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Akello, G.; Reis, R.; Richters, A.

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Silencing distressed children in the context of war in northern Uganda: An analysis of its dynamics and its health consequences☆

Grace Akello [a,*], Ria Reis [b,c], Annemiek Richters [b]

[a] Gulu University, Faculty of Medicine, P.O.Box 166, Gulu, Uganda
[b] Department of Public Health and Primary Care, Leiden University Medical Center, The Netherlands
[c] Department of Sociology and Cultural Anthropology, University of Amsterdam, The Netherlands

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ABSTRACT

Children in northern Uganda who are the focus of this article were born and raised in the context of war. The research presented here is based on a one-year ethnographic study (2004–2005) with children aged 9–16 years. Various qualitative and quantitative methods used in this study were geared to this age group. A grounded theory approach was followed to trace the reasons for the silencing of their distress. Throughout the study a child actor perspective was implemented: children were approached as social actors capable of processing social experience and devising ways of coping with life. We found that their lives were characterized by high rates of exposure to extreme events, such as deaths, child abductions, disease epidemics, gender-based violence and poverty. As a consequence, their level of emotional distress was high. However, they did not readily speak about their distress. The article identifies and analyses a complex set of reasons for children's distress and its silencing by the children themselves and other members of society. A distinction is made between the processes of victim blaming, self blaming, mimetic resilience and mirroring resilience. In addition, the consequences of the silencing children are presented. Children expressed their emotional suffering primarily in physical aches and pains and used pharmaceuticals and herbal medicines to minimize their distress. The result was a medicalization of psychological distress. In conclusion, we reflect on the necessity of a multi-pronged approach to address children's distress.

Introduction

In 2005, the Gulu district of northern Uganda had been in a state of complex emergency and armed conflict for over two decades. The major fighting parties were the Lord's Resistance Army (LRA) and the government army. The violence caused extreme suffering for the population, but during an ethnographic study conducted in 2004 and 2005 among children aged 9–16 years, these children hardly shared their emotional distress. The children in our sample either spent the night in night commuters' shelters for children, were the main caregivers in child-headed households or took care of a sick family member. In their dire circumstances and having to fend for themselves, they mainly talked about physical complaints. Many of them, however, depended on tranquillizers to overcome their sleeping problems (Akello, 2009:109). This detail made us question why children were reluctant to express their emotional distress. The data that generated an answer to this question were mainly collected during the second phase of our research in Gulu.

After a presentation of the methodology, we present our findings in four parts. We start with excerpts from children's narratives, which provide insight into the nature, severity and expression of children's symptoms of distress. The second part describes children's recognition of emotional suffering and their views on coping strategies. These data point to silencing as a dominant strategy to cope with suffering. The third part aims to unpack the various social processes that together comprise the silencing of children's emotional distress. We discuss the role of the community, state actors, intervention agencies and health-care personnel in this silencing. Finally we examine the consequences of the various silencing processes for children's health and call for a multi-pronged approach and ecological approach that recognizes the diversity of children's situations and of the silencing processes.

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* Corresponding author. Tel./fax: +256 4713209613.
E-mail address: Akellograce@hotmail.com (G. Akello).

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Methodology

Our study was conducted in the Gulu district, an area which had experienced armed conflict for 20 years. Due to insecurity, people were displaced from their livelihoods and settled in safer areas of Gulu municipality and protected camps. The main aim of the study was to examine children's illness experiences, medicine use and other coping strategies from their own perspectives. Consent was obtained from the displaced primary schools, night commuters' shelters and World Vision food distribution points for clients in its antiretroviral therapy program, where children were recruited.

The first phase of the study took place from July 2004 to January 2005 and the second phase lasted from July 2005 to January 2006. During the first phase children aged 9–16 years were interviewed, asked to draw timelines and tell their life histories. In a survey using a semi-structured questionnaire children ($N = 165$) were asked to name the illnesses that affected them in the past one month and the medicines they used. A sample of 24 children was extensively followed during both phases for an in-depth investigation. In 2005 qualitative techniques included workshops on severe wartime experiences and coping strategies, focus group discussions, interviews, and participant observation. Key informant interviews were conducted with 2 psychiatrists, 5 nurses, 5 clinical officers, 2 pediatricians, 15 counselors, 28 primary school teachers and 13 clinic owners.

