30%
Isolation/withdrawn attitude	3	00.90%
Delirium/ Hallucinations	2	00.60%

Table 4. The proportion of children showing symptoms of mental health problems 15 months after the initiation of our intervention

Thus, residual symptoms were dominated by behavioral disorder, insomnia and headaches. None of the children showed signs of palpitations, fits of crying, suffocation, loss of appetite, logorrhea, or suicide.

After the first phase of intervention, the diagnosis assessment showed:

- PTSD ranging from 53.38% to 2.90% (8 children)
- A rate of depressed children ranging from 20.29% to 01.45% (5 children)
- Anxiety disturbance ranging from 12.10% to 00.58% (2 children)
- Acute psychotic disturbance ranging from 12.81% to 04.35% (12 children)
- Schizophrenic disturbance remained stable (01.42%, 4 children)

During this 2007 September mission, we noted an improvement in social behaviors. An inter-village sport and cultural event were organized. The children presented sketches, dances and they played football. User-friendliness and brotherhood were the orders of the day.

The field agents organized also awareness campaigns on the dangers of circumcision. The topic was rather delicate because, at the same time, five girls involved in the project had

retired in the bush to be excised. A meeting was organized and the matron responsible for that activity empowered us to talk to the girls. When we asked them about their motivation for genital mutilation and pointed that the Government had prohibited such practices, and that some were already mothers (like two of them), one of them argued that excision favors marriage because a non excised woman is a source of evil to her husband. Even if they lose some sensibility during coitus and their libido will be negatively affected, excision is worth being carried out. Our questions seemed to disturb some of the girls, and a dispute even cropped up.

Before such a practice, the field agents were powerless and villagers barely listened to them. One of them explained laughing that all the talks made by the officer was meaningless because if the woman is not excised she could bring evil to her husband (confirming thus the opinion expressed by the young girl). What could be added if ancestral beliefs are so strong?

At the final assessment of our intervention in August 2008, only 58 children were assessed. Many were the children who had left the area before the project came to an end without an assessment of the impact of the actions undertaken and without a real reintegration. It was hoped that any improvement in the mental health of the children would permit the children to view their future with hope and resume normal life activities for survival after the war.

The children who better rebuilt their life were those who returned to school or those who learned sewing: the young girls of *Pantrokin* who enlisted in the sewing project built their own sewing shop; they bought new machines and were receiving customers. One of the boys, Joel, who demonstrated leadership capacities, was handling alone truck farming and breeding. As for the other boys, they had, either left the village or abandoned the project.

In *Ké-bouébo* and in *Béoué*, breeding and farming were abandoned. Only the vestiges of a promising project remained (abandoned hen houses, fallow ground).

The overall appreciation of that mission is the following:

In general, the children were better off on the psychopathological point of view though of them showed a reactivation of psychiatric symptoms (psychotic disturbances, depressions).

The community volunteers seemed to have given up their commitment toward these children possibly for a variety of understandable reasons including lack of funds (therefore no salary), lack of food donation and perhaps because the NGO local agents were no longer there to provide the services they did before.

8. Reflexions from this experience

8.1 Who are the Ivoirian children soldiers?

8.1.1 They are boys and girls also

Most of them were boys (60.3%). Girls made up 39.7%. The children revealed the presence of girls among the child soldiers. The girls were used as cooks (20%), fighters (5.22%), dish and clothes washers (3.19%), security guards (2.32%) and porters (2.03%).

The number of girls used for sexual purposes was not specified. It is difficult to establish a ratio between the numbers of girls out of a total size of children present with the armed groups. In some countries, girls represent up to 40% of the child soldiers, like, for example, within the *Tigres de Liberation de l'Eclam* in *Shri Lanka*. Those children are also brought to carry a number of functions as we have seen (Huyghebaert, 2009; Ayissi& Maia, 2004). Girls play different roles on the same day; they are fighters, cooks, messengers, spies, nurses, sexual slaves, even "captive wives", as it was the case of a young girl we met at *Ké-bouébo*.

In some countries, according to Ayissi & Maia (2004), women fighters are also used as suicide bombers and in delicate tasks like the security guards of warlords or in spy missions and infiltrations of enemy troops because of their efficiency and fidelity to “their” men. The same authors argue that, even if boys are not saved from these troubles, it is girls and teenagers who pay a heavy cost in rape and sexual abuse. Those abuses are followed by serious physical injuries, sometimes painful and disabling, as a result of unplanned pregnancies followed by high-risk abortions. This corroborates the data on the sexual violence that we were talking about.

