



Mental health problems, family functioning and social support among children survivors of Colombia's armed conflict

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Mental health problems, family functioning and social support among children survivors of Colombia's armed conflict

Abstract

Purpose - Colombia presents with one of the largest armed conflicts in the world. Children exposed directly or indirectly to armed conflicts live the emotional footprints left by war. This study identified mental health problems among children survivors of Colombia's armed conflict and associated factors. **Design/methodology/approach** – A cross-sectional study with (n=80) children aged 7 to 11 years (M=9.8 years; SD= 1.4) was conducted using the Child Behavior Checklist, Family APGAR, and MOS social support survey adaptation to children. **Linear regression analyses were also performed with emotional and behavioral problems as the outcomes and related factors as the predictors.** **Findings** - Clinical levels of emotional and behavioral problems were found in 56.3% of children. Internalizing problems (63.7%) were more common than externalizing problems (51.2%). **Older children had greater emotional problems at the trend level, and those with higher functioning families had lower emotional problems. Children with higher perceived social support had lower behavior problems at the trend level.** **Research limitations/implications** - This study includes a sample facing multiple risks and uses a holistic approach to consider family and social resources that may support children who are survivors of the armed conflict in Colombia. These results provide a foundation for future promotion and prevention programs related to children's mental health problems to support peacebuilding within the framework of the Colombian post-conflict process.

Originality/value – To the best of authors' knowledge, this is the first study to collect empirical data on the mental health of children survivors of Colombia's armed conflict focused in the Atlantic Department.

Keywords: Mental health problems, Family functioning; Social support; Emotional and behavioral problems; Colombian Armed conflict; Children

Paper type - Research paper

Introduction

Mental health in childhood means reaching developmental and emotional milestones, such as learning healthy social skills and how to cope with problems. Children with good mental health have a positive quality of life and can function well at home, in school, and in their communities (CDC, 2019; Lippman et al., 2011; U.S. Department of Health and Human Services, 2001; World Health Organization, 2005). Children with mental health challenges face serious changes in the way they typically learn, behave or handle their emotions, which cause distress and problems getting through the day. Occasional mental health challenges, such as fears and worries or disruptive behaviors, are common in childhood. If symptoms are severe and persistent, however, it may interfere with school, home, or play activities. Such mental health challenges are an important public health issue because of their prevalence, early onset, and impact on the child, family, and community (Perou et al., 2013).

Mental health challenges in childhood may be related to proximate risks factors within the family, such as sexual, physical, and psychological abuse, low social support, violence, history of traumatic experiences or parental abuse of alcohol or drugs, and to broader social risk factors, such as poverty, inequality, war and displacement (Cree et al., 2018; Karam et al., 2008; Karam et al., 2014; WHO, 2004). For example, in Latin America, the exposure to violence has been identified as a predictor of mental health problems, particularly among people living in poverty (Franco et al., 2006). War can leave an emotional footprint on children that persists