During the study a child actor perspective was implemented: acknowledging that even very young children make sense of and are co-constructors of their social worlds (James & Prout, 2000; Panter-Brick, 2002; Woodhead & Faulkner, 2000), children were approached as social actors capable of processing social experience and devising ways of coping with life. We used a grounded theory approach throughout the research process on the issue of silencing (Strauss & Corbin, 1990).

Ethical considerations

The National Council of Science and Technology in Uganda approved the study. In Gulu district, the Resident District Commissioner, Chief Administrative officer, and District Director of Health Services gave their approval. In schools, permission was sought from the headmasters and when interviews were done in children's homes and night commuters' shelters, we sought consent from the adults who took care of the children.

Children were told about the objectives of the research and the need for regular visits to their homes over a one-year period by the researcher. Children who participated in the research gave verbal consent and expressed willingness to participate by further suggesting joint activities to be done.

All names used are pseudonyms to protect the participants in the study. Some children whose distress was regarded as severe by the first author were referred to psychiatric or psychosocial counseling. Children who were found in dire material needed were given some assistance.

Children's emotional distress in the context of war

Okello's narrative

One of the children the first author frequently interacted with in 2005, and thus had developed a good rapport with, was Okello, a then fifteen-year-old boy. His father had died in an LRA ambush on the Kitgum-Gulu highway in 1995 when he was about five years old. After this incident Okello continued to live in peace with his mother and two siblings. However, in 2000 his mother re-married a retired soldier who had lost his wife to HIV/AIDS. According to Okello, this event was the worst thing that ever happened to him.

> This man [this was how he generally referred to his stepfather] 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's 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.
>
> 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, cups and sugar in a small shop close to home. We had a bicycle before, and this man had misused it 'til it was beyond repair. He also sold our World Food Programme [WFP] card to his debtors, hence making it difficult for us to receive WFP food rations. He 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.
>
> 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 has the same pain, we have resorted to going for prayers at Pentecostal Assemblies of God.

This excerpt shows the complex context of children's lives in a society experiencing civil war. While it was common practice among the Acholi for children from past husbands to be sent away by new husbands and be given back to the mother's original family, the war has aggravated the circumstances in which these children have to live. It has resulted not only in direct loss of life, but also in poverty, a failing healthcare system and the destruction of the social fabric, leading to a lack of support, neglect and sometimes outright abuse of children.

Children taking care of kin with HIV/AIDS

Children who took care of sick kin with HIV/AIDS described symptoms similar to those described by Okello. Six such children participated extensively in the ethnographic study; four of them frequently complained of persistent headaches and bodily pain. Fifteen-year-old Akwero explained:

> 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 in these circumstances were frequently absent from school due to the admission of their relatives to the hospital or because of responsibilities at home. They lived in fearful expectation of the death of their kin. In addition, they met stigmatization on the part of other children both in their community and at school once it was known that they took care of people with HIV/AIDS.

Victims of sexual violence

Sexual violence, in particular rape, also led to deep emotional distress among children. It was difficult to discuss such experiences in the first person, but during the course of the fieldwork it became clear that when girls alluded to 'being attacked' and suffering from a 'stomach ache' they were speaking of sexual violence. One Sunday in October 2005, while attending prayers at Christ Church, the first author was seated with a girl of about fifteen years. She had been quiet throughout the church service, sitting intently and simply observing. When the reverend called for people who needed prayers, she first stood up to go, then hesitated and sat down again. When she was asked why she did not go to be prayed for, she indicated:

I do not feel sick but I am not well. Yesterday as we were on our way to the shelter to sleep there, boys attacked us even though it was only seven o'clock. 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, the girl went to be prayed for. Although the girl never made it explicit that she had been raped, we conclude from other case studies that her mention of stomach pain alluded to this.

