Wartime children's suffering and quests for therapy in northern Uganda

Akello-Ayebare, G.

Chapter Twelve

Silencing distressed children in the context of war: An analysis of its causes and health consequences

Introduction

In this chapter I aim to answer the question of why children were generally reluctant to discuss their experiences of an emotional or psychological nature, and there were indications in this research that children often present their psychological suffering in the form of physical complaints. Adults too did not readily share their psychological distresses with researchers, intervention agencies, or people representing healthcare institutions. This non-readiness to discuss psychological distress, I argue, has repercussions for the way children and adults who have experienced emotional distress present and deal with such problems, so I will analyse the causes and health consequences of this issue. In the discussion, I will reflect on the value of silencing as a coping strategy and of its health consequences.

This chapter first provides a case study followed by some children's narratives, which picture the severity of their emotional distress and how they presented it. These narratives also aim to give an impression of the context of these children's lives, which was characterised by high rates of exposure to extreme events such as deaths, child abductions, various disease epidemics, gender based violence, and a severely damaged social fabric. Finally, the narratives depict the various approaches children have for dealing with the distress. After this, key informants' viewpoints and the institutional processes which have led to the silencing of victims of emotional distress will be presented, followed by an analysis of the empirical data.

12. Findings

12.1. Children's suffering and critique of public expressions of emotional distress

In this section I present children's perspectives on the various causes of distress, and how they dealt with them. In particular, attention is given to the issue of the silencing of sufferers as a coping strategy. I will first present a detailed case study of fifteen year

old Okello. Thereafter, I will present other children's narratives suggesting attempts to conceal emotional distress, the community's reward for people who suffer in silence, and the health consequences of this phenomenon.

Case study: Okello's presentation of and coping with emotional suffering

One of the children I frequently interacted with in 2005, and with whom I had thus developed a good rapport, was Okello, a then fifteen year old boy. One day he told me that the worst thing that had happened to him was his mother re-marrying, and not his father's death as I would have expected. His father had died in an LRA ambush on Kitgum-Gulu highway in 1995, when he was about five years old. After this incident he continued to live in good peace with his mother and two siblings. However, in 2000, when he was ten years old, his mother re-married to a retired soldier who had lost his wife to HIV/AIDS. Okello narrated his experience as follows:

> This man (this was how he generally referred to the new husband of his mother) is the source of all my sufferings. After two months of marriage with my mother this man ordered her to find me somewhere else to live. He told my mother that I was too old to share a hut with them. My mother took me to my aunt's place. There, I was mistreated. My aunt told me she had no more money to pay for my school fees. I had to stop going to school. She sometimes refused to give me something to eat, and often she sent me to sell foodstuffs in the market and bring all the money to her. I escaped from my aunt's home after one year and went against my mother and her husband's wishes to stay with my mother. Since I came back to Kirombe, I sleep in the neighbouring Pentecostal Assemblies of God Church. My mother said that *jal magwoko wan ni* (the man who houses us) will not be happy with my coming back.
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> When I came from my aunt's home, I found everything we had had been sold by this man. All the businesses of my mother had collapsed. Previously she sold paraffin, salt, sugar, and other household items in a small shop close to home, but the business had collapsed. We had a bicycle before, and this man had misused it 'til it was beyond repair. This man also sold our World Food Programme (WFP) card to his debtors, hence making it difficult for us to receive WFP food rations. He had also sold all my mother's pigs and she has never seen where the money went. Of late, my mother has resorted to a business of pottery. Still, this man tells her about the many debts he has to pay, and she subsequently gives him all the money.
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> When I came back, I borrowed money from my friends to start a small scale business of selling boiled eggs, paraffin, and salt. Each time this man borrowed money from me, he never paid it back. I stopped doing this business because I did not have money anymore. Lately he is always having diarrhoea and is very sickly. I also feel sick. I have not been well for five months now since I always have strong headache. It starts with something very painful moving around my head and body. By the time it returns to my chest and head, I feel a lot of chest pain and headache. At first I used to take two tablets of Hedex and it would go. These days, even when I take three Hedex and Action tablets, it only reduces. Shortly afterwards I feel the same headache again. Since the problem is becoming worse, and my mother also has the same pain, we have resorted to going for prayers at Pentecostal Assemblies of God.

Children's views about Otika and his public expression of emotional distress

In order to explore children's experiences of emotional distress and their perspectives on its appropriate management, I presented a vignette about a boy called Otika (see below) to groups of between seven and fourteen children aged ten to fifteen years, followed by a discussion of the story. In seven discussion groups, viewpoints were elicited from girls and boys separately.

Vignette: The story about fourteen year old Otika

> In Kanyagoga there was a boy called Otika. He likes staying alone. He does not easily laugh, even when other boys talk about funny things. Wherever he sits he is always touching his cheek. His face looks like that of someone who has been crying. Sometimes, when he is sitting alone and you greet him, he does not answer. He keeps on looking very far away while touching his cheek. Otika cries very often when he is seated alone, even though no one has beaten him. When asked why he is crying, he says nothing has happened to him. Sometimes he denies that he had been crying. Sometimes he does not want to eat. His sisters told us that he keeps on telling them that it is useless to live. Otika says that he does not sleep well. When he goes to his bed at night, he keeps on turning on every side of the bed, sometimes 'til morning. Some nights he just decides to sit outside at night.

After the vignette had been read out, children were asked whether they had similar experiences, and if yes, how they dealt with them and what advice they would give to Otika. Typical answers gathered from several such discussions are presented below. They are exemplary of the silencing of emotional suffering that occurred within this community at the time of study.