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3 throughout their lives, with indirect effects on subsequent generations (Chapple et al., 2005;
4 Fremont, 2004; Kadir et al., 2019). These findings suggest the need to study the intergenerational
5 transmission of war-related trauma in internally displaced children and children indirectly
6 exposed to armed conflict (Flink et al., 2013). Because of their age and compounded exposure,
7 children may be vulnerable to mental health challenges posed by armed conflict (Gómez-
8 Restrepo et al., 2018). Toward this end, global research has found high rates of post-traumatic
9 stress disorder (PTSD), internalizing behaviors, anxiety, and psychosomatic symptoms (Bannon
10 et al., 2009; Chemtob et al., 2008; Dimitry, 2012; Kaufman-Shriqui et al., 2013; Klein et al.,
11 2009) and externalizing behaviors (Pat-Horenczyk et al., 2012; Thabet et al., 2006; Zahr, 1996)
12 among children affected by war, because the experience of trauma may contribute to inputs that
13 may take a person closer towards engaging in aggression (Worthington, 2012). Yet, the family
14 environment may help children respond to war stress. For example, a well-functioning family
15 may provide social support for children, which can have a positive impact on their mental health
16 (Slone & Mann, 2016).
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36 Complementing the existing research on the effects of armed conflict on children's mental
37 health, the current study focuses on the impact of the Colombian armed conflict (Gómez-
38 Restrepo et al., 2018) and family factors on children's mental health. Over the past 50 years,
39 Colombia has lived in a permanent situation of internal armed conflict resulting from complex
40 phenomena of political violence (Centro Nacional de Memoria Histórica, 2013; Gómez-Restrepo
41 et al., 2016). One of the world's longest conflicts, it has left in its wake countless victims and
42 almost irreparable consequences (Rojas, 2016). Although Colombia's armed conflict is often
43 described as 'low intensity', independent data suggest remarkably high levels of exposure to
44 conflict-related violence in the civilian population (Tamayo Martínez et al., 2016). Almost 9
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3 million people, where 1,151,130 are children between 6 and 11 years old, have been recognized
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5 as victims of this conflict and have been included in the National Registry of Victims (2020).
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8 Yet, in Colombia, violence does not occur in the same space and intensity throughout the country
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10 (Taylor., 2012).
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13 The Atlantic Department is on the Colombian Caribbean coast, which is a developing
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15 region divided into five municipalities with 2,342,265 inhabitants (Departamento Administrativo
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17 Nacional de Estadística - DANE, 2019). This population represents 3% of the Colombian
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19 population (Rangel-Buitrago et al., 2017). The Colombian Caribbean coast has been affected by
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21 the growth of paramilitarism, drug trafficking, and the increase in criminal organizations, which
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23 has implications for adult mental health (Taylor, 2016a; 2016b). As a result, the Atlantic
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25 Department has received many displaced populations from surrounding regions (Gómez Builes
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27 et al., 2008). Currently, the National Registry of Victims confirms that over 50,000 children
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29 between the ages of 6 and 11 are survivors of this conflict, and approximately 16,000 children
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31 need psychosocial attention in the Atlantic Department. Rooted in this reality, the current study
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33 focuses on children survivors of the armed conflict in this department. The choice of 'survivor',
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35 vs 'victim's' is more than semantic (Bustamante, 2017). It reflects the emphasis in Colombia and
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37 the Atlantic for survivors to take part in their holistic healing, energizing possibilities for deeper
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39 attention, help, and reparation. Although Colombia has had a prolonged internal conflict, not
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41 much is known about the mental health status of survivors, particularly of children.
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43 Consequently, this study aimed to describe the impact of the armed conflict on the mental health
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45 of the child population in the Atlantic Department. Bearing in mind that health requirements in
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47 the child population highlight the need for the assessment of mental problems and disorders in
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49 the child population affected by the armed conflict to plan a subsequent timely intervention in
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3 them (Ministerio de Salud y Protección Social, 2013). In sum, we make the following
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5 hypotheses. First, we expect that children survivors of Colombia's armed conflict in the Atlantic
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7 department had mental health problems, similar to previous research and studies in Colombia
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9 and worldwide. Second, we hypothesize that some related factors were associated with mental
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11 health problems among these children. The article concludes with implications for mental health
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13 problems, family functioning, and social support among children survivors of Colombia's armed
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15 conflict.
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20 **Methods**

21 *Participants*

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26 A cross-sectional, correlational study was conducted. 80 children living in the Atlantic
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28 Department took part, ranging from 7 to 11 years ($M = 9.8$, $SD = 1.4$; 67.5% female, 32.5%
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30 male). The vast majority (95%) were from the lowest socioeconomic strata, while 5% were from
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32 the second-lowest. Children were recruited through the Atlantic Department Victims
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34 Association. The project was shared with social leaders, and they agreed to provide support for
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36 direct contact with the children and their families. The sample was purposefully selected.
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40 *Procedure*

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43 Informed written consent was obtained from a parent or caregiver of the participants prior
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45 to their participation. The informed consent stated the purpose of the study, data confidentiality,
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47 and the voluntary right of participation in the study, and provided the guarantee that no
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49 participant suffered any harm because of his/her participation in the study. Only children with
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51 opt-in parental consent took part in the study, and children provided written assent before taking
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53 part. First, children were interviewed individually to complete the APGAR Family test and MOS
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3 test that took around 10 min to complete. Second, children's mental health problems,
4 demographic information, and historical victimization due to the armed conflict were reported by
5 one of their caregivers through face-to-face interviews lasting approximately 60 minutes. All
6 data were collected from February 2019 and March 2020.
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12 ***Measures***

