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Research paper

Broken Childhoods, Fractured Minds: The Mental Health Burden on Street Children in Eastern Democratic Republic of Congo

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ABSTRACT

Street children living in active conflict regions represent one of the most psychologically imperilled populations on earth, yet they remain among the least studied and most structurally invisible. This article draws on a narrative synthesis of peer-reviewed literature, humanitarian field data, and institutional reporting spanning 2012 to 2025 to examine the mental health burden borne by street children and conflict-displaced youth in eastern Democratic Republic of Congo (DRC) - specifically the provinces of North Kivu, South Kivu, and Ituri, the three provinces at the epicentre of the 2024-2025 escalation of armed conflict and forced displacement. Drawing on neurobiological trauma theory, ecological systems frameworks, cultural formulations of distress, and moral injury scholarship, the article argues that conventional PTSD-centred diagnostic frameworks systematically underestimate the psychological damage sustained by this population, and that intervention design must be radically reoriented toward community-embedded, culturally congruent, and developmentally informed models. The findings carry urgent policy implications amid this same escalation, during which verified grave violations against children in the DRC increased by approximately 150 per cent in South Kivu alone between the December 2024 and March 2025 reporting periods. The article concludes with a five-point framework for reform and a call for the epistemic and political reorientation this crisis demands.

Keywords: street children, mental health, complex trauma, eastern DRC

Discussions of the global mental health crisis tend to conjure images of overburdened clinics in European capitals or underfunded counselling services in North American suburbs; they rarely extend to a roadside drainage ditch in Goma - the provincial capital of North Kivu and the largest urban centre in eastern DRC - where a nine-year-old boy, separated from his mother during a January 2025 attack by the M23 (Mouvement du 23 Mars, an armed rebel group that has driven much of the recent escalation in eastern DRC), sleeps beneath a torn tarpaulin and wakes screaming into the equatorial dark. Still less attention is paid to the hours of morning that follow navigating the threat of sexual exploitation from older street youth, the risk of arrest or assault from security forces, the hunger that sharpens into something physical and permanent, and the dissociative episodes that older community members will interpret not as trauma symptoms but as spiritual possession. This article concerns itself with that child, and with the tens of thousands like him across the conflict-shattered provinces of eastern Democratic Republic of Congo - children whose psychological suffering rarely registers in the categories through which humanitarian systems, and academic research, decide whose distress counts.

Eastern Democratic Republic of Congo is, by any credible measure, one of the most prolonged and lethal humanitarian crises in contemporary Africa. Over three decades of armed conflict, involving more than 120 identified armed groups at various stages, have progressively dismantled the social infrastructure of North Kivu, South Kivu, and Ituri provinces (ACAPS, 2025). The consequences for children are catastrophic in their scale and specificity. By April 2025, more than 7.3 million people were internally displaced within the DRC (ACAPS, 2025) - the highest number ever recorded in the country's history - with children constituting approximately 40 per cent of that figure. Save the Children (2025) reported that at the start of 2025 alone, escalating violence had displaced more than 100,000 people, of whom roughly 52,000 were children. Across eastern DRC, intensifying hostilities forced over 700,000 people to flee dismantled displacement camps in search of safety in Goma and Bukavu (IOM, 2025) where instead of refuge, they found themselves displaced again, this time into urban destitution.

Among the displaced, a subset exists in conditions of total institutional abandonment: street children. These are children who have been separated from family units through conflict; who have fled abusive displacement camps; who have been demobilised from armed groups with nowhere to return to; or who have drifted to urban centres in search of survival and found instead a different kind of danger. They are not refugees in the legal sense. They are not internally displaced persons in the statistical sense. They occupy a liminal, unmapped space between categories - and it is precisely this categorical invisibility that makes their mental health crisis so acute and so poorly addressed. Invisibility is not an accident of geography or circumstance. It is an effect of political economy of who counts in a humanitarian system built around legible categories like "IDP," "refugee," or "unaccompanied minor." Children who do not fit these categories do not easily generate the data, the advocacy, or the funding that might address their needs.

For the purposes of this study, "street children" refers to children for whom the street constitutes the primary space of survival and socialisation, including those who are entirely without family support as well as those who maintain intermittent or fragile contact with caregivers. What distinguishes street children from adjacent categories such as internally displaced children, refugees, and demobilised former child soldiers still living within family or camp structures is the absence of a stable, protective adult presence organising their daily survival: an internally displaced or refugee child, however precarious their circumstances, is typically registered within a household or camp structure and retains at least nominal caregiver oversight, whereas a street child's survival, shelter, and protection from exploitation depend on the child's own resourcefulness or on informal peer networks. This absence of sustained adult protection, rather than displacement status, legal category, or geographic location alone, is what produces the heightened exposure to unmediated risk and the relative invisibility within institutional and humanitarian frameworks that this article treats as the population's defining features. The analysis therefore maintains a specific focus on street-connected children even as it draws on the closely related literatures on internally displaced children and former child soldiers, given the acute shortage of research conducted with street children as a distinct population.