In one focus group discussion, a twelve year old boy, Ocan (or Innocent Jimmy), spoke extensively about the vignette, while eight other children nodded in agreement, sometimes laughing or adding to what he said:

> Otika has *can* (emotional suffering) and *cwer cwiny* (sadness/bleeding heart) due to the death of his father, but he is disturbing people for nothing. He needs to be told how other people have seen and experienced worse things than him, yet they do not behave like he does. For example, there is a woman in Cereleno who has lost all her children, but she is strong. She does her work normally, talks to people, and it is only when people begin to talk about LRA rebels and how they have brought about suffering that she can cry. Still, she first goes and locks herself in her hut.
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> If Otika cannot sleep, he should be given *yat nino* (medicines for sleep). This should be done by about four o'clock in the evening so that by the time it starts getting dark he is dizzy, drowsy, and too drunk with these medicines. In that case he will be able to sleep throughout the night without tossing about or opening the hut to go and sit outside. Otika should be beaten, even for his constant crying. It irritates people for him to keep on crying and showing people his *can* [from the context this implies individual emotional pain which could become collective emotional suffering or social pain]. If his mother has money, she can take him to Kampala or any town and show him nice things, promise to buy for him cars, mobile phones, or anything which

attracts his attention. However, she should trick him, saying that she will do this only if Otika stops misbehaving.

But importantly, Otika could be told about people in the army and rebel groups, how they suffer; sleeping in the bush, having nothing to eat, and that anytime they can be attacked and killed. He should be told that he would be taken there if he continues disturbing people. Otika should even be happy that he had known his father. Most children here in Gulu do not even know who their fathers are. It is something to celebrate if you have at least lived with your father for a short period.

Twelve year old Ocan had insisted to me that his name was Innocent Jimmy and that he did not have another name. His mother had been raped by several soldiers while in captivity, became pregnant, and had wanted to terminate the pregnancy but was advised against it. After she gave birth to Ocan, she had disappeared with another soldier. When Ocan reached primary school age his grandmother registered him at school as Innocent Jimmy. After various attempts to find out his Acholi name, he reported to me one morning with the name Ocan. He mentioned, however, that he did not care much if he was simply known as Innocent Jimmy.

A thirteen year old boy, Oketch, added to the discussion by sharing his experience:

I lost both parents to abductions and LRA killings. Within a few months, my elder brother also died in a motorcycle accident. I have since then become like a father and mother to my younger sisters. There are many times when we do not have food to eat. Twice we have been told to leave the huts where we were staying due to our inability to pay monthly rent. In both cases, the hut owners just threw away our belongings while insulting us. If Otika thinks he has the most severe forms of suffering, he should contact me. How can he refuse food when there are so many people who do not even have anything to eat?

Apio, a fourteen year old girl, also gave an account of the source of her own severe emotional distress. Nevertheless, she stressed, she had to be strong:

I had to be strong when my mother became mad due to *malaria madongo*. Children in the Abili camp frequently laughed at us, saying my mother was not ashamed anymore of walking naked where people were. I and my younger brother Bernard suffered a lot during that time. My father took us to close relatives, neighbours, our step mother, and even our aunt, but they all mistreated us. That is how my father rented a hut for us in Layibi. In Layibi we have many problems but I never sit down to cry or refuse to eat food! I can have *par madong*o (deep painful thoughts), *can dwong ataa* (deep emotional pain), and *cwer cwiny* (sadness), but I cannot show it to people. I sometimes simply close myself in the hut in order to cry about all these problems.

Fifteen year old Omony discussed his views on Otika's suffering, and his own experiences of severe emotional distress:

Being a boy also makes Otika's frequent crying and talking about his suffering so annoying. If there are many girls who have *can dwong ataa* but are not crying all the time, how annoying is it for a boy to keep on crying! [Here the other eight children laugh, and they request me to show them where Otika lives].

> For me, the saddest moment this year was when our hut was accidentally burnt down. In it were the harvested crops, all the money we had earned, clothes, and utensils. I almost reached the stage of Otika, but I had to be strong. This is because people even praise you if you can ignore your problems and not disturb them with misery. I think it is because so many people have seen problems with this war that even when someone dies, they spend there a very short time and then go about their business. Some time back a neighbour in Kirombe lost his two year old child due to diarrhoea, but as she kept on weeping, other people were asking her to get up and prepare for them something to eat.

On one hand, the above narratives give a brief impression of what children experienced and how they suffered from it, and on the other hand they also show how the overt expression of such suffering by Otika was actively condemned by the children themselves. In some instances they expressed irritation and disregard for other people's emotional distress. From the case study and the discussions with children several themes emerge that are related to the value of keeping emotional distress out of sight of others. Being silent about one's emotional distress was apparently associated with strength, and showing it in public was a sign of weakness. Showing weakness in public was shameful mainly for boys and men, but it also applied for girls and women. By showing one's emotional distress in public, others were confronted with it, which means that they were burdened by it as well. Everybody was suffering, and seeing another person's distress reminded them of their own losses and grief. Therefore to show one's grief in public was inconsiderate to other people's losses, and amounts to misbehaviour. Such misbehaviour was met with condemnation, ridicule, or even punishment. Grieving in public when others did not openly express their distress could also mean belittling the grief of others. In that sense, displaying emotional distress in public amounts to a form of boasting.