Be they victims of the barbarism of fate, those young girls and all the children in general, remain profoundly traumatized both physically and psychologically through the hardships that they endured in their early age.

Most children that we saw were aged between 5 and 15 years (58.2%). In countries like Sudan, the Democratic Republic of Congo, Sierra Leone or Liberia, child soldiers were enrolled between 7 to 18 years of age (Baingana & Bannon, 2004). Though Huyghebaert (2009), citing an ILO publication (2006) concerning the child soldiers’ enrollment age, places the age of teenagers at 15 or more at the time of their enrolment, the young boy enrolment at 7 to 8 years tends to become more and more frequent.

The children that were the object of our study found themselves in a situation of war at an age when education was an important element of life, at a period of great psychological vulnerability when a human being is growing, where the child is socializing and where he develops psychologically. In that part of the country, sending children to school is difficult on the one hand because of lack of classrooms, and on the other hand because of the general poverty levels of the populations. The conflict has played a role in this context, leading thus to mass removals from schools (60.50%). One of the NGO addressed this problem by introducing literacy classes and a strategy of school resumption by providing school equipment and by helping families in sending back children to school, either in the village or in the nearby town. Children who returned to school had good results. That situation in *Guiglo* is different from what is seen in general as underlined by Tomkiewicz (1997) who cites extreme difficulties in having the Ugandan civil war children back to school.

8.1.2 Did they take or were they given arms?

Some of those children from *Ké-bouébo* were recruited, or enrolled forcibly. Only 17.68% handled or manipulated weapons. The use of non-combatant children mirrors our case like in many other countries as evidenced by Mouzayan (2003), for whom those children were enrolled for dangerous and alienating activities (fights, chores, spying, messengers, and sexual slaves). Whatever children are involved directly or indirectly in they are in danger (Anwo, 2009). Many reasons motivated those children of *Moyen-Cavally*. They put it bluntly that revenge was the N° 1 motive (13.91%) though as Honwana (2006), argues, in some conflicts, a variety of reasons, including coercion, poverty, or sheer violence turns young men into assassins before they are able to understand the complexities of morality. As seen on the field, all the children were not enrolled by force, or by constraint. In fact, some became “willing” members of a gang or an armed force to protect their family or themselves, changing thus their status: from children who must be protected by parents, they become those on who lies the survival of the family. For others whose family members became victims of the conflicts a desire for revenge (Huyghebaert, 2009) motivated them to take up arms as we found it. For Ayissi & Maia (2004), children are above all vulnerable physically, mentally and emotionally, and therefore more docile and more malleable than

the adults, while if their engagement is “voluntary”, it comes from a desperate strategy for survival. To boot, when the war gets stuck and decimates whole families, a number of children become orphans, with no perspective of subsistence than joining the armed groups where to bear a weapon will give them the feeling of existing and to be protected. If it is true that those children are the real victims, Jézéquel (2006), cites researchers like Paul Richards, who, while denouncing the violence on children during the war, shows that children are the real actors capable of displaying their own tactics in a field of constraints imposed by war dynamics.

8.2 Ravaged lives in a ravaged region

8.2.1 Pain or psychic suffering?

The war attacks children and destroys them as Bertrand (1997) puts it; those who survive will carry almost irreversible marks. Even if this argument carries a rather violent character, it is however the sad reality.

The war generates psychic wounds with which children are doomed to live with because they are part of their history. Those “invisible wounds” are visible, identifiable, through their own expressions in children's behavior and through their relation to others and to the outside world.

The encounter with those child soldiers was followed by a direct contact with an important psychic pain. This psychic pain is different from psychic suffering. Citing Ferenczi, Bertrand (1997) recalls that this pain may have extremely serious effects; destroyers of the individual. The risk may be the sudden decomposition under the form of a delirium or traumatic cleavage, but also as depression, somatizations, and disabling chronic pains with no detectable lesions. The idea of the existence of this pain in the children's psyche could explain the various clinical charts that we mentioned. Anguish and pain are limits to experiences, at the border of our being; limit of both the possibility of existence and of the possibility of subjectivities.

With those children, this brutal and raw pain, assimilated with difficulty because the trauma could not possibly be comprehended by their young minds, and therefore still carried (even after a period of four years) of its emotional impact, was palpable at the beginning of our fieldwork. Is it not an important obstacle to the possibility of being fully human for those children? For Tomkiewicz (1997), psychic disturbance could be the must link between traumatic stress and its psychological consequences.