THEORETICAL FRAMEWORK

This article is organised around Urie Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979) as its primary theoretical lens, on the grounds that the mental health of a street child cannot be understood as an individual, intrapsychic phenomenon but only as the product of nested and interacting environmental systems. In Bronfenbrenner's model, the microsystem comprises the child's immediate relationships and settings - caregivers, peers, and the street itself as a space of survival; the mesosystem concerns the connections, or their absence, between these settings, such as the broken link between a demobilised child soldier and any surviving family network; the exosystem covers structures the child does not directly inhabit but which shape their life regardless, including humanitarian funding decisions, school closures, and the deployment or withdrawal of peacekeeping forces; the macrosystem encompasses the broader cultural, political, and economic conditions - the war economy built on coltan and gold, cultural understandings of trauma and possession, and the international hierarchy of humanitarian attention, that set the boundaries of what is possible for this population; and the chronosystem captures how these dynamics shift over time, most starkly in the 2024-2025 escalation of violence that reshaped displacement patterns and risk exposure within the period this article covers.

The ecological systems model is used here as an organising structure rather than a standalone explanation, and it is deliberately read alongside three complementary bodies of theory that address dimensions it does not, by itself, capture. Neurobiological trauma theory explains how the chronic, systemic adversity described at the macrosystem and exosystem levels becomes embodied within the child, altering brain structures and stress-response systems in ways that mediate between environment and outcome. Cultural formulations of distress supply the interpretive frameworks, such as attributions of psychological suffering to witchcraft or spiritual possession, through which communities within the microsystem and macrosystem make sense of symptoms that biomedical models describe differently. Moral injury theory, meanwhile, addresses a dimension of harm specific to former child soldiers that neither ecological nor neurobiological accounts on their own capture: psychological damage arising not from

victimisation but from the child's own perpetration of violence within a system that offered them few alternatives. Read together, this framework treats the psychological suffering of street children in eastern DRC as simultaneously structural, embodied, culturally mediated, and, for some children, morally injurious - and it is this multi-level reading that subsequent sections of the article apply to the evidence.

METHODOLOGY

This article draws on the psychological literature, UN reporting, and NGO field data across the period 2012 to 2025 to characterise the mental health landscape of this population; interrogate the adequacy of current diagnostic and intervention frameworks; examine the neurobiological foundations of conflict-induced developmental trauma; and advance a culturally grounded agenda for structural reform. Its purpose is to construct and defend an argument from the best available evidence, not to exhaustively catalogue or statistically pool that evidence; it therefore does not attempt a systematic review or a statistical meta-analysis, and makes no claim to have identified every relevant source. The article is organised in seven substantive sections: contextual background; a narrative synthesis of findings on mental health prevalence; neurobiological dimensions of chronic conflict trauma; structural determinants and compounding vulnerabilities; the intervention landscape; a reform framework; and a concluding reflection on the ethics of scholarly and humanitarian attention.

The evidentiary basis for the argument was assembled through purposive engagement with three bodies of source material: peer-reviewed academic literature on child and adolescent mental health in conflict and displacement settings; institutional and humanitarian reporting from bodies including UNICEF, WHO, IOM, MSF, ACAPS, and Save the Children; and clinical and field-based accounts of intervention programmes operating in the DRC and comparable conflict-affected contexts. Sources were located through academic databases (including PubMed, Scopus, Web of Science, and Google Scholar) and the publication archives of the institutions named above, using search terms such as *street children*, *mental health*, *PTSD*, *complex trauma*, *child soldiers*, and *DRC*. Sources were selected for their relevance to child and adolescent mental health in conflict or displacement settings within the 2012 to 2025 period and for the analytical weight they could bear in the argument, rather than through the fixed inclusion protocol and exhaustive database-by-database screening characteristic of a systematic review.

Given the acute scarcity of research conducted with street children as a distinct population, evidence from closely related populations - internally displaced children, refugees, and former child soldiers - was incorporated where contextually appropriate, with the differences between these populations and street children made explicit wherever the distinction bears on interpretation. This purposive approach carries a limitation worth stating plainly: because sources were selected for relevance and argumentative weight rather than identified through an exhaustive, replicable search protocol, the resulting picture, while representative of the best currently available evidence, cannot claim the completeness of a systematic review, and a reader seeking a comprehensive accounting of every study published on this topic should treat this article as a starting point rather than a substitute for one. The analysis itself is guided throughout by the interdisciplinary framework set out above, integrating ecological systems theory, neurobiological trauma theory, cultural formulations of distress, and moral injury, so as to interpret the evidence beyond what conventional diagnostic categories alone would allow.

CONTEXTUAL BACKGROUND: EASTERN DRC AS A CUMULATIVE TRAUMATOGENIC ENVIRONMENT

Understanding the mental health of street children in eastern DRC requires first understanding the region as what trauma scholars call a cumulative traumatogenic environment, a setting in which trauma is not episodic but constitutive of daily existence; not something that happened but something that is perpetually happening.