Another fifteen-year-old girl narrated how her friend was 'attacked' by three boys on her way to one of the night commuters' shelter:

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 feeling sick, but did not tell any of the administrators what had happened. She only told us, her friends, because she knew we would not tell anyone. People in Bardege [the village where the girls lived] can just keep pointing fingers and talking about you if they hear such stories that boys 'attacked' you.

Children extensively discussed the dangers that young girls experienced when they went to dance at night. They were lured by big men, especially soldiers, to have sex with them, and when they refused, these men simply took them by force. Children argued that nobody would intervene out of fear that the soldiers, whether LRA or government, would shoot at rescuers. They were convinced that reporting rape to the authorities would not lead to action against perpetrators.

Children who committed violence

Some of the children interviewed were former child-soldiers working for the LRA or were 'wives' of commanders. In addition to their violent victimization, their active involvement in violence led to emotional distress. Apio, a girl of about fourteen years, narrated:

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 foodstuff. 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 the man. I killed him on my initiative. Since that night, the *cen* (spirit) of that man disturbs me. In some nights or even during day, he comes with a gun 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.

In the next section we will show how children reflect upon their own and others' suffering and how they feel it should be expressed and dealt with.

Children's views on coping with emotional distress

In order to elicit children's experiences of emotional distress and perspectives on its appropriate management, we used a vignette (cf. Hill, 1997). On the basis of children's narratives collected in 2004, a short scenario about a fictional boy called Otika was developed and presented to seven groups of between seven and fourteen children.

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. Sometimes, when he is sitting alone and you greet him, he does not answer. 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 stays awake, sometimes 'til morning. Some nights he just decides to sit outside.

After the vignette had been read out, children were asked whether they had had similar experiences, how they dealt with them and what advice they would give to Otika. In one focus group discussion a twelve-year-old boy, Ocan, spoke extensively about the vignette, while eight other children nodded in agreement, sometimes laughing or adding to what he said:

Otika has *can* (emotional distress) and *cwer cwiny* (sadness) due to the death of his father, but he is disturbing people for nothing. He needs to be told how other people have 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 the LRA

that she can cry. Still, she first goes and locks herself in her hut and only cries there.
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 drunk with these medicines. In that case he will be able to sleep throughout the night and not sit outside. Otika should be beaten for his constant crying. It irritates people when he keeps on crying and showing people his *can* [given this context *can* implies individual distress which could become collective emotional distress]. But importantly, Otika could be told about people in the army and rebel groups, how they suffer; sleeping in the bush, and that anytime they can be attacked and killed. 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.

Ocan's life history, told on another occasion, revealed that his mother had been raped 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 man, leaving the boy to live with his grandmother.

A thirteen-year-old boy, Oketch, shared 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 the hut owners have thrown away our belongings while insulting us due to failure to pay monthly rent. 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?

Anek, 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* (severe malaria). Children in the Abili camp frequently laughed at us, saying my mother was not ashamed anymore of walking naked where people were. My younger brother Bernard and me suffered a lot during that time. 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 madongo* (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 own experiences of severe emotional distress as follows:

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 the first author to show them where Otika lives].
For me, the saddest moment this year was when our hut was accidentally burnt down. 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 her 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.

From the excerpts from discussions with children presented above, it is clear that children identified and recognized different forms of distress. Children spoke of *cwinya cwer* (sadness), *can dwong ataa* (deep emotional pain), *par madongo* (deep painful thoughts) and *cen* (revengeful spirits). They recognized crying, stomach aches, persistent headaches, sleeplessness and bodily pain as symptomatic of such distress in themselves and others. Children were well aware of the link between such symptoms and the traumatic events and social injustices that they had experienced. However, when discussing how to deal with distress children seemed to agree that one should suffer in silence. In the next section, we will analyze the complex set of social processes that lead to this type of coping.

The role of children and adults in silencing distressed children

In the children's narratives above, evidence suggests that attempts to express and disclose individual emotional suffering were met with indignation, condemnation, irritation, disregard of the victim's emotional distress, and the citing of other's comparatively *worse* experiences. What reasons lay behind children's own strategy of suffering in silence and why did children in general argue against the public expression of emotional distress? To what extent did adults and organizations that aimed to address their suffering support this strategy?