12.2. Silencing children taking care of sick close kin and suffering effects of sexual violence

Children who had to take care of kin sickly with HIV/AIDS suffered from specific problems. Four of the six such children that participated extensively in this ethnographic study frequently complained of persistent headaches and pain in the body. Fifteen year old Akwero often stated how "I do not feel very sick, but my head keeps paining me when I think of what will happen to me when my mother dies". Here is how she discussed her experience of *can* (emotional pain) and *can dwong ataa* (deep emotional pain):

> I am always absent from school because I have to take care of my sick mother. Sometimes it is because she coughs the whole night and often vomits out blood. I need to be awake and keep cleaning her. When she has diarrhoea and she fears going out in the dark alone, I stay awake to help her. When there is no paraffin at home, and I have to keep helping her at night, it is very

> difficult to take care of her. Even washing dirty clothes and bathing her is difficult when we do not have soap. Sometimes *pii loya* (I am discouraged) when I sit down to think about what will happen to me after her death. I feel deep emotional pain (*awinyo can dwong ataa*) if I think of these things.

Children taking care of close kin sickly due to HIV/AIDS were frequently absent from school due to admissions to hospital or because of their responsibilities helping the sick person at home. Such children lived in fearful expectation of the death of their kin. This was evident in statements they commonly made concerning what would happen to them if their parent(s) died. However, it was only during home visits, and when they collected food items at World Vision's food distribution points, that they talked about their problems with caring for their sick kin. In primary schools, HIV/AIDS was discussed as a sexually transmitted disease, and anyone who disclosed their status or suggested that they had a close kin who was sick was stigmatised, either as sexually promiscuous themselves, or because they were taking care of sexually promiscuous sick kin. Unlike in the school context where children ridiculed those who took care of kin sickly due to HIV/AIDS and sometimes discriminated against them, at food distribution points the children who were present had a commonality among them – they all took care of a kin member sick with HIV/AIDS. Thus these children were specifically targeted there for various counselling sessions organised by World Vision for its clients in the antiretroviral therapy programme.

Another type of experience that led to deep emotional distress, but which was very difficult to discuss, was sexual violence, in particular rape. Only when children were asked if they knew or had heard about incidences of rape of other children was it possible to discuss the issue. For example, one fifteen year old girl narrated how her friend was 'attacked' by three boys on her way to one of the night commuters' shelters:

> Just last week, my friend who works for the staff at World Vision was delayed at home. Her caretaker had many visitors, so she had a lot of work to do. Instead of leaving home by seven o'clock, she left after eight o'clock in the night. On her way, three boys [students from the neighbouring secondary school] ran after her and raped her. They ordered her to go to the shelter afterwards. She reached the shelter very late and feeling sick, but did not tell any of the administrators. She simply went to bathe and later slept. She only told us, her friends, because she knew we would not tell anyone. People in Bardege can just keep pointing fingers and talking about you if they hear such stories that boys 'attacked' you.

One Sunday in October 2005, while attending prayers at Christ Church, I was seated with a girl of about fifteen years. She told me her name was Angella. She had been quiet throughout the church service, even when choruses were sung, sitting intently and simply

observing what was going on. At the time when the reverend called for people who needed prayers, Angella first stood up to go, then hesitated and sat down again. When I inquired as to why she did not go to be prayed for, in her response she indicated:

> I do not feel sick but I am not well. Yesterday we were going to sleep in the shelter. It was just seven o'clock but boys attacked us on the way. They stoned us. I am feeling pain all over me and also stomach ache. I am not sick but because of bodily pain I need prayers.

After a second thought, Angella went to be prayed for. Although the girl never made explicit that she had been raped, her mention of stomach pain alludes to this. Some girls expressed in a non-somatic way distress as a result of gender based violence by telling me about their nightmares where huge men wanted to rape them.

Children extensively discussed with me the dangers 'young girls' experienced when they went to dance at night. They were often lured by big men, especially soldiers, to have sex with them. When they refused, soldiers and policemen simply took these girls by force. Nobody would intervene since the soldiers could easily shoot at rescuers. Children were convinced that reporting rape to the authorities would not lead to action against perpetrators. The general impression I gained was that the authorities downplayed the complaint and preferred that victims themselves address the issue of rape.

The silencing of victims of gender based violence was multifaceted, involving disinterest in reported cases, the ridicule of victims, disregard of their emotional distress, and sometimes the blaming of victims. In addition, stories of suffering related to stigmatised sexually transmitted diseases or sexual violence show that public expression of one's distress in such circumstances brings to the fore ambivalent ideas about accountability. Openly showing one's distress in such cases means admitting to having been part of something in which one is considered compromised or partly accountable (for instance rape) or for which a stigma applies.

12.3. Key informants' perspectives and institutional processes which led to the silencing of distressed children

State and institutional processes

It was a known fact that girls who spent nights at night commuters' shelters were sometimes waylaid by soldiers, night commuting boys, and security personnel. One evening I observed a sobbing girl of about twelve years approaching Noah's Ark night

commuters' shelter. Five boys, about her age, followed closely while laughing. When I inquired what had happened to the girl, she disclosed how she had been 'attacked' by these boys. I contacted the nurse and centre manager, however they showed disinterest in taking any action, and expressed surprise at my involvement, stating how "such cases were common", and besides the boys had already run away. One of the centre managers outlined his position, and Noah's Ark policy, as follows:

> It is up to the girls to make sure they move from their homes before dark. What is more, Noah's Ark's mandate is only to provide a place to spend nights. Noah's Ark cannot engage in such issues, including ensuring the safety of children when they are outside the shelter.

The coordinator of Noah's Ark also disclosed how less than half of the children turned up at the shelter on days when the discotheques in Gulu Municipality were open throughout the night. She discussed how it was risky for young girls to go to discotheques because older men readily took advantage of them, including raping them. There was no way to address such cases when these girls exposed themselves to them.