The conflict in eastern DRC has deep roots in the 1994 Rwandan genocide, which generated massive refugee flows into then-Zaire and fatally destabilised regional ethnic politics. What followed was a sequence of wars - the First and Second Congo Wars (1996-1997; 1998-2003), the continued insurgency of the Forces Démocratiques de Libération du Rwanda (FDLR), the successive iterations of the Congrès National pour la Défense du Peuple (CNDP), and later the March 23 Movement (M23) - that have made violence a structural feature of life in the Kivus and Ituri rather than an aberration from it. The DRC ranks among the least peaceful nations globally, driven by territorial disputes, ethnic tensions, political struggles over governance, and economic contestation over extraordinary mineral wealth: coltan, gold, cassiterite, and wolframite. These resources, far from generating development, have fuelled a predatory war economy in which armed groups, state actors, and regional powers compete with devastating consequences for civilian populations.

By 2024, the resurgence of armed violence and interethnic conflict was compounded by climate-related disasters and disease outbreaks, collectively resulting in a severe and deteriorating humanitarian situation for children in eastern DRC (UNICEF, 2025), with approximately 6.5 million people displaced in eastern DRC alone. At the start of 2025, fighting escalated to levels not seen in decades: M23 forces, allied with Rwandan troops, entered Goma

in January 2025 triggering mass displacement and the systematic dismantling of dozens of displacement camps. Violence in South Kivu followed, forcing more than 850,000 people from their homes by March 2025, nearly half of them children.

For children broadly, this environment produces a compound architecture of adversity. UNICEF (2025) reports that more than 80 per cent of DRC children have experienced at least two major deprivations in their lifetime, including absence of food, housing, water, and medical care. The closure of 1,593 schools in 2024 - including 211 occupied by armed groups or repurposed as displacement shelters - left more than 500,000 children out of school. The UN Secretary-General's 2024 Children and Armed Conflict report, covering April 2022 to March 2024 (United Nations Security Council, 2024), documented an 8 per cent rise in verified grave violations against children violations UNICEF (2024) described as reaching a "staggering scale": 4,006 children were forcibly recruited into armed groups; 2,028 were abducted; and thousands were killed, maimed, and subjected to sexual violence.

For street children specifically, this context adds further layers of precarity: the absence of a protective adult guardian; the constant threat of sexual exploitation; the risk of conscription by armed actors operating in urban peripheries; engagement in hazardous informal economic activities including scavenging in artisanal mining areas; and the near-total absence of any institutional safety net. Research conducted in Burundi (Crombach et al., 2014), a geographically and culturally proximate post-conflict society, has confirmed that even minor violent incidents in the lives of already-traumatised street children are sufficient to trigger and reinforce PTSD symptomatology. By analogy, for a population in eastern DRC exposed to major violent events on an ongoing basis, the implication is severe, though this extrapolation from a neighbouring context has not been directly tested among DRC street children themselves.

NARRATIVE SYNTHESIS OF THE EVIDENCE: THE MENTAL HEALTH PROFILE

Prevalence and diagnostic patterns

The mental health epidemiology of conflict-affected children in sub-Saharan Africa is, relative to the scale of the crisis, substantially under-researched. Research in this area faces compounding methodological challenges: affected populations are mobile and hard to enumerate; trust between communities and formal institutions is minimal; locally validated psychometric instruments are limited; and ethical constraints on research in active conflict zones are considerable. Notwithstanding these limitations, the available evidence paints an alarming portrait. Because peer-reviewed academic research focused specifically on street children remains scarce, the discussion below draws first on institutional and field-based data, generated by agencies working directly with affected populations, before situating these findings against the broader academic literature on adolescent mental health in the region; despite being methodologically distinct from peer-reviewed research, such institutional data often represents the most direct and current evidence available for a population that formal academic study has largely bypassed.

In eastern DRC specifically, psycho-traumatic effects have been reported in over 80 per cent of the population in provinces affected by prolonged violence, according to field research cited in a 2025 scoping review on psychotrauma in sub-Saharan Africa (Cikuru et al., 2025). Among children attending Médecins Sans Frontières (MSF) mental health services in DRC between 2009 and 2012, the most common precipitating event was sexual violence, accounting for 36.5 per cent of cases (Lokuge et al., 2013). The most common presenting complaints were anxiety-related disorders, followed by mood disorders, behavioural problems, and somatisation, a pattern consistent with the clinical literature on complex developmental trauma rather than single-incident PTSD.

Set against this field-based picture, Hart and Norris (2024), writing in Global Health Action, report a 27 per cent prevalence of depression, a 30 per cent prevalence of anxiety disorders, a 21 per cent prevalence of PTSD, and a 12 per cent prevalence of suicidal ideation among adolescents in the region broadly. These figures, derived from the general adolescent population, provide a baseline for understanding mental health burden in the region. However, evidence from research conducted with street children in comparable conflict-affected settings (Crombach et al., 2014) suggests that these patterns are likely amplified among street children, whose conditions of life involve the absence of caregiver protection, stable shelter, and other moderating social supports. Street children face multiplicative risk factors absent in community-based samples: they lack caregiver protection, stable shelter, consistent nutrition, educational engagement, and peer social support - each of which functions as a protective factor moderating the mental health effects of trauma exposure, consistent with the broader scoping-review evidence on conflict-displaced children and young people (Otorkpa et al., 2024).