Victim blaming

Based on the content of the narratives of children who cared for kin with HIV/AIDS, we linked their reluctance to communicate about their suffering to their shame connected with this disease. In primary schools, HIV/AIDS was mainly discussed as a sexually transmitted disease. Children were aware of the fact that people who disclosed their positive status ran the risk of being stigmatized as sexually promiscuous and of being accountable for their own suffering. Having a close family member who was ill due to HIV/AIDS meant being related to someone who was sexually promiscuous and thus led to discrimination because of one's association with a stigmatized person. Such courtesy stigma has been well described in the literature, including young children's awareness of it, as well as strategies for non-disclosure to prevent it (Armistead et al., 1999; Murphy, Roberts, & Hoffman, 2002). Children avoided public expression of one's emotional distress related to the care of such a person in order to prevent drawing negative attention to oneself and one's family.

Children also reported victim blaming in relation to sexual violence. Girls who were sexually violated were commonly held responsible for not protecting themselves. Admitting to being 'attacked' amounted to admitting to having willfully involved oneself in sexual relations. All children in the study knew that girls who spent nights at night commuters' shelters were waylaid by soldiers, night commuting boys, and security personnel. However, it was impossible to ask for acknowledgment, let alone retribution, from the organizations that their attackers were part of, despite the fact that these organizations had as their main aim to protect and support the children in their care.

Other data confirm this conspiracy of silence regarding sexual violence against girls: it was well known to exist, but by tacit communal unspoken consensus was neither talked about nor acknowledged (McKinney, 2007). One evening the first author observed a sobbing girl of about twelve years approaching Noah's Ark night commuters' shelter. Five boys about her age followed

closely while laughing. Upon inquiry about what had happened to the girl, she disclosed how she had been 'attacked' by the boys. The first author contacted the nurse and center manager. However, they showed disinterest in taking any action and expressed surprise at her involvement, stating how "such cases were common". One of the center managers outlined the policy of Noah's Ark, 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.

In 2005 UNICEF reported that over 50% of displaced women and girls in the Pabbo camp had been victims of rape and other forms of gender-based violence. The various local stakeholders had mixed reactions in response to this UNICEF report. The district army spokesman based in Gulu called a press conference to categorically deny any army involvement. There was even militaristic harassment of research assistants in the UNICEF study, with soldiers forcing them to make public apologies for their infamous research findings. At the Gulu District Security Committee, only general statements were made by individuals, not by the committee. 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 the Pabbo camp, conditions in Gulu Municipality were conducive for such crimes since girls and boys commuted to night commuters' shelters in the dark and there was no registration of regular attendance of children in the shelters.

To some extent, healthcare institutions that children sought support from reinforced a silencing of distress. A thirteen-year-old girl who repeatedly sought medical attention for stomach ache at Gulu Regional Referral Hospital (GRRH) over a one-year period in 2005 received a diagnosis of hysteria, which was addressed by administering placebo intravenous fluids. The physician involved recognized that the latter approach did not solve or minimize her problem, which was directly linked to an episode of sexual violence. The girl adopted the only legitimate idiom that was available – a somatic idiom – to express her suffering in relation to sexual violence and ended up with the medicalization and trivialization of her problem. McKinney (2007:291) refers to this process as 'psychomedicalization'.

Self-blame

The blaming processes also culminated in self-blame, which made it even more difficult to share experiences and emotional distress. Apio took full responsibility for the killing of an innocent shopkeeper and was haunted by his revengeful spirit (*cen*). Akello, Richters, and Reis (2009) discuss how former child soldiers, many of whom were forced to commit violence themselves, were met by stigmatization and rejection by their communities. Their emotional distress was met by highly ambivalent notions of accountability. The argument was that *cen* as an idiom of distress should be taken serious and that a diagnosis of *cen* should lead to attention to the serious problems that former child soldiers and their communities face regarding accountability for crimes committed by these children. Furthermore, we concluded that the specific blending of Western values and psychotherapeutic approaches, driven by the belief of the essential innocence of children, were not able to effectively address children's own feelings of guilt and remorse.