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14 Sociodemographic variables, the variables of gender, age, caregiver's educational level,
15 household socioeconomic stratum, and family historical victimization because of the armed
16 conflict were collected.
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24 Children's emotional and behavioral problems were measured using the Child behavior
25 checklist (CBCL-6-18) (Achenbach & Rescorla, 2001). The CBCL-6-18 is a reporting
26 questionnaire assessing behavioral and emotional symptoms across several domains
27 administered to a respondent who knows the child well (usually a parent or other close
28 caregiver). Includes 113 items responded to in a Likert scale format (0–2), with higher scores
29 corresponding to more problems. Cut-offs for the *t* scores prescribed by the original author were
30 used in classifying each score as “clinical”, “borderline” or “normal”. For narrow-band scales
31 (Syndrome scales and DSM-oriented scales), *t* scores of 65–69 are in the borderline clinical
32 range, which shows a need for professional help. Scores above 69 are in the clinical range,
33 showing a probable need for professional help. For broad-band scales (Internalizing,
34 Externalizing, Total Problems), *t* scores of 60–63 are in the borderline clinical range, suggesting
35 a need for professional help. Scores above 63 are in the clinical range, indicating a probable need
36 for professional help. The reliability of the instrument is .79 for the social competence scales, .78
37 to .97 for the specific behavior scales and for the total scales .95. This list has been used in
38 multicultural studies (Guerrera et al., 2019; Muetzel et al., 2018; Zandstra et al., 2018) was
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3 validated by Hewitt Ramírez et al., (2012) and used in the Colombian population (Hewitt
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5 Ramírez et al., 2014; Sánchez-Villegas et al., 2020; Trejos et al., 2015).
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8 Family APGAR has frequently been used for assessing family function (Smilkstein et al.,
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10 1982). It is a 5-item questionnaire (with each item rated on a 3-point scale) measuring five
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12 constructs: “Adaptability,” “Partnership,” “Growth,” “Affection,” and “Resolve.” This scale
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14 assesses how children perceive the level of functioning of the family unit. For children, the range
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16 is from 0 to 10 for children. A score of 0–3 denotes a severely dysfunctional family, 4–7 a
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18 moderately dysfunctional family, and 8–10 a highly functional family (Carballo et al., 2014).
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20 The test shows good construct validity, while its internal consistency (Cronbach’s alpha ranged
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22 from 0.80–0.85) and used in the Colombian population (Cogollo & De la Hoz, 2018; González-
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24 Pastrana & Díaz-Montes, 2015).
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30 Perceived Social Support was measured with a scale adapted for children (Rodríguez
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32 Espínola, 2011). The 20 items include dimensions of structural support (e.g., size and density of
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34 the social support network.) and functional support (e.g., access to and maintenance of the social
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36 relations in the network). The response to functional social support ranges from 19 to 57.
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38 Cronbach's alpha coefficient was .84 for the total scale. Previous research has found similar
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40 results (Chemisquy & Oros, 2020; Rodriguez Espínola, 2010). In the current study, Cronbach's
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42 alpha coefficient was .84 for the scale.
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46 **Results**

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49 All the analyses were performed with SPSS version 23. [First, sociodemographic data,](#)
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51 [including family exposure to conflict-related violence, were explored.](#) Next, the clinical levels of
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53 [mental health problems and descriptive analyses of family functioning and perceived social](#)
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3 [support were described. Finally, bivariate relations and linear regressions predicting emotion and](#)
4 [behavioral problems were conducted.](#)
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8 Of the 80 children who took part in the study (68% female, 32% male; Mage = 9.08, SD
9 = 1.44, range 7-11 years old), all their families were in the bottom two socio-economic strata
10 (95% lowest, 5% second lowest). All the families also had experienced some violent event
11 resulting of the Colombian armed conflict. For example, 50% of the families survived threats and
12 displacement, followed by 30% who, besides receiving threats and being displaced, experienced
13 the death of a family member. 10% of the families experienced the disappearance of a family
14 member. Also, 5% of these families had a double displacement, 2.5% of these families were
15 dispossessed of their land, and 2.6% of these families reported kidnapping of family members
16 and extortion. Families reported that paramilitary groups handled 75% of those acts, 21.3% were
17 committed by members of guerrilla groups, 2.5% were committed by members of the ELN and
18 1.3% were committed by members of the FARC.
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34 **Emotional and behavioral problems**

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37 Based on caregiver or parents' reports, 56.3% of the children (n= 45) had a clinically
38 significant level of emotional and behavioral problems, showing a probable need for professional
39 help. While 17.5% (n= 14) fell into the "borderline" category, implying a need for professional
40 help, the rest 26.3% (n=21) were considered "normal" in terms of the sum of problems. In this
41 sample, clinically significant emotional problems were observed in 51.2% (n=41) of the children
42 whereas 63.7% (n=51) of the children showed clinical levels of problems externalizing problems.
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44 As showed by the breakdown of behavioral problems into syndrome scales in Table 1,
45 withdrawn/depressed, somatic complaints and aggressive behavior were the commonest
46 emotional and behavioral problems reported by caregivers.
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Table 1

Mean Scores on Broad-Band and Narrow-Band Scales and “Clinical”, “Borderline” And “Normal” Categories from Child Behavior Checklist (N = 80)