A 2024 cross-sectional study of displaced Sudanese school-age children conducted in Ad-Damar, River Nile State, and published in BMC Public Health (Awad et al., 2024) offers a partial comparative reference, though the comparison must be drawn cautiously given the substantial differences between the two populations. Among 246 participants aged 6 to 18, 68 per cent frequently reported sadness, 73 per cent reported anxiety, and 29 per cent had diagnosed mental health conditions including PTSD and depression. Unlike DRC street children, this

Sudanese sample retained access to a school system and at least some family structure, both of which function as protective factors; on this basis, prevalence rates among street children, who lack both, would plausibly be higher still, though this remains an inference rather than a direct finding. A more appropriate benchmark - street children living in stable, non-conflict-affected countries - would allow the specific contribution of active armed conflict to be isolated from the general vulnerabilities associated with street life; the absence of such comparative data in the literature is itself a limitation this article cannot resolve and flags as a priority for future research.

The inadequacy of the PTSD framework

A central argument of this article is the structural inadequacy of the DSM-5/ICD-11 PTSD framework as the organising diagnostic lens for street children in eastern DRC.

PTSD, as a clinical construct, was developed primarily through research with American combat veterans and disaster survivors in high-income settings. Its diagnostic architecture assumes: a discrete traumatic event with a discernible temporal boundary; a period of relative safety following exposure; and a stable social environment within which symptoms can consolidate into identifiable patterns of intrusion, avoidance, negative cognition, and hyperarousal. These assumptions hold only partially in the case of street children in eastern DRC, for whom trauma is less discrete and more continuous than the model presumes. For these children, trauma is not an event but a climate. There is no post-trauma; there is only ongoing trauma of varying intensity.

The clinical constructs more appropriate to this population, Complex PTSD (CPTSD), Developmental Trauma Disorder, or what Judith Herman (1992) originally framed as Disorders of Extreme Stress Not Otherwise Specified (DESNOS), capture dimensions of psychological damage that conventional PTSD misses: chronic affect dysregulation; disturbances in self-perception and consciousness; alterations in relational patterns; and somatisation. ICD-11's inclusion of CPTSD as a distinct diagnostic category represents progress, but its clinical application in humanitarian field settings remains far behind its conceptual development.

Research in Burundi (Crombach et al., 2014) describes the mechanism precisely: persistent insecure and violent situations continuously trigger and enlarge the fear network, the associative memory architecture connecting perceptual triggers to trauma-related cognitions, emotions, and somatic responses. When this network is activated daily rather than episodically, it does not produce discrete intrusive memories and avoidance behaviours. It produces a reorganisation of the entire cognitive and relational architecture of the developing self. The child who has lived for months or years in a state of hypervigilance does not have anxiety - that child has become anxious. This distinction matters clinically because it shifts the target of intervention from symptom management to developmental repair.

THE NEUROBIOLOGICAL DIMENSION: WHAT CONFLICT DOES TO THE DEVELOPING BRAIN

One of the most important contributions of recent neuroscientific research to the scientific understanding of childhood trauma has been the demonstration that psychological damage is not merely cognitive or emotional - it is embodied, written into the architecture of the developing brain in ways that persist long after the traumatic environment is left behind, and that are dramatically worsened when that environment is never left behind at all.

Early childhood is a period of extraordinary neurological plasticity - the brain forms at its most rapid rate, establishing the synaptic connections, regulatory systems, and structural proportions that will shape cognitive and emotional functioning across the life course. Adverse experiences during this window, abuse, neglect, violence, poverty, chronic unpredictability, cause documented alterations in brain regions including the prefrontal cortex, amygdala, hippocampus, and corpus callosum, impairing cognitive functions such as learning, memory, and executive functioning (Alpugan, 2024; Ford et al., 2013). For street children in eastern DRC, who often have trauma histories beginning in early childhood and continue to experience chronic adversity through adolescence, these neurological effects are profound.

Chronic stress disrupts the hypothalamic-pituitary-adrenal (HPA) axis - the body's primary stress response system - resulting in chronically elevated cortisol levels that impair emotional regulation, increase vulnerability to mood and anxiety disorders, and damage hippocampal volume. This HPA axis dysregulation is not merely a mechanism for distress; it actively undermines the capacity for recovery. A child whose stress system has been calibrated by years of conflict to remain in constant hyperactivation will find it difficult to benefit from even well-designed therapeutic interventions while they remain in an environment that continuously reactivates the threat response.