In 2005 UNICEF reported that over fifty percent of displaced women and girls in Pabbo camp had been victims of rape and other forms of gender based violence. The various stakeholders produced mixed reactions in response to this UNICEF report. The district army spokesman called a press conference to categorically deny any army involvement in gender based violence, including rape. There was even militaristic harassment of research assistants in this study, with soldiers forcing them to make public apologies for their infamous research findings. At the Gulu District Security Committee level there was total silence about the high number of incidents of gender based violence, which were rarely addressed. At best, general statements were made by individuals, not by the committee; for example, one key officer in the security committee discussed during interviews how "it was women's own responsibility to take care of themselves and avoid situations which might expose them to rape". In comparison to Pabbo camp, conditions in Gulu Municipality were conducive for such crimes since girls and boys commuted to night commuters' shelters in the dark when various security personnel were stationed within the municipality, and there was no strict follow-up concerning regular attendance of children at the shelters.

Another example comes from the case presented in Chapter Eleven of the thirteen year old girl who repeatedly sought medical attention at Gulu Regional Referral Hospital (GRRH) over a one year period in 2005 for stomach ache. The ultimate diagnosis of

hysteria and the administering of a false IV did not solve or minimise her problem, which had direct links to an episode of gender based violence. I believe this to be an exemplary case, bringing to the fore the effect of silencing distressed people. The victim adapted legitimate idioms which were mainly physical symptoms to present the issue at stake within the healthcare sector, only to end up with the pharmaceuticalization and trivialisation of her problem.

Professional counselling and NGOs' approaches to expressions of emotional distress

During the second phase of ethnography there were frequent radio advertisements in Gulu for people with psychosocial suffering to seek free help from Caritas. Caritas was only one of numerous NGOs in Gulu that offered counselling to ensure the wellbeing of war-affected people. In the same vein, such NGOs conducted numerous sensitisation seminars, radio talk shows, and individual and group counselling sessions.

From the children's narratives above, it is clear that Omony met the criteria for counselling at Caritas because of his persistent lack of sleep, disturbances by *cen*, and living in abject poverty and misery. With his permission, I took Omony to Caritas for counselling; this is how Omony discussed his experience with a professional counsellor:

> The counsellor told me that she also suffered like me. She comes from a similar family like mine, but for them they were nine children compared to only five of us. Unlike me, she was the oldest in that family. When her father died, she was still very young, younger than me, but she managed to take care of her siblings. Sometimes she would absent herself from school to take on 'jobs' in order to secure basic needs. She told me that I should know that there were numerous people with problems just like or more than mine. She further discussed how the *cen* of her late father constantly disturbed her but she called the Catholic Charistmatics to pray for her and drive away the *cen.* That was how she solved that problem. She told me to try out the same procedure. But again she recommended that I tell my mother to organise for the *guru lyel* (last funeral rites) ceremony.

Ultimately, Omony's assessment of the procedure was as follows:

> These people [in reference to the counsellor] know how to talk to others. They can make you laugh even when you have a problem. The lady who talked to me even mixed the talk with dancing and some ululations. She also told me about her life which is very similar to mine. She, however, persisted with the problem 'til she studied and reached where she is!

In order to gain more insights into the process of the professional counselling of children, on behalf of the school administration of two displaced primary schools – St Peters Bwobomanam and St Kizito Alero-Cuku – I invited counsellors from Caritas to conduct a session. Three counsellors from Caritas tackled topics including the challenges of living

in displaced persons' camps, the causes of nightmares and how to deal with them, and the problems of growing up.

One counsellor first stated that he resided in Lacor camp, just like most displaced children, and he was therefore better placed to tell them how to deal with their challenges. It produced a difficult scenario because one child immediately asked him which camp he meant, since at the time there was no camp in Lacor. All people who had lived in Lacor camp had been relocated to Unyama camp in 2002, and now there was only a night commuters' shelter at Lacor hospital for children below eighteen years. The counsellor shifted the discussion without answering, saying that he still had enormous knowledge concerning children's difficulties and how to solve them, which was why he had come to advise them. Using a question and answer technique, he inquired into the emergence of the new phenomenon of child headed households, as stated in the invitation letter, and other issues to enable him to assess the children's lives. By observation, there was a visible lack of enthusiasm from the displaced children concerning what he was 'teaching' them. A substantial proportion of children preferred to talk or play with each other, or simply to look at him as he laboured to solicit responses.

The topic which was discussed extensively in this group counselling session was nightmares. In a dream analysis, one counsellor elaborated on the causes of nightmares, and how to avoid or deal with them. Nightmares are 'playbacks' of events experienced, seen, heard, or thought about by individuals. According to the counsellor, the events in conflict zones which make children have nightmares include the killings and shootings of people by both the LRA and state army, but also include the fact that children watch violent videos, and discuss the deaths of close kin and other frightening episodes. The advice given to the children was that it was 'normal' to have nightmares, and that people who had violent dreams should be left and not woken up or interrupted.

In the same counselling session, another graduate counsellor extensively discussed the problems of growing up and adolescence, much to the children's amusement. First he sent away more than three-quarters of the child participants, since they were still 'too young' for the theme. Those who remained behind preferred, however, to ask him questions about how to address problems such as lack of school fees and lack of money to buy food, and whether there were material needs which would be given to children in child headed households if they went and told them to 'counsellors' at Caritas.

In sum, the approach taken by the counsellors was to redefine children's problems as a lack of information, and to normalise their experiences so that they would not worry so much. Although the intended effect of the counsellors' session was that the children should start to view their problems of nightmares as normal, among the Acholi people dreams are given meanings. For example, when a child is constantly confronted in a dream by his/her deceased kin demanding *guru lyel*, it means there is a need to conduct such a ceremony so that that child will no longer be disturbed by the spirits. It is therefore tantamount to ridicule by the counsellors to describe such dreams as 'normal' playbacks and 'nothing to worry about'. Counsellors told the children about others who had experienced more complex problems, which seemed to imply that the children had no right to complain and led to a reinforcement of children's silence.