Problem scale	M (SD)	“Clinical” (%)	“Borderline” (%)	“Normal” (%)
Broad-band scales				
Total problems	63.78 (8.86)	56.3	17.5	26.3
Emotional problems	64.75 (9.92)	63.7	11.3	25.0
Behavioral problems	62.24 (10.18)	51.2	11.3	37.5
Syndrome scales				
Anxious/depressed	62.95 (9.51)	15.0	28.7	56.3
Withdrawn/depressed	65.29 (10.14)	30.0	22.5	47.5
Somatic complaints	61.00 (12.05)	22.5	15.0	62.5
Social problems	60.80 (9.80)	15.0	18.8	66.3
Thought problems	57.59 (9.85)	11.3	10.0	78.8
Attention problems	59.00 (11.02)	12.5	18.8	68.8
Rule-breaking	60.20 (9.05)	17.5	21.3	61.3
Aggressive behavior	63.79 (10.17)	28.7	18.8	52.5

Note: Mean *t* scores on each scale are reported along with standard deviations within parentheses.

Family functioning and perceived social support

As shown in Table 2, 76.3% of children reported high levels of functioning in their family, while 23.8% recognized average levels of satisfaction, which translates into medium family dysfunction. In addition, to analyze the perceived social support levels, descriptive statistics were used through 3 cut-off points. Identifying that 26.2% were in a low range, 22.5% in a medium-range, and 51.3% in a high range. It should be noted that the higher the score got, the greater the presence of perceived social support for children.

Table 2
Gender Comparisons of Family Functioning and Perceived Social Support

	Female	Male	Total
	%	%	%
Family functioning			
High level	51.2	25	76.3
Average level	16.3	7.5	23.8
Perceived Social Support			
Low	16.2	10	26.2
Medium	15	7.5	22.5
High	36.3	15.1	51.3

Bivariate correlations and regressions

Table 3 shows the bivariate relationships among key study variables. Children's mental health problems were negatively correlated with family functioning ($r = -.26$, $p < .05$); In higher functioning families, there was a lower number of mental health problems. There was no correlation between children's total mental health problems with perceived social support. For emotional problems, specifically, there was also a negative correlation with family functioning ($r = -.32$, $p < .01$) and no correlation with perceived social support. Externalizing problems alone

were not correlated with family functioning, but negatively correlated with perceived social support ($r = -.26, p < .05$); Children with lower support reported a greater number of externalizing problems. Finally, family functioning and perceived social support were positively related ($r = .56, p < .01$).

Table 3

Means, Standard Deviations, and Bivariate Correlations for all Variables (N = 80)

	M	SD	1	2	3	4	5
1.Children Total Problems	63.78	8.86	-	.67**	.83**	-.26*	-.19
2.Children Emotional Problems	64.75	9.92		-	.37**	-.32**	-.14
3.Children Behavioral Problems	62.24	10.18			-	-.17	-.26*
4.Family Functioning	7.87	1.78				-	.56**
5.Percieved Social Support	56.83	7.26					-

* $p < .05$; ** $p < .01$

Two linear regression analyses examined the predictors of children's emotional and behavioral problems. In short, older children had greater emotional problems at the trend level, and those with higher functioning families had lower emotional problems. Children with higher perceived social support had lower behavioral problems at the trend level.

Table 4

	Emotional Problems	Behavioral Problems
	β	β
Male	<u>-0.16</u>	<u>0.04</u>

<u>Age</u>	<u>0.21^t</u>	<u>-0.08</u>
<u>Perceived Social Support</u>	<u>0.04</u>	<u>-0.25^t</u>
<u>Family Functioning</u>	<u>-0.34^{**}</u>	<u>-0.04</u>
<u>Conflict-related Violence</u>	<u>0.12</u>	<u>-0.02</u>

^t $p < .10$; * $p < .05$; ** $p < .01$

Discussion

Reflecting the history of displacement in Colombia due to the armed conflict (United Nations High Commissioner for Refugees, 2018), the families of all children in this sample had been threatened or displaced, a fact that is mentioned by Shultz et al. (2014), where more people have been displaced by violence in Colombia than in any other country in the world. As a result, half of the children exhibited emotional and behavioral problems in the clinical range, warranting professional help, and consistent with previous research (Flink et al., 2013; Gómez-Restrepo et al., 2018; Hasanovic, 2011; Hewitt Ramírez et al., 2012; Layne et al., 2010; Posada & Parales, 2012; Taylor et al, 2019). This strongly suggests an increasing trend of mental health problems among children although with no direct exposure to traumatic events (Jayuphan et al., 2020).