Longitudinal research has found that lower family income at age nine predicts reduced prefrontal cortex activity and impaired amygdala suppression during emotional regulation in adulthood (Kim et al., 2013) - demonstrating the long temporal reach of early deprivation on brain function. For children in eastern DRC who are

simultaneously displaced, unprotected, exposed to active violence, nutritionally deprived, and lacking stable caregiving, the neurobiological burden is multiplied across all these dimensions at once.

The neuroscience literature, notably the dimensional model developed by McLaughlin and Sheridan (2016), helpfully distinguishes between two dimensions of early adversity with different neurological signatures: threat (exposure to violence, abuse, and direct harm) and deprivation (absence of stimulation, nurture, cognitive engagement, and stable caregiving). Street children in conflict zones are exposed to both simultaneously and at extreme intensity. Threat exposures primarily affect amygdala-based fear circuitry and stress response systems. Deprivation exposures affect the prefrontal cortex, white matter development, and the neural architecture of higher cognition. The combination produces children whose capacity for both emotional regulation and rational cognition is compromised - not through any failure of will, but through the cumulative biochemical and structural consequences of an environment that systematically destroys the conditions of healthy human development.

These neurobiological findings carry direct implications for intervention design. A child with severely disrupted stress regulation cannot absorb trauma-focused cognitive behavioural therapy in the same way as a child with intact executive function. Effective interventions must first create the physiological preconditions for therapeutic engagement: safety, predictability, nutrition, sleep, and the experience of a consistent, non-threatening relational environment. These preconditions are precisely what street life in a conflict zone systematically denies.

STRUCTURAL DETERMINANTS AND COMPOUNDING VULNERABILITIES

Family separation and attachment disruption

The foundational psychological resource for child development is a stable, protective attachment figure. Armed conflict systematically destroys this resource through death, displacement, separation, and the psychological incapacitation of surviving caregivers through their own trauma. In eastern DRC, verified abductions of children numbered over 2,000 in the 2022-2024 reporting period - a figure representing only documented cases. For street children, the absence of a caregiver represents not merely an emotional loss but the removal of the primary regulatory system through which a child manages fear, processes experience and builds the neural architecture for social cognition and emotional self-regulation.

Research from South Kivu, registered in the Pathways to Improved Adolescent Mental Health clinical trial (ClinicalTrials.gov, n.d.-a), documented that childhood exposure to multiple adversities in the DRC, particularly when unmediated by protective relationships, generates trajectories of poor mental health that compound across developmental stages. Children exposed to violence who maintain at least one consistent, caring adult relationship show significantly better outcomes than those who do not. Street children are, by definition, the population least likely to have access to any such relationship.

Recruitment, militarisation, and moral injury

For street children in eastern DRC, pathways into and out of armed groups represent a critical dimension of their lived experience. Among the most psychologically devastating experiences available to a child in eastern DRC is forced or coerced recruitment into an armed group. The UN's 2024 Children and Armed Conflict report (United Nations Security Council, 2024) documented 4,006 children forcibly recruited in the 2022-2024 period - again, only verified cases. Research on former child soldiers in the DRC found that children who grew up entirely within armed groups showed greater exposure to, and perpetration of, violence, greater severity of trauma-related suffering, and higher levels of appetitive aggression than adult ex-combatants (Hermenau et al., 2013). Appetitive aggression - finding violence intrinsically rewarding - was linked to higher military ranks, voluntary recruitment, and higher rates of re-enlistment, suggesting that for some children, the armed group becomes not only a survival mechanism but a source of identity and belonging in a world that has otherwise offered them nothing.

By extension, demobilised child soldiers who transition to street life can reasonably be expected to face a compound and specific mental health burden: the neurological sequelae of combat exposure; the moral injury of having perpetrated violence; the stigma that prevents reintegration; and the absence of family structures that formal programmes presuppose. The concept of moral injury - psychological damage arising from the violation of one's own moral beliefs through perpetration is underutilised in humanitarian frameworks that focus primarily on victimisation. Yet for former child soldiers surviving on the streets of Goma or Bukavu, moral injury may be among the most functionally significant dimensions of their burden.

Evidence from the UNICEF-supported Goma transitory care centre (Humphreys, 2009) where approximately 250 demobilised children were grouped into "family" units of around 30, deliberately mixing ethnic and armed group backgrounds, and supported by assigned counsellors and peer mutual support - suggests that community-based models addressing relational rupture and identity reconstruction alongside trauma processing may be more effective than individual clinical modalities for this population.

Sexual violence and gender-specific trauma

Sexual violence in eastern DRC has been systematically documented as a deliberate weapon of war, used to destroy community cohesion, enforce territorial control, and punish civilian populations (CARE International, 2023).