During the planning session of one international humanitarian organisation which I observed, aimed at discussing projects organised for displaced persons over a five year period, one project – promoting the peaceful co-existence of people in communities – included varied sensitisation seminars to train beneficiaries. The planners argued that because people in the target communities had lived in a conflict zone for twenty years, they did not know anything about the issue at hand. In other words, they lacked information about the core causes of their suffering and how to deal with them. I envisage that Okello and the other children who shared their emotional experiences above would be potential target beneficiaries, and that in workshops, sensitisation seminars, and short courses – which were a common occurrence in Gulu at the time of this study – they would be trained in various thematic issues pertinent to peace, and psychosocial and general wellbeing. They would also be trained in how to identify and 'help' a traumatised person overcome their severe experiences through counselling.

From the descriptions above I may conclude that the techniques of counselling distressed children as generally practiced in Gulu at the time of this study greatly reinforced the themes that I identified in children's own views and strategies regarding the expression of emotional distress. Although no doubt well meant, and perhaps fuelled by the way professional counsellors were trained, their own experiences with suffering, and their reluctance to display their emotions, it is clear that their efforts of normalising, trivialising, and redefining their problems into a lack of information did not do justice to the experiences of the children and to the children's felt needs.

12.4. Indigenous and religious healers' perspectives on expressions of emotional suffering

12.4.1. Indigenous perspectives

In this general climate of the widely shared need, both among children and adults, to suppress the display of grief and emotional distress, the extent of suffering was clearly so great that true suffering in silence was virtually impossible. There were various attempts by people to communicate their emotional suffering, couched in legitimized somatic idioms. That is how anger, frustration, and depression were expressed as all over body pain, especially in the heart, persistent headaches, and as something painful moving all over the body.

One way in which a substantial number of children addressed their suffering and emotional distress was through the use of painkillers, medicines for sleep, and *atika* plants. For example, in Apio's narrative of having nightmares and disturbed sleep, she gave this account:

> When I was still in the bush, the younger soldiers were often used as spies. One day we were told to go and find out which shops had more things at Kitgum town so that when we attacked at night we would go directly to those shops. In one of the shops was a man who sold nice clothes, toys, and food stuffs. I asked him how much a cloth cost and he told me a high price. He did not want to reduce it. At night I led our group to that shop. After taking all we wanted, the commanders did not know what to do with that man. I killed him on my initiative. Since that night, the *cen* of that man disturbs me. In some nights or even during day, he comes with a gun and sharp knives to kill me. In such times I scream in my sleep. Each night I burn *atika* branches on a partially broken pot. I crush its seeds and leaves to smear on my head and mat. I have also placed branches of *atika* at my doorpost and window.

Other narratives suggest the use of *yat nino* (medicines for sleep) to minimise emotional distress. In Part III of this thesis, I discuss that such an approach is but short term, and core issues remain unaddressed and symptoms may recur thereby leading to the over-use of pharmaceuticals. The efficacy and long term benefits of such short term curative approaches are questionable. Here then is a negative effect of short term curative approaches in dealing with emotional distress; at best, the problems may recur, and at worst, the sufferer may simply disguise the same persistent problem in other legitimised somatic idioms, thus blurring or even preventing adequate solutions to their suffering.

If there were any attempts to actively alleviate individual and community distress, then they were quite subtle. Sufferers were told about people with comparatively worse experiences, reflected in children's comments such as 'there are people with more problems

than you'. Children or indeed adults who stoically confronted or concealed their suffering were rewarded with appreciation and praise. It was apparently preferred that individuals suffer in silence. For example, in one of the children's narratives above, it was indicated that many people expressed a disregard for one unfortunate woman's emotional distress; some mourners instead demanded that she stopped weeping and prepare a meal for them. While I have shown that if people frequently wept simply because they remembered an extreme event which they had experienced, their suffering would be unbearable, I suggest that in this context, it would be appropriate for mourners to recognise and validate the bereaved woman's grief.

12.4.2. Religious healers' approaches

One place where people converged to let out their grief and suffering was in churches. During one morning service at Christ Church in Gulu Municipality, the reverend called forward people who needed prayers for their physical, social, and emotional problems; more than half of the congregation (about fifty to eighty people out of approximately one hundred) went to be prayed for. An interview was organised with the reverend about the recent introduction into the Protestant Church services of sessions to pray for the sick. She disclosed that people frequently came to church, even during week days, to request for prayers. People also gave testimonies about the prayers 'working for them' when they had problems of persistent pain in the body, headaches, and other complaints. She mentioned how the majority of people she prayed for (over seventy percent were women and girls) often had problems such as headache, bodily pain, stomach aches, pain in the chest, and other problems which were pain related. These somatic complaints are attributed in this thesis to the consequence of the active silencing of sufferers of emotional distress; but as it was then, even the reverend could hardly tell why over seventy percent of her clients had such complaints.