Around 56% of the children had seen a man killed under their own eyes. Dapic & Coll (2002) have studied this parameter with primary school children (Grade 5) victims of the Bosnia-Herzegovina war, in a Sarajevo district. 90.7% of them had seen war wounded and 74.3% had seen a dying man.

Among our sample, before the “show” of execution of a person, some were said to be abreactive (8.41%), scared (25.51%), and shattered (9.27%); other emotions had been described as joy (4.93%), pity (2.32%), revolt (1.45%). 3.78% said to have been traumatized.

The issue of social support in the course of events was also brought forward. Most of the time, the children had accompanied someone they knew into the war (36.52%) and 26.38% said that they had followed a parent. Others have certainly experienced solitude, but few talked about it. On this subject, Tomkiewicz (1997) explains that solitude may be considered as an aggression, because it engenders or increases suffering. It pervades children when they have lost their families, their bearings, their friends and their dearest around them;

when they find nobody with whom to share their fear, their anguish, and their hope. The absence of schools and of any educational and socializing institution participates to this solitude. The question in this context is how the children who lost everything including social networks (27.6% who joined armed groups out of solitude) could ever be helped to find solace in their lives.

8.2.2 Psychiatric and social consequences

Our data revealed that 9.6% of the children were victims of sexual violence and they are forever marked by this aggression; 52.17% were sexually active and among them 36.67% had many partners, perhaps as a method of coping with their experiences and aggression from the war as, a child told us: "when I think of all that happened and of what I saw during the war, I don't sleep and consequently, I could go with five or six girls a day."

In the course of the conflicts, cases of child abuses are probably countless, sometimes increasing the risk of exploitation and sexual abuse. Cases of abuse apparently continue into the "post-conflict" period: chores becoming servitude, recrudescence of child trade, and sexual violence and exploitation in refugee camps (Huyghebaert, 2009).

However, the issue of violence is pushed into the background, as no direct allusion to sexual abuse transpired in the course of our discussions with the former child soldiers. This observation may be explained by the customs of the people of the western region of Côte d'Ivoire where teenagers have been raised with the idea that having a child is a sign conferring the status of adult and challenges mental health professionals' concerns over child sexual abuse as an explanation for psychological problems in times of conflict and war. Since early active sexual involvement is socially accepted in Cote d'Ivoire, 27% of the girls were mothers at the 1st assessment and at the 2nd assessment, and this rate rose to 34%. Moreover, despite awareness campaigns, one had more than 30% of the children had evidence of STI recurrence.

Though the early involvement of the children in Cote d'Ivoire exposes them to the risk of health problems and crime (early and unwilling pregnancies, STI/HIV/AIDS, infanticide, deserting children) the link with mental health problems is not explainable as early sexual activity is socially and culturally sanctioned. Some studies indicate HIV sero-positivity in post-conflict period of 60% nationwide (Leblanc, 2004). Concerns exist concerning the welfare of children born during the period of violence to mothers who were themselves victims of violence. However Tomkiewicz (1997) explains that most of the time, the children who survived conflicts reach a better social adaptation than that could have been predicted. The same author claims that more or less rapidly, those children succeed in integrating into an "after war" society, and very few become really marginalized. As Tomkiewicz (1997), our results allow us to reach such a conclusion, as from one village to another, "survivors" were more or less integrated

As a matter of fact, most children surveyed had been integrated in the villages because they used to live there and were able to resume, for most of them, an activity: returning to school, farming or breeding. That's how most of the children interviewed had been integrated into the villages because they lived there and were able to resume, most of them, an activity: back to school, farming or breeding ... This is especially important that the integration (re-integration) refers to a social return be inserted individually in the community clean. Our data agrees with observations made in Mozambique where families of former child soldiers rejected the children who faced social integration problems as a result (Green & Honwana,

2001). Explanations for the rejection of former child soldiers in Mozambique resides in the enrolment motivation in Mozambique where children were fighting outside their communities, where as those of *Moyen Cavally* in Cote d'Ivoire took up arms to defend their communities. In return, the community fully supported them. The Ivoirian children of *Moyen Cavally* were motivated in great extent by the desire of revenge or the liberation of their village, which has a great community connotation. As Gannagé puts it, parents must act as protecting filter and as pare-incitement to the child. The capacity of the children to dominate and to memorize trauma depends on their parents' capacities of elaboration and implementation of trauma, of figuration and representation, to think and to communicate to the child about the event.