For girl children on the streets, who lack both family protection and physical capacity to resist older perpetrators, the risk of sexual exploitation is ambient and continuous, a vulnerability consistent with the gendered dynamics of street life documented in the broader Nigerian streetism literature (Olaniran & Oyewole, 2021). That literature situates streetism within intersecting economic and cultural pressures household poverty and inadequate parental supervision on one hand, and communal norms that normalise children's presence on the street on the other (Ojelabi & Oyewole, 2012, 2013) root-cause dynamics that, while documented in a comparatively stable Nigerian urban setting, plausibly compound rather than substitute for the acute, conflict-driven displacement pressures examined here for eastern DRC. U.S. Department of State (2025) reporting notes that sex trafficking in the DRC is primarily concentrated in large cities such as Goma and Kinshasa, and that traffickers specifically recruit from IDP camps and economically disadvantaged areas - the precise environments from which street children originate. Some girls, facing starvation, engage in what researchers term "survival sex", a category that inadequately captures the coercive dynamics of a transaction where one party's alternative is destitution.

The mental health consequences of sexual violence are compound and longitudinal: acute stress reactions; chronic depression and CPTSD; sexual dysfunction; disruption to self-concept and bodily integrity; and, for those who experience pregnancy resulting from rape, the additional burden of raising a child within communities that stigmatise both mother and child. Qualitative research from Beni, Goma, Bukavu, and Uvira has documented survivors being rejected by husbands, excluded from families, and shunned within communities (Physicians for Human Rights, 2024), a social rejection that, for a street child with no family to retreat to, is total.

Substance uses as a coping mechanism

An underreported dimension of the mental health profile of street children in conflict zones is the use of psychoactive substances - alcohol, cannabis, glue-sniffing, petrol inhalation - as self-regulatory and coping strategies. For children with chronically dysregulated stress systems and no access to formal mental health support, substances represent the only available pharmacological intervention. The consequences are severe: impaired cognitive development; increased risk of violence and victimisation; heightened vulnerability to exploitation; and dependence that further marginalises children from any formal support. Mental health programming that does not address substance use cannot adequately serve this population, and programming that addresses substance use without addressing the underlying trauma and structural deprivation will achieve only temporary remission.

The collapse of educational structures

Education functions as a critical protective factor for conflict-affected children - providing routine, structured time, peer relationships, cognitive engagement, and access to adults who can identify distress and facilitate referral. The systematic destruction of educational infrastructure in eastern DRC removes not merely learning opportunities but mental health protection. In 2024, the closure of 1,593 schools left more than 500,000 children outside the education system. Street children are already excluded from formal education, and the further collapse of the school system eliminates even the theoretical possibility of re-entry as a pathway back to structured institutional support.

INTERVENTION LANDSCAPE: WHAT EXISTS, WHAT WORKS, WHAT FAILS

Current provision and evidence base

Mental health services for children in eastern DRC exist at the margins of the humanitarian response, a pattern consistent with the wider evidence on child mental health provision in war-affected settings globally (Vostanis, 2024) chronically underfunded, geographically inaccessible in many conflict-affected areas, and architecturally designed for settled populations rather than mobile, street-based, and institutionally disengaged children who represent the highest-need group.

MSF has operated mental health programmes in DRC since the early 2000s, focusing particularly on survivors of sexual violence. Brief trauma-focused therapy - MSF's primary therapeutic modality - has shown promising outcomes where applied: among patients who completed care in the 2009-2012 DRC programme, 97 per cent self-reported improvement in their presenting complaint. However, programme dropout rates were high at 45.7 per cent, and the programmes reached only a small fraction of the affected population (Lokuge et al., 2013). The dropout rate is itself informative: it reflects the structural barriers facing conflict-affected children in accessing and

sustaining clinical engagement - barriers of distance, distrust, competing survival demands, and the fundamental incompatibility of multi-session therapeutic programmes with the instability of street life.

The 2025 systematic review of child public health interventions in conflict settings, published in PLOS Global Public Health (Kadir et al., 2025), examined 51 intervention studies from conflict-affected settings worldwide, of which 51 per cent were from Africa. The review found growing evidence for psychosocial support programmes, structured group activities, child-friendly spaces, and school-based mental health interventions. Critically, the review identified a persistent evidence gap for interventions specifically designed for street children - who fall outside the household- and school-based architectures most commonly evaluated.

A registered randomised controlled trial in eastern DRC (ClinicalTrials.gov, n.d.-b) has evaluated a 15-session, group-based, culturally adapted, Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) intervention with former child soldiers and "street boys" aged 13 to 17 - the only intervention study known to specifically target this population in this setting. Additionally, a 2025 study in DRC reported positive outcomes from music therapy incorporating songwriting for vulnerable populations in conflict settings (Zook et al., 2025), pointing to the potential of arts-based, non-clinical modalities accessible to street children who would not engage formal clinical services.

Structural failures and funding gaps

The mental health system in DRC is not merely under-resourced - it is, in the provinces most affected by conflict, functionally non-existent. The 2025 Humanitarian Response Plan for the Democratic Republic of the Congo sought USD 2.5 billion to assist 11 million people (OCHA, 2025). Mental health, consistently treated as a tertiary priority behind food, shelter, and physical health, receives only a fraction of this already limited humanitarian funding. Humanitarian funding for DRC and other African emergencies has consistently lagged behind assessed need, with the region repeatedly identified among the world's most underfunded and neglected crises (ACAPS, 2025). This pattern establishes an effective hierarchy of suffering in which African children's psychological needs are treated as less urgent than children elsewhere.