In order to gain more insight into the processes of professional counseling of children, the first author, on behalf of the administration of two displaced primary schools, invited counselors from Caritas to conduct a session. Nightmares constituted one of the topics discussed. In a dream analysis, one of the counselors elaborated on the causes of nightmares and how to avoid or deal with them. Nightmares were discussed as 'playbacks' of events experienced, seen, heard, or thought about. According to the counselor, such events include the killing and shooting of people but also the fact that children watched and discussed violent videos. The advice given to the children was that it was 'normal' to have nightmares and that people having them should be left alone and not woken up or interrupted. The latter seems hardly an efficient piece of advice to someone who believes that the slain person whose angry spirit visits her in a dream is justified in haunting her.

One day in November 2005, fifteen-year-old Okello was for once visibly happy. He told the first author that he had recently participated in three days of prayer and fasting at the Pentecostal Assemblies of God church. The pastor had prayed for him as well and had instructed him to forgive all those whom he was holding in his heart. He had subsequently forgiven 'that man' for all he had done to him and his family, and was indeed feeling much better. One week later, however, Okello's complaints had returned; in fact, he described his body aches as being worse.

The causes of Okello's anger towards his wrongdoer and Apio's feelings of guilt are well known by the adults and organizations to which they turned for help. Indeed, forgiveness may in many cases relieve distress. However, asking Okello to individualize and internalize problems that are caused by damage to the social fabric far beyond his power amounts to a subtle complicity in the silencing of his emotional distress, for the perpetuation of his complaints could now be blamed upon his inability to fully forgive those who hurt him. Not acknowledging Apio's own feelings of guilt and approaching her as a victim of circumstances does not relieve her from self-blame. The neglect and condemnation of feelings of anger, frustration, and guilt merely caused a translation of these emotions into the local idiom of revengeful spirits and into somatic symptoms. We will come back to this issue in the next section.

Mimetic resilience

The discussions of the children about our fictional boy Otika drew our attention to a rather different process underlying the silencing of children's emotional distress in which children's own moral judgments are implicated. For one thing they condemned Otika's public expressions of distress because, in comparison to others, his suffering was less severe. This judgment was followed by an admonishment: one should compare one's suffering with that of others who suffer in silence. Suffering in silence is considered a sign of strength, a value even more important for boys than girls. Children or indeed adults who stoically confronted or concealed their suffering were rewarded with appreciation and praise.

We propose the term mimetic resilience for this comparative or even competitive way of dealing with one's own suffering, which children describe as a strategy to enhance strength in a person. The narratives of the children and other research data confirm that this strategy is widely supported in the community in general but also by NGOs. For instance, in 2005 Omony was counseled by one of the NGOs. Omony suffered from persistent lack of sleep, disturbances by *cen* (evil spirits), poverty and wartime misery.

> 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 Charismatic believers 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 she also recommended that I tell my mother to organise for the *guru lyel* (last funeral rites) ceremony.

In cross-cultural psychotherapy it is recognized that offering one's own experiences for comparison is not an effective therapeutic approach to help clients cope with emotional suffering (Bankart, 1997; Ivey & Ivey, 1999; Tol, Jordans, Regmi, & Sharma, 2005). The question we will address below is to what extent the public condemnation of distress as a weakness and the call for mimetic resilience in the context of counseling may be the best strategy to apply in a wartime society where suffering is so abundant and professional therapeutic services are not available.