The best social reintegration (in the sense of being able to contribute anew to the development of one's community) is perhaps that of the *Péhé* and *Pantrokin* children. In saying it, we have in mind the idea that some factors linked to the recuperation environment have positively influenced this normalization of social life. In fact, *Péhé* is a sub prefecture endowed with a number of commodities like *Pantrokin* the nearby village. This standard of living as well as the advantages, which go with it in terms of employment, contributes to reintegration. Yet, even here, as in *Kébouébo*, a village with no drinking water and electricity as well as in *Béoué* and *Kaadé*, located on a tarred road, provided with water and electricity, a good number of children had hard time to readapt and to invest in the activities proposed to them. Even if all children of the project initially had the same motivation to participate to the war, the socio-cultural post-conflict reintegration to promote better for most of them.

As for the conditions of girls, Huyghebaert (2009) argues that it is difficult for girls who have been kidnapped and who, during their captivity, gave birth to babies to return to their families and communities. Reintegration therefore proves to be a complex process of re-adaptation and, at times, of community expiation, as well as negotiation with the families to convince them to accept to take back their children and, the children of their children. Concerning the girls that we met and their progenitor, the cultural context encouraging maternity has probably contributed to facilitate their reintegration and the acceptance of their children's babies born to the enemy or the invaders. .

Thirty-seven percent of the children in our sample used alcohol, and fourteen percent used drugs such as gunpowder and cannabis (14.49%). The use of psychoactive substances is a misuse because there are no data to discuss here an insulated handles abuse. But the children have told us to use these substances to overcome the atrocities they saw, lived and committed. They sought out the effects of these mind-altering substances.

The misuse of alcohol and other psychoactive substances enhanced the children's ability to act and endure the hardships, psychic pain and anguish, insomnia, and physical pain of war (Douville, 2007). Alcohols (*cane juice*, *koutoukou*) that children took came primarily from local manufacturers and were sold at low prices and were easily accessible to the poor.

In our sample the war was still present in the children's mind and the possibility of the resumption of war was not brushed aside. Personalities were marked with fragility and by narcissistic flaws. The children expressed their anger, their aggressiveness and their revolt. One could notice, at times, a great pessimism associated with a feeling of a blank future and a social disinvestment. The children were moving about in the village in groups. The need to reform them was evident and urgent: it seemed imperative to set up a reform program in order to neutralize "the many bombs of aggressiveness" in the children.

Many of the children (81.45%) showed evidence of mental disturbance before intervention. Our estimates are higher than those of Cordahi et al (2002) who found 62.5% of Lebanese

children and teenagers who went through the 1996 “*raisins of wrath*.” were psychologically affected one year after the events of war and loss of a father/mother. We might explain the high rates of psychiatric disturbance in our sample of children and teenagers by the duration and number of traumatic events, the scarcity of communal resources, social disorganization and the threat of Cote d’Ivoire been split into two countries at the time of our intervention in the border region with Liberia, a country that had itself been in conflict for years.

As observed in other war areas, the commonest diagnoses in our study were post-traumatic stress disturbance (53.38%) and depression (20.29%) four years after war. However the rate of post-traumatic stress disorder among children one year after war in a study conducted by Schwarzwald et al in 1994 and cited by Jolly (2000), was 12% with those whose house had been bombed showing a more significantly prevalence: 23.8 *versus* 9.1% (Green & Honwana, 2001). In 1994, in the course of the conflicts between Muslims, Croats and Serbs, a study of displaced Bosnian children aged 6 to 12 years old, showed a PTSD rate of 93.8% and the rates of associated disorders were observed: sadness (90.6%), anxiety (95.5%), feeling of guilt (66.6%) and anorexia (59.7%) (Green & Honwana, 2001). These and our study show that a traumatic event provokes fear, horror, a feeling of disarray and desperation.

The experience or commission of violence creates a staggering level of depression and a melancholic behavior that could lead to suicide (Douville, 2007).

As in other studies, the physical pain that participants in our study experienced was palpable, the violent emotions were, so intense that words could not tell, the narration being interrupted the liberating power of words sometimes became incommunicable because, in the first place, the traumatized people were unable to talk about them for a number of reasons including the low literacy of the children, the lack of opportunity for the children to talk about their experiences, and the relative lack of skills among our organizers to enhance liberating cathartic communication from the children about their experiences.