The disengagement of MONUSCO operations - initiated at the Congolese government's request under UN Security Council Resolution 2717 (2023), with military and police personnel fully withdrawn from South Kivu by June 2024, while a reduced mandate continued in North Kivu and Ituri (MONUSCO, 2024) - further eroded the security umbrella under which humanitarian mental health programming could be attempted, precisely in the province, South Kivu, that saw the sharpest subsequent escalation in violence against children. Many areas where street children concentrate are now effectively inaccessible to international actors. This retreat of formal oversight compounds an existing accountability gap: documented cases of sexual exploitation and abuse perpetrated by humanitarian personnel themselves in the DRC (Alternatives Humanitaires, 2024) mean that the shrinking humanitarian footprint is not an unambiguous loss of protection for street children, who are also among those most exposed to exploitation by the very actors meant to assist them.

Community and cultural resources

A persistent tendency in international humanitarian mental health programming is the treatment of affected communities as passive recipients of externally designed interventions. In eastern DRC, community structures - family networks, religious institutions, traditional healing practices, community elders - have historically provided the primary mechanisms through which psychological distress is processed and social cohesion restored after violence. These structures have been severely damaged by decades of conflict, but they have not been entirely destroyed, and any sustainable mental health response must be built on their remnants rather than bypassing them.

The 2025 scoping review by Cikuru et al. (2025) noted that in DRC, mental distress is frequently attributed to supernatural causes - witchcraft, ancestral spirits, demonic possession - particularly among older community members and in the rural areas from which many street children originate. Younger cohorts showed greater openness to medical explanations, but traditional frameworks remain pervasive. Critically, this is not simply a barrier to biomedical treatment: traditional healing practices that provide ritual, community witnessing, and symbolic restoration of integrity may offer genuine psychological benefit that narrowly biomedical frameworks cannot replicate. Music therapy's documented effectiveness in DRC may partly reflect its resonance with existing cultural traditions of communal musical expression as a vehicle for emotional processing. Intervention design that ignores these traditions forfeits the most accessible therapeutic resources available.

However, these intervention models are largely structured around school- or household-based populations and therefore systematically exclude street children, who remain the least reachable group.

A framework for reform: Five structural imperatives

The evidence synthesised in this article supports the following structural imperatives for addressing the mental health burden on street children in eastern DRC. These are not aspirational guidelines but minimum requirements for any response that claims seriousness about this population's psychological wellbeing.

Imperative 1: Mainstream mental health into humanitarian response from the outset.

The 150 per cent surge in verified grave violations against children in South Kivu, comparing March 2025 to the December 2024 baseline (UNICEF, 2025, March), is severe enough to be reasonably characterised as a psychological mass casualty event, requiring immediate, simultaneous mental health response alongside emergency food, shelter, and medical care. Concretely, this means embedding trained psychosocial first responders within the same rapid-response teams that deliver food and shelter, rather than routing mental health support through a separate referral pathway that street children, lacking fixed addresses or caregivers to navigate it, are structurally unlikely to reach. The current model in which mental health is addressed as a recovery phase concern after physical needs are met is both clinically inappropriate and practically self-defeating. Children who spend months in acute psychological distress without any support will develop chronic and treatment-resistant conditions that are far more costly to address than early intervention. The humanitarian community's treatment of mental health as secondary is not a rational prioritisation; it is a failure to understand what mental health is and what its absence costs.

Imperative 2: Culturally and developmentally adapt diagnostic frameworks.

Instruments validated in Western high-income settings cannot be applied unchanged to Congolese children whose experience of trauma is continuous, cumulative, and culturally interpreted through distinct explanatory models. Cultural formulation approaches including structured attention to how local frameworks of supernatural causation interact with symptom presentation must be integrated into training for all humanitarian workers interacting with children in conflict settings. The ICD-11 framework for CPTSD, which captures the affective, relational, and self-conceptual disturbances characteristic of ongoing complex trauma, should replace single-incident PTSD as the primary organising clinical framework for this population.

Imperative 3: Resource community-embedded, non-clinical modalities as primary interventions.

Safe spaces, arts-based therapies, structured recreational programmes, peer support circles, and child-friendly spaces are not soft add-ons to 'real' clinical mental health work, they are the primary modalities accessible to street children, who are least likely to seek or be referred to clinical settings, who most need the experience of safety and belonging rather than symptom management, and whose neurobiological state most requires the physiological regulation that comes from consistent safe environments. The children's clubs operated by the NGO Street Child in eastern DRC- providing mental health support, structured social activity, and safe space for play represent exactly this kind of embedded, non-clinical approach and deserve significant scaling.

Imperative 4: Address demobilised child soldiers as a discrete high-need category.