One day in November 2005, fifteen year old Okello was for once visibly happy. I inquired into what had made him happy. He disclosed that he had recently been for three days of prayer and fasting at the Pentecostal Assemblies of God church. The pastor had prayed for him as well, instructing him to forgive all those whom he was holding in his heart. He had subsequently forgiven 'that man' for all he had done to them, and was indeed feeling much better. What is rather disappointing is that one week later, Okello had the same complaints of body aches; in fact, his pain was worse. Could this be because

in the main focus to minimise Okello's bodily aches, and in partially addressing his hate without the attendance of the new husband of his mother in the prayer session; hence leaving the structural factors causing the emotional distress intact, the problem was only partially solved? Could it be that ordering Okello to forgive 'that man' and call him uncle constitutes an even more complex way of silencing him and neglecting the core issues at stake? For example, Okello's anger towards that man was part of his experience; his hate, his anger, and his addressing such an experience, would require a focus not only on his body pain but also his social and economic wellbeing. I also recognise the fact that Okello's own failure to deal with his negative emotions through forgiveness, although justified, fundamentally contributed to his persistent body aches. Perhaps Okello needed to be told by the pastor that his hate and anger are negative feelings destroying not only himself, but also the people he interacted with. Additionally, the man Okello identifies as the main cause of his distress could be invited for some of the prayer sessions and advised about his behaviour.

Christians from Pentecostal churches had reservations concerning the use of *atika* plants for emotional distress. For example, Okello and all other saved children interviewed vehemently denied ever using herbal remedies. This is how Okello argued out his position:

> I used to use herbal remedies such as leaves of eucalyptus plants for cough, roots of Sodom apples for diarrhoea, and other herbs, before I was saved. My mother would collect them from the bushes in case anybody was ill at home. When I got saved, the pastor told us that we should no longer use such medicines. He said that it was because it is Satan who gave people knowledge concerning those herbs. It is in using these herbs that people 'welcome *cen*' to disturb them. For example, the pastor said that if a saved person uses *atika* plants, or plants which people put or burn in their huts, that attracts *cen*, and they will be increasing the chances of attack.

It is noteworthy that displaced children who used *atika* plants mentioned that they were 'driving off' or 'warding off' *cen* and not 'attracting *cen*' to their huts. One girl specifically discussed how she was presently able to sleep without the disturbance of the *cen* of a huge man wanting to rape her because she frequently burnt *atika* plants in her hut.

Religious healers conducted deliverance sessions for psychological sufferers. For instance, during one narrative by eleven year old Abonga, and during the deliverance sessions which I attended with two families which had sick kin due to HIV/AIDS, the pastors always instructed them to repent of their sins, and sometimes they drove away the *cen* which caused such suffering; at other times, they admonished sufferers to forgive

or release those people they were holding in their hearts. The sufferers were thereby expected to leave their heavy burdens of hatred, lack of forgiveness, and grudges at the cross of Christ and be set free, and encouraged instead to take on the light burdens of love, forgiveness, and peaceful co-existence.

In effect, during healing services children were led into a process of confronting destructive emotions, and it was suggested that if they surrendered these emotions to Jesus, in return they would walk away with constructive emotions. However, this was not enough to free the children of the effects of structural inequity, injustice, and social suffering they experienced at the time of the study.

12.5. Discussion

In the children's narratives above, evidence suggests that most of those who experienced emotional distress suffered in silence. Commonly, attempts to express and disclose individual psychological suffering were met with indignation, disregard of children's emotional distress, and often the citing of others' comparatively worse experiences. I believe that the aggrieved were actively silenced for the purposes of making suffering bearable, and in order to avoid being faced with a society which constantly expresses distress with an unbearable excess of sadness, bitterness, frustration, bereavement, and anger. As the children frequently put it, people should keep silent about their personal suffering or else they "would be seen crying for nothing, just because they had remembered some of the suffering in their lives in the recent past, or anything bad which had ever happened to them".

However, as empirical evidence suggests, children who experienced psychological distress frequently complained of bodily aches and pains. Children and indeed adults with these bodily aches and pains frequently used analgesics, medicines for sleep, antibiotics, and *atika* plants, but nonetheless their body aches always recurred. Subsequently, data suggests the over use and abuse of pharmaceuticals and herbal medicines. While these medicines were vital in providing short term symptomatic relief, recurrences of the same symptoms reflect a misguided approach to managing emotional suffering, and the focus on bodily symptoms shows that there were limited attempts to address the core causes of psychological distress. I will return to this shortly.

This chapter proposes that children expressed their psychological suffering in somatic idioms because it is only somatic suffering which is considered legitimate. Data

also shows that the indigenous and professional procedures designed to deal with such suffering in Gulu actively silenced them. Silencing took many different forms. I can discern it as a specific contextual expression and dealing with problems at the individual or social level which goes further than just emotional distress. It has symbolic, political, and social dimensions. Children themselves form part of it and frowned upon explicit emotional expressions. They were both victims and 'victimisers'.

The way in which episodes of gender based violence, including rape, were regarded or managed in Gulu during the time of the study similarly amounted to the silencing of victims. It is not only that local legal structures and administrators showed little interest in following up such cases, but also that in the very communities where these incidents occurred, the victim was instead blamed or ridiculed for it. Therefore, in the main, these acts constituted ways of silencing the victims of sexual violence, which subsequently made it quite difficult to assess.

Since it is my contention that redefining wartime people's complex problems as a lack of information is a way of silencing them, I believe that sensitisation seminars organised by NGOs for people in conflict zones, to tell them about trauma and its symptoms, amount to the silencing of the aggrieved. In effect, I suggest that this redefinition of children's emotional suffering – caused by having to take care of terminally ill kin – into problems of being sinful, or lacking information, amounts to the act of silencing them. In a large part, the emotional problem is rated as an individual or bodily issue and not a socio-economic one, and thus the fundamental problems underlying suffering are neglected or actively ignored.

It is a basic premise in this study that the target beneficiaries have agency. Children are able to name their problems, deal with them themselves, and are able to suggest ways in which they could be better addressed. For example, during extensive interaction with displaced children, evidence suggests that they were able to identify the core problems of their own and others' emotional distress, and their reactions during a workshop to sensitise them – their insistence on talking about issues of poverty, for instance – show their need to have the fundamental problems underlying their distress addressed.