Tomkiewicz (1997) asserts that, if one wants to save a child victim of war, it is not enough to heal his body, his wounds, his lesions; it is not enough to give him something to eat, to vaccinate him; we need to caress him, to smile to him, to talk to him. To be able to talk to him and to listen to him, it is necessary to associate him to a local team, whose members could infuse confidence in him. We could not wholly act according to this principle for a number of reasons including the fact that our own humanness was too upset by this human catastrophe, by this dehumanizing catastrophe at the beginning; the organizers’ emotional equilibrium, and ours was seriously too inadequate to restore a minimum of decent psychic and social life among our participants.

The local organizers were themselves, either veterans, or war victims and were ill equipped to help our participants to talk about their emotional and psychic pain. The relations of the organizers with those children were most of the time conflicting.

8.3 The status of children in African societies

African societies have developed and they retain at times their own perceptions of childhood (Jézéquel J.H, 2006; Ferme, 2001). It transpires from the works of anthropologists such as Ferme (2001) that childhood is, in sub-Saharan Africa, sometimes assimilated to a time of ambiguity, an unstable and hybrid situation. In Ivory Coast a number of children were involved in the conflict, most of the time by taking up arms, to defend their village, in the place and along side adults. They fought and they gained (at an early age) a status of adults, of defenders, of liberators; this status conferred upon them a special position in the

village. Thus the children are not denied any capacity as adults in society (Howana, 2000). But, in reality, it is a precarious position and psychologically unbearable situation to be no longer a child and not to be a real adult. The young freedom fighters hold interstitial social spaces, between the adult and juvenile worlds. In Côte d'Ivoire it appears that the place of the child is ill defined, ill conceptualized, moving from a traditional conception of the child (submissive, usable and stooge for the parents) to a more modern conception that parallels what is going on in the West. Even if the relation between children and parents is changing, the perception of children as potential labor force remains still very strong (Berry, 1985). The issue of child soldiers appears to parallel a long history of child labor force in colonial and postcolonial African economies.

8.4 The shake-up of social order

Jézéquel (2006) explains that war situations are marked by inversion phenomenon through which elders lose their authority over the youngest, whole towns are conquered by bands of teenagers not always controlled by their leaders. This is due to the mass deterioration, loss of links to reference and to the ancestry caused by the war. Conflicts lead children and teenagers to roam about feeling that they have been destroyed in their actual humanness. There is a fragmentation of the society. The possible role of family running over social running is destroyed, sometimes inexorably so that the common space limit is often narrowed to extremely precarious clans (Douville, 2007). Douville goes on to say that there is a destruction of the image of the other and that when is war over, children and teenagers have much difficulty in entering an ordinary social link. In addition to generation gap, war aggravates the erosion of parental and adult authority and family links are disrupted and destroyed (Bertrand, 1997). As war dismantles and destroys the civil organization of a country, schools, justice system, police and post office services, children run the risk of losing all their marks of common life and fail to conform to what is permitted or what is good or forbidden and bad (Tomkiewicz, 1997).As Tomkiewicz puts it, the apparent ignorance of the law and the loss of bearing constitutes the main expression, or at least the most visible psychological consequences of the war on short term.

8.5 When culture invites itself, we should not avoid it

Most of the time, post conflict recovery programs aim to demobilize and reintegrate children associated with force or armed groups. For children affected by the conflict, there are usually no programs of social reintegration, of education (private lessons, for example), of vocational training, of cultural activities, of sport and/or income generating activities (for example, setting up small businesses). Destined to all the children affected by the conflict and not exclusively targeting child " soldiers" or child victims of sexual violence, programs, while privileging a communal reintegration that should be as inclusive as possible, constitute sound programs of preventing (re) enrolment. To this extent, children and community's involvement in the choice of programs of reintegration finds its place in order to optimize the latter (Huyghebaert, 2009).

To have children and communities get involved at a certain level of the project implementation relies on taking into account the socio-cultural considerations in order to foster the success of social re-integration programs. It is important, not only to take care of investigating the psychological and societal aspects peculiar to the host milieu, but also to insure the approval of the parents and community members. The passion of some adults, in

the villages where we worked, to thwart, even to destroy the projects and the difficulties met by our agents in overcoming this difficulty leads us to argue that it is imperative to prepare field through a good alliance with the villagers and the parents of the beneficiaries of post-conflict reintegration programs. The question was to offer the possibility of the villagers to accept the activity through an understanding of the project and a better knowledge of the short and long term benefit for the children, but also for them and for the whole community.