The compound burden of trauma, moral injury, stigma, and absent family structures carried by former child soldiers now living on streets requires interventions specifically designed for their situation, not generic youth mental health programmes, and not programmes that presuppose intact family structures. The African Union Peace and Security Council's 2025 emphasis on child-focused reintegration strategies (Amani Africa, 2025) must be matched with technical specificity and adequate funding. Interventions must address appetitive aggression alongside trauma symptoms, recognising that for children who grew up within armed groups, violence has become a form of identity and relational language that cannot be extinguished through cognitive techniques alone without the simultaneous construction of alternative sources of belonging and purpose.

Imperative 5: Reform the international funding architecture.

The persistent underfunding of humanitarian appeals in DRC and other African crisis settings, repeatedly documented among the world's most neglected crises (ACAPS, 2025), is not an inevitable product of scarcity - it is an outcome of political choices reflecting whose suffering is visible, legible, and media-saturated enough to command donor attention. Structural reform of the humanitarian funding architecture to ensure needs-based rather than visibility-based allocation is beyond the scope of a single article, but it is not beyond the scope of coordinated advocacy by the academic, humanitarian, and policy communities whose work this article represents.

CONCLUSION

There is an epistemic violence in the systematic under-study of street children's mental health in conflict zones. It mirrors, at the level of knowledge production, the structural violence that these children endure in their daily lives. To study a population inadequately is, in some measure, to consent to their invisibility. To design interventions that cannot reach the most vulnerable that presuppose family structures, school attendance, or geographic stability that street children do not possess is to replicate, within the humanitarian system, the same logic of categorical exclusion that made them street children in the first place.

This study has advanced three core arguments. First, that the mental health burden borne by street children in eastern DRC - specifically in North Kivu, South Kivu, and Ituri is catastrophic in scale and inadequately captured by the dominant diagnostic frameworks through which it is currently understood. The PTSD model, designed for episodic trauma, cannot hold the weight of what these children carry: cumulative developmental trauma, neurobiological restructuring, moral injury, sexual violence, family annihilation, and the chronic physiological hyperarousal of life in an active war zone. Second, that existing interventions, while containing genuine bright spots, are architecturally misaligned with the population they need to reach - designed for settled populations, requiring family engagement, and delivered through clinical institutions that street children systematically avoid or cannot access. Third, the deficit of funding, research, and political attention directed toward this population is not an accident of scarce resources but a structural outcome of a humanitarian and knowledge system that has, whether consciously or not, decided that some children's suffering is more fundable, more researchable, and more legible than others.

Research from Sierra Leone and from the DRC itself has consistently demonstrated that even children who have spent years in armed groups, who have perpetrated violence as well as suffered it, can achieve meaningful psychological recovery when provided with consistent safety, relational repair, community acceptance, and structured support. The term "lost generation" carries markedly different meanings across historical, sociological, and clinical usage, and is invoked here descriptively rather than diagnostically: applied to child soldiers and street youth in post-conflict settings, it is not itself a clinical finding and treating it as though psychological damage were fixed and irreversible would be a failure of imagination and investment rather than an accurate reading of the evidence above.

This argument rests, by necessity, on a narrower evidentiary base than the scale of its claims might suggest: much of what is known about the psychological effects of chronic conflict trauma is drawn from former child soldiers, internally displaced children, and conflict-affected adolescents generally rather than from research conducted with street children as a distinct population, and the inferences drawn from these adjacent literatures, while reasonable, remain inferences rather than direct findings. This is not a reason to withhold judgement until the ideal dataset exists for a population this acutely at risk, that would itself be a form of neglect - but it is a reason for the reform agenda above to be paired with a parallel research agenda: primary, street-child-specific data collection, using culturally validated instruments, is the single most consequential gap this article has identified.

Eastern DRC's street children do not lack psychological complexity, resilience, or the capacity for healing. What they lack are the structural conditions within which those inner resources can be directed toward flourishing rather than mere survival: safety, food, shelter, attachment, cultural recognition, and the sustained attention of individuals and institutions willing to treat their psychological lives as seriously as their physical ones.

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Ethical Statement

This article is a narrative synthesis based exclusively on previously published academic literature, institutional reports, and publicly available humanitarian and field-based evidence. No primary data were collected from human participants, and no identifiable personal information was used. Consequently, ethical approval and informed consent were not required for this study.

Competing Interests

The author declares that there are no competing interests regarding the publication of this paper.

Author Contributions

The author was solely responsible for the conceptualisation, literature review, methodology, analysis and synthesis of the evidence, interpretation of findings, and preparation and revision of the manuscript. The author read and approved the final version of the manuscript.

Data Availability

No new dataset was generated or analysed for this study. The article is based on previously published literature, institutional reports, and publicly available humanitarian and field-based evidence. The sources used in developing the article are appropriately cited and listed in the reference section.

AI Disclosure

The author declares that artificial intelligence (AI) tools were used solely to assist with language editing, grammar checking, and improvement of manuscript clarity. AI tools were not used to generate or analyse the underlying research evidence or data. All intellectual content, interpretation of the evidence, arguments, and conclusions remain the sole responsibility of the author.

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