This chapter therefore questions whether the approach of silencing of victims, and externally conceived psychological interventions, are effective in the context of wartime Gulu in terms of alleviating psychological suffering. In particular, I have sought to

shed light on the active silencing of victims as an attempt to make the individual's or community's emotional suffering bearable. In contexts where a substantial proportion of people have recently been exposed to severe events, it may be the best of all possible ways to cope. In short, there may be sense in the idea that showing one's suffering to others will lead to more suffering. Further, I have linked the general indigenous practice of downplaying or trivializing suffering to the explicit silencing of sufferers as-it-were by professional counsellors in Gulu at the time of this study. The common denominator which underpined such silencing by both professional counsellors and people who had to confront the consequences of extreme events is in telling the victim about their own or others' comparatively worse experiences, and highlighting how they had managed to 'work through' them. The only difference between professional counselling and indigenous active silencing, I argue, is that professional counsellors made it explicit that their approach was a therapeutic procedure.

The analyses in this chapter are not, however, consistent with the dominant explanations for why people in non-Western societies express their mental or psychological distress in somatic idioms, which mostly place emphasis on cultural differences or 'culture', or on not 'knowing' psychological illnesses in the Western sense (Mechanic 1972:1132; Kleinman 1977, 1980:76; Lin 1983:105-107; Drakapoulou 1985:40; Van Dijk 1998:245). For example, Mechanic (1972:1134) proposed a 'cultural formulation' which added several important factors to the general case formulation for a psychological health assessment, thereby allowing the clinician a framework for understanding the patients' cultural identity and cultural explanation of illness, the cultural factors in the psychosocial environment, and the cultural elements of the relationship between patient and clinician, in a bid to comprehend why patients present their emotional suffering in somatic idioms. Kleinman (1977, 1980:76) demonstrated that among Chinese populations, and indeed for the populations of many developing countries with predominantly agrarian cultures, depression manifests itself with somatic symptoms – 'somatisation' – unlike among general American population categories who label depression as a psychological problem. In a similar vein, Lin (1983:106) suggested that Korean folk etiological beliefs centre on anger as the precipitant of numerous illnesses, and case reports frequently discussed a diagnosis of depression engendered by negative life circumstances and expressed by patients as somatic complaints. Further, Van Dijk (1998:245) presented several stereotypes, including that Moroccans and Turks are unable to handle the distinction between body and mind

and do not know psychological illnesses in the Western sense; and that the vague somatic symptoms and physically felt pains which the Mediterranean patient presents could have a psychological cause apparently beyond his/her comprehension. Emphasis in this instance is placed on cultural differences, and far less on similarities (see Fabian 2002:1-35).

In short, a focus on culture – and the framing of 'culture-bound syndromes' to describe the psychological distress of people from non-Western countries – has had a limited positive effect on enhancing understanding of the sufferers' plight. The stereotypes, in short, epitomize what Van Dijk (1998) calls 'culture as an excuse', and have led to the failure of both medical practitioner and patient to adequately address the issues at stake. Drakapoulou (1985:40) demonstrated well the effect of relegating the expression of psychological suffering in somatic idioms to culture. He nicely states that "the social worker regards culture as an obvious cause of all misery and is thus released from the task to absorb himself in suffering of the patient". And Van Dijk (1998: 246) states:

> Too often cultural differences and language problems are used as alibis. The care provider keeps clean hands. The problem lies with someone else. The culture of the help seeker functions as a 'comfortable' explanation for the inadequacy of the service. The care provider cannot get hold of the symptoms; he cannot interpret them and bring about a cure or alleviation of the problem. He does not succeed in passing on his view on the nature of symptoms. His feelings of impotence and frustration are softened and camouflaged by the cultural label.

During this study's data collection process, I did observe how diagnosis was made at outpatients' clinics in four health centres in Gulu. In the main, clinical officers focused on physical complaints and readily attributed them to malaria. In Chapter Five I gave an example of a distressed child whose frequent presentation with headache ended with a clinical diagnosis of malaria despite the fact that he had at one time made it clear that he "did not think his headaches and body pains were due to malaria". While it is true that contemporary medical training has a major emphasis on the germ theory and physical health, it is also true that there was no specific place in most health centres in Gulu where psychological distress could be presented and addressed. It is possible that this phenomenon subsequently prompted distressed people to adapt and present their suffering in somatic idioms. Helman (2001:80) and Van Dijk (1998:247) attribute patients' somatic presentation of psychological suffering to the general focus by professional healthcare workers on objectively demonstrable physical changes in the body's structure and function, which can be quantified by reference to 'normal' physiological measurements.

This chapter, however, suggests that the silencing of sufferers by both professional and indigenous healthcare providers contributes substantially to the presentation of psychological suffering in somatic idioms. A similar explanation is given by Van Dijk (1998), who asserts that the general practitioner and migrant are faced with the joint task of reaching a workable definition of the situation. They must try to reach an agreement on what is wrong. As a result of differences in explanations and expectations, an interaction develops in which the body becomes the arena of assistance. There is a marginal communication whereby one party is trying to present the physical symptoms as clearly as possible and the other is constantly looking for symptoms of illness. In the search for the correct way to express his/herself, the migrant will use what he/she considers the language of the practitioner: the language of the body and pain. Because the psychological (and/or psychosocial) aspect is considered taboo, the practitioner sees his possibilities restricted to medico-technical procedures aimed at the body (Van Dijk 1998:248).