8.6 Which efficiency, during and after those actions?

In September 2007, we noted an improvement rate in the health condition of 89.32% of the participating children and teenagers. Residual symptoms were dominated by behavior disorders, insomnia and headaches. Most studies have reported an improvement in symptoms or a decline in the level of psychopathology in the course of time (from some months to a number of years) with the majority of the children. The duration and the degree of remission depends, on the degree of exposure to traumatic stress, of the manner in which families react and of the social support for families (Cordahi & al, 2002).

To back our psychotherapeutic action, we implemented medical treatment, especially some amitryptillin (35-75 mg/day).

The premature giving up of the drugs parallels a general observation marked by the difficulty for Ivoirians to take drugs on a long term basis, which could explain the short period of medication and the lack of compliance. Or the medical treatment, especially anti-depressive may permit to attenuate the symptoms and favor thus the verbalization of the psychic pain and allow a psychotherapeutic access (Deniau& Cohen, 2011).

The continuous psychosocial help permits the improvement of emotional disorders in children and teenagers. Supported by a psychosocial environment, the children had seen their situations improve. This is particularly the case when antidepressant medication is used to support psychotherapeutic and psychosocial intervention. However the reluctance of Ivorians to take medication on a long-term basis often undermines the potential clinical outcomes of post-conflict interventions for psychological consequences of traumatic stress. In line with African tradition, which argues that a child belongs to the community before belonging to his parents, child orphans always found someone to accommodate them in our study settings. The fact that the children returned to their village after the war, that they found a home, a house, and a place in the community was certainly comforting for children who returned from war. In our view reintegration of former child soldiers into accepting homes gave the children new meaning to the children against the background of chaos brought about by the war and its associated trauma. Finding a home gives the child a new sense of being human, hope as a member of the human community where war dehumanizes, to find parental comfort and love where solitude and acts of violence enslaves human beings.

9. Conclusion

This project, which lasted 4 years after the conflicts in the western region of Côte d'Ivoire during the 2002 war aimed at assessing the magnitude of post-traumatic stress disorder.

Tomkiewicz (1997) argues that, if we want to save child soldiers, it is not enough to heal their bodies, their wounds, their lesions; it does not suffice to give them food, to vaccinate them; we must caress them, smile to them; we need to talk to them. In order to be able to

talk to them and to listen to them, it is absolutely necessary to associate them to a local team whose members could bring confidence in them. Even if we find this idea judicious, this seemed difficult to implement in our context for several reasons.

On the one hand our own humanness was too upset by this human catastrophe, and by this dehumanizing catastrophe. At the beginning, the organizers emotional equilibrium, and ours was seriously required by anything to be done in order to restore a minimum of decent psychic and social life to permit us help the traumatized former child soldiers.

On the other hand, the local organizers were themselves, either veterans, or war victims and their relations with the children were, most of the time conflicting.

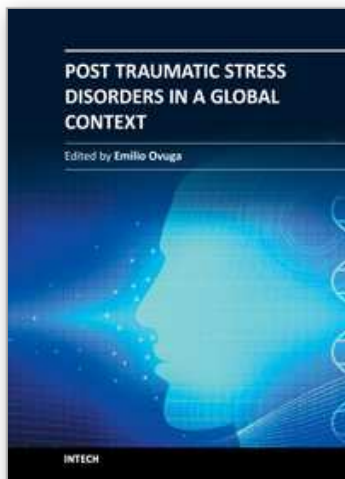
Our results indicate that 89.32% of the children achieved some degree of improvement in their mental health situation.

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Post Traumatic Stress Disorders in a Global Context

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If, as a health care or social service provider, one was called upon to help someone who has experienced terror in the hands of a hostage taker, an irate and chronically abusive spouse or parent, or a has survived a motor vehicle accident, landslide, earthquake, hurricane or even a massive flood, what would be one's priority response? What would be considered as the most pressing need of the individual requiring care? Whatever the answer to each of these questions, people who have experienced terror, suffer considerable psychological injury. Post-Traumatic Stress Disorder in a Global Context offers some answers to meet the needs of health care and social service providers in all settings, whether in a hospital emergency room, at the war front, or natural disaster site. The take home message is, after providing emergency care, there is always a pressing need to provide mental health care to all victims of traumatic stress.

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University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
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InTech China

Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

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