Despite high levels of mental health problems in children, the findings also showed relatively high satisfaction with family functionality. Despite the high levels of violence experienced at the family level, this sample has exhibited the capacity for recovery and adaptation following traumatic events (Betancourt & Khan, 2008; Fernando & Ferrari, 2011; Haroz et al., 2013; Mels, 2012; Núñez-Ariza et al., 2020; Sharlin, Moin & Yahav, 2006; Ziaian et al., 2012). This condition only could be possible in a developmental context that is relatively free of other chronic adverse conditions such as an unsupportive family environment (Karam et al., 2019).

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3 Children's perceived social support, however, revealed more mixed findings. For
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5 example, half of the children reported low and moderate social support from family and friends.
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7 In this setting, the forced displacement may disrupt important social ties in the children's
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9 environment (Valencia-Suescún et al., 2015). Although the other half of the sample reported high
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11 perceived social support, suggesting adaptive capacities (Hewitt Ramírez et al., 2014), this
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13 construct was not related to children's emotional problems. In an adult sample in Colombia,
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15 social support was linked to lower emotional problems only in cohesive communities (Taylor,
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17 2016b). However, children with higher social support had fewer behavioral problems. This
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19 finding suggests that social support may be linked with other observable behavior in children,
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21 rather than internalized mental health difficulties in this sample.
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27 Within a setting of victimization and adversity, children and their families, are important
28
29 target groups for prevention and intervention related to mental health outcomes (Taylor et al.,
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31 2020). Although significant progress has been made in the peace process, Colombia still
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33 experiences high levels of ongoing violence and a legacy of over five decades of armed conflict,
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35 when most citizens have yielded to the encroachment of violent norms, language, and
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37 imaginaries, allowing these to infuse their social roles and interactions and the socialization of
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39 children and youth (McGee & Flórez López, 2016). Faced with such a crisis, institutional
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41 support for mental health has been inadequate and faces challenges in the future. Despite a law
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43 enacted in 2013 that recognizes the state's obligation to guarantee the promotion of prevention,
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45 diagnosis, and treatment of mental disorders, many people outside of the country's major cities
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47 do not have access to a psychiatrist (Daniels, 2018). For this reason, there is an urgent need to
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49 develop psychosocial interventions, considering how armed conflict has a direct impact on
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51 children as well as an indirect impact through the family. Given the role of family functioning in
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3 the current study, programs aiming to improve psychological wellbeing should extend beyond
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5 the individual child to strengthen family dynamics. For example, psychosocial support and
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7 training in parenting patterns for caregivers who are survivors of armed conflict may provide one
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9 avenue. More addressing structural challenges that weaken families can help to reduce post-
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11 exposure symptoms and promote recovery among conflict-affected children (Betancourt et al.,
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13 2015; Cummings et al., 2016; El-Khodary et al., 2020; Hall et al., 2014; Marroquín Rivera et al.,
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15 2020; Panter-Brick et al., 2014; Sim et al., 2018; Tol et al., 2014; Taylor et al., 2016a). **Better**
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17 **integration of mental healthcare into primary care may be an additional step that has the potential**
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19 **to address the wider systemic effects of armed conflict on mental health (Rodríguez de Bernal &**
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21 **Rubiano Soto, 2016).**
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26 27 **Strengths and limitations**

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30 This study includes a sample facing multiple risks and uses a holistic approach to
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32 consider family and social resources that may support children who are survivors of the armed
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34 conflict in Colombia. Focused on the Atlantic Department, these results provide a foundation for
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36 future promotion and prevention programs related to children's mental health problems.
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40 Limitations include a cross-sectional design, therefore, not able to test causality or
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42 direction of effects. Although the instruments used have been validated and widely accepted, the
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44 findings cannot be interpreted as a diagnosis. Also, the use of parent reports of children's mental
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46 health could have led to reduced reporting of symptoms. Future research should also compare
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48 similar findings to a comparative group of children who are not immersed in the dynamics of the
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50 internal armed conflict.
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Conclusions

The data revealed that children survivors of the armed conflict in the Atlantic Department of Colombia exhibit several mental health problems related to emotional and behavioral problems. Besides, these problems were related to contextual factors such as family functioning and perceived social support. The findings inform holistic interventions aiming to improve not only individual child mental health with direct experience but also include those indirectly exposed to violence but also family functioning and social support, through an interdisciplinary and integrative perspective. Mental health in adults in Colombia has been a key predictor of civic participation and attitudes toward peacebuilding (Taylor, 2015; Taylor et al., 2016b); thus, future research should explore these potential links among children.

Competing interests

The authors declare that they have no conflict of interest

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