In psychopathology there are psychological and somatic diseases, and Holmes & Rahe (1967) and Kleinman (1988) has demonstrated that psychosocial stress can produce either psychological or physiological disease, or both. It is possible that experiences with severe events have caused the physical pains in war-affected children and indeed adults in Gulu. In addition, it is argued in this chapter that the silencing of distressed children leads to the adoption of legitimised somatic idioms in order to communicate distress, thereby giving the impression that there is a low prevalence of psychological suffering. For example, take the narratives above, which present various physical health complaints symptomatic of psychological suffering: perhaps it is because such suffering is not new in this context; perhaps people are not courageous enough to listen to, label, confront, and deal with such suffering; perhaps it is not yet useful to pay attention to such suffering since the community, the legal or administrative systems, and other sufferers will not respond to pleas for help to solve the issues at hand. Needless to say, the community and institutional and district administrators' reluctance in dealing with the core causes of distress in the general population reinforces the expression of emotional suffering in legitimized somatic ways and in turn serves to blur and simplify the core issues.

In the pharmaceuticalization of complex problems as part of the quest for therapy, I see dimensions of pragmatism which propel persons to engage in any activities which

might minimise their suffering, albeit only on a short term basis. While these short term approaches are implemented, the search for likely concrete solutions is blurred by the communication and identification/diagnosis of the problem as being in the body(psyche), yet the core causes of the distress are likely to be social, economic, and political in nature.

It is proposed in this chapter that when sufferers do actually start to make deliberate attempts to identify the specific core causes of their psychological suffering, and implement procedures to address them, these approaches will contribute to the healing and minimising of somatic expressions of psychological suffering. Put differently, it is only in correctly identifying the sources of psychological distress and appropriately addressing them that the high prevalence of physical complaints symptomatic of psychological suffering can be minimised in Gulu.

Desjarlais et al. (1995:47-50) suggest that a collective healing process almost always involve people talking openly about their pain and suffering, but that often the authorities have imposed a 'wall of silence' that has to be breached before healing can take place. I recognise that expressing one distress or discussing the extreme events people were exposed to either in public or to a therapist, is one way that people can give meaning to their experiences, enabling them to leave the past behind them; but indeed, in Gulu both professional and indigenous procedures silence people experiencing emotional suffering. Perhaps, as noted earlier, silencing distressed people was the best way to cope at the time of this study. In Akello et al. (2006) we gave an example of how one former child soldier exposed herself to various forms of backlash and violence as a result of freely sharing her experiences during captivity. Concerning the paediatrician's diagnosis of hysteria in the case of the young girl with stomach ache, I cite Szasz (1974:230) who put it this way: "those who want to deal with the so-called hysterical patients must therefore learn not how to diagnose or treat them but how to understand their special idiom and how to translate it into ordinary language". In the case study of this girl, the administering of a false IV (intravenous fluids) suggests a neglect of her emotional suffering. I suggest that it could have been more appropriate to view the girl's persistent presentation of stomach aches as an essential distinctive feature of a hysterical disorder, whereby a dysfunctional bodily state is substituted for a personal problem (for example sexual violence). Subsequently, an approach to address the physical and psychological consequences of being exposed

to sexual violence would be the more effective way of assisting this girl in escaping her anxiety.

Conclusion

In sum, when confronting psychological suffering in northern Uganda, silence or 'the stoical, be strong attitude' was more common than the demonstrated vulnerability of someone suffering and expressing his or her emotional distress to others. Perhaps this is due to the fact that the persons in this study had lived for up to twenty years in the context of armed conflict, displacement, abductions, and killing of close kin; the community would become pathological if everybody cried and talked about their experiences, or mourned their abducted kin. In general, since everybody has his or her own suffering, it is preferred that each one suffers in silence. Thus displaced persons actively silenced each other by telling them to consider others in the neighbourhood with worse problems, and in disregard of others' emotional distress or the ridicule of sufferers. Such an approach was similar to professional ways of dealing with psychological forms of suffering, for instance through counselling. Nevertheless, children's desperate attempts to be indifferent to psychological suffering have instead culminated in sufferers adapting legitimised idioms to communicate the same problems. However, these adapted legitimised idioms have been less useful to both the sufferers and healthcare providers since the immediate effect is to simplify, focus on body symptom based management, or pharmaceuticalize. The core issues of emotional distress remain unsolved, hence the persistence of suffering and the chronicity of somatic complaints.

I propose in this chapter that in order to discover the issues underlying the persistent somatic complaints linked to emotional suffering, to start with there must be greater openness and attempts made to create a forum for sufferers of emotional distress which is conducive for discussion and addressing core causes of distress. By such a forum I mean a space (real or imagined) where the sufferer is free to discuss his/her emotional distress, or the core causes thereof, and their grievances, without fear of encountering disregard for their emotional distress, ridicule, or being told of a comparatively worse problem somewhere else. In this forum there should be the open acknowledgement and redress of causes of psychological suffering – including bitterness, anger, frustration, fear, worry, living in misery, and shame – and manifestations of such suffering should be legitimized.

Another step which should be taken is to implement activities in accordance with what people themselves suggest as appropriate for minimising their suffering and dealing with the core issue at stake. For example, fifteen year old Okello and his family could be encouraged to express their problems, grudges, anger, and frustrations brought to the family by 'that man'. They could even be encouraged to take legal steps to seek compensation for their lost income, much as such a step might create more suffering.

To an extent, some protection against emotional suffering existed in Gulu at the time of the study, especially if sufferers had family, friends, and people from their own community around them, or support from voluntary workers. Religious and indigenous healers also played a role in social support. Nevertheless, the socio-economic and political issues facing many people displaced by war desperately need to be addressed, and it will be the return of displaced people to their homes, becoming reconciled with their aggressors, and coming to terms with the severe experiences they were exposed to, which will mark the beginning of the healing process.