Mirroring resilience

When discussing children's dislike of publicly displayed distress, they alluded to a fourth process, closely related to an urge for mimesis, but in a sense the other side of the coin. We propose the term mirroring resilience for the choice to hide one's distress out of compassion for the suffering of others. Children argued that showing one's emotional pain might cause resonating feelings in others. It is egoistic, inconsiderate and bad behavior to trigger an eruption of collective suffering. One should not make it more difficult for others to keep strong but instead hold up a mirror of resilience to others so that one's own distress does not 'contaminate' others. Interestingly, no support for this particular norm of children's behavior, which speaks about caring for others, could be found in the analysis of data from NGOs and other organizations that aim to address children's suffering. In other words, this 'constructive silencing' does not seem to result from cultural transmission (Cohen, 2002, p. 51–75) as mimetic resilience most probably does, at least to a certain degree.

Disguised expression

Even though silencing of distress was the common strategy, in a prolonged complex emergency the extent of the suffering among children and adults clearly was so great that true suffering in silence was virtually impossible. Churches were the rare places where people converged to let out their grief and suffering. 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 of approximately one hundred people, including children, went to be prayed for.

Another way in which distress found expression was through somatic symptoms. Children who participated in our study frequently complained of physical aches and pains. They regularly used analgesics, medicines for sleep, antibiotics, and herbal medicines such as *atika* plants, but nonetheless their complaints persisted. They advised each other which medicine to buy or were advised by other children, neighbors, family members or drug vendors selling their (counterfeit) drugs in local drug stores or markets. Children went to dispensaries to access the medicines they could afford to buy. Their strategies led to the over-use of medicines for sleep (such as diazepam), antibiotics, chloroquine tablets for headaches and fever attributed to malaria although this diagnosis was never confirmed by laboratory diagnosis. It is evident that over-use of medicines resulted in a great risk of developing drug resistance both at the level of individual children and the population (Akello, 2009).

During this study's data collection process, diagnostic practices at outpatients' clinics in four health centers in Gulu were observed to reinforce these processes. At the time of the study there was no specific space in most health centers in Gulu, nor in the whole of Uganda for that matter (Atwine, Cantor-, Graae, & Bujunirwe, 2005: 562), where emotional distress could be presented and professionally addressed. Overall, clinical officers focused on physical complaints and readily attributed them to malaria. It is likely that their disregard for the emotional distress in their clients was partly caused by the type of professional training they got in listening to, confronting, and dealing with the trauma of war, especially as there were such minimal resources in the community, the legal and administrative systems, and among other sufferers to effectively respond to pleas for help. Needless to say, the community, institutional and district administrators' reluctance and lack of power to address and deal with core causes of distress in the general population reinforced the expression of emotional distress only in the legitimized, somatic way and averted attention from the social, economic, political and moral causes of the suffering involved.

Conclusion

In our study we worked with children who had lived their whole lives in war circumstances and primarily had had to fend for themselves in the context of extreme poverty. Our presupposition that children are co-constructors of their social world proved helpful. Most children contributed to the economic survival of their households through income generating activities. Many were caretakers of siblings or of a parent with HIV/AIDS. Since children in our study seemed to function quite well in their daily lives and did not readily talk about emotional distress, data from the first part of the study suggested a low prevalence of such suffering amongst them.

Children's frequent use of tranquillizers to overcome their sleeping problems alerted us to psychological problems, but it was only after the researcher created safe spaces for them that children overcame their reluctance to talk about their emotional pain. Once children started talking we found, in addition to evidence of their ability to cope with adversity, also evidence of high levels of emotional distress (cf. De Berry, 2004). In this article we neither balanced both kinds of evidence with a quantitative study (Panter-Brick, Eggerman, Gonzalez & Safdar (2009)), nor were we able to distinguish between general psychological distress and severe mental health disorders (Jordans, 2010). Our aim was to understand why children were reluctant to talk about their emotional distress.

Our findings suggest that children in distress were silenced through four different social processes: victim blaming, self blaming, mimetic resilience, and mirroring resilience. Above we suggested some of the underlying causes of these processes. We showed how the expression of emotional distress through somatic idioms leads to negative consequences for children's health and averts attention from the social, economic, political and moral causes of children's suffering. Here we propose that in order to uncover the issues underlying children's persistent somatic complaints linked to emotional distress, there must first be greater openness and attempts made to create spaces conducive for sharing daily problems (cf. Richters, Dekker, & Scholte, 2008). In these spaces (real or imagined) children should be free to discuss their emotional distress and grievances, including their core causes, without being silenced. Research on the psychosocial consequences of the war and interventions for children in Uganda seems to suggest some positive effects of narrative exposure therapy and

other approaches that make use of creative-expressive techniques for specific groups of children (Amone-P'Olak, 2005; Bolton et al., 2007; Onyut et al., 2005). However, in a systematic review of psychosocial and psychiatric interventions for children in war, Jordans, Tol, Komproe, De, and Jong (2009) found the evidence base for the efficacy and effectiveness of such interventions to be weak, as well as a complete lack of research into treatment mechanisms. Furthermore, one has to be cautious to impose Western preoccupations with verbalization and dialogue on other people's ways of dealing with suffering (Jackson, 2004: 55). On the basis of our data no claim can be made that the open expression of emotional distress would have been therapeutic for the children involved. However, ours is not so much a plea for breaking the silence as a healing approach, but as a way for children to be listened to and heard (cf. Roberts, 2000). Our data show that children in Gulu were able to describe their own emotional suffering and that of others, theorize about and discuss the causes underlying them, as well as describe the coping strategies that they devised or that they approved of. It is only through listening to children that we learned about the depth of their suffering, but also about the diversity of experiences of different children and the varied processes that can be at play in the silencing of their distress. Hearing them implies that we recognize the complex structural factors that are at play in causing their emotional distress, e.g., poverty, stigma, neglect, and abuse, all grievances that were explicitly mentioned by children when they described their deep sorrow. Our research therefore calls for the need to ensure that children live in environmental conditions which contribute to ecological resilience (Bronfenbrenner, 1979:27). Other authors write about an ecological approach to the prevention of and interventions for psychosocial and mental problems of children in contexts of war (Betancourt & Khan, 2008; Bolton et al., 2007; Tol, Jordans, Reis, De, & Jong, 2009). Our data also support a multi-pronged approach that recognizes the diversity of children's situations and of the silencing processes that may be involved. A sexually abused girl may keep silent to prevent victim blaming, whereas a girl who grieves the death of her parents may be motivated rather by mimetic resilience. Interventions need to be tailored to this type of diversity and complexity, e.g., destigmatization may be a priority for some but not all children.

The different coping strategies that the children in our study devised evidenced their resilience as well as their vulnerability. Somatization of their emotional distress served as a channel for seeking self-help, but also led to overmedicalization processes that in the long run were detrimental to their health and that of others, and did not lead to structural solutions for their suffering. Mimetic resilience could be one of the appropriate ways of dealing with emotional distress, and in the still fragile post-conflict setting where emotional distress is so abundantly prevalent among children and adults alike, and safe spaces for expressing and gaining acknowledgment for one's grievances are absent, there may be few other options available. Mirroring resilience speaks of consideration for the suffering of others and also in particular of children's competence to enhance the restoration of the social fabric. Again, the somatization of emotional distress and children's tendency to turn to pharmaceuticals and herbal medicine for sleep and nightmares point to the relative ineffectiveness of children's strategies in these particular contexts. On the one hand, support for children should build on their strengths and resilience; on the other hand, we have to acknowledge that some of their coping strategies are detrimental to their own health.

The children in our study did not refer to cultural resources for healing other than herbal medicine and healing churches. To the extent that other cultural resources in the form of, for instance, rituals were available in their surroundings, they were far beyond what was accessible and affordable for them. Although we did find notions in the narratives of the children we worked with, which referred to cultural treatment trajectories they had knowledge of, we found the rituals the first author witnessed in Gulu similarly silencing children's distress. We feel strongly that although it is of importance to recognize the rich Acholi cultural resources for dealing with distress, one should not fall into the trap of romanticizing them.

Finally, our data also call for recognition of the mostly unconscious or subconscious silencing mechanisms practiced by counselors and medical practitioners and the need for a dialogue about the therapeutic efficacy of their interventions and the provision of skills for psychosocial and mental health (Pillay & Lockhat, 1997).

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