

# Children in Africa with experiences of massive trauma





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# Foreword

## **Children in Africa, psychological health related to post-war trauma and AIDS**

The impact of wars and AIDS on children in Africa is immense. Eighteen of the fifty-three countries on the continent are currently involved in, or emerging from armed conflicts. In conflicts where terrorizing civilians has become a routine means to political and military ends, women and children are deliberately targeted for torture and death. Apart from being exposed to wars or even participating in wars as soldiers, there are more than 12 million orphans in Africa today due to the AIDS epidemic. This overwhelming number of needy children has meant that kin support structures can no longer cope.

In recent years, UNICEF, USAID, and many private, voluntary organizations such as Save the Children have developed various types of psycho-social programs to assist children affected by war situations. Yet therapeutic techniques for war-affected children remain at a very preliminary stage of development. More research is needed to find out to what extent western psychotherapeutic techniques, which were originally developed to treat Europeans and Americans' would be appropriate and effective for children in Africa. One concern lies in that the therapeutic techniques used are centred on the individual patient, rather than the family or community, which might be more meaningful in many countries in Africa. It is important to gain a deeper understanding of this field of research, to identify what knowledge gaps exist and what further research is needed.

This report is a review of research on children's psychological health related to post-war trauma and AIDS in Africa. It forms part of Sida's inventory to identify research for possible future support. It examines what has been achieved, points out knowledge gaps and identifies promising research groups and researchers. The review has been carried out by Dr. Suzanne Kaplan, a psychoanalyst with a PhD in Education. Dr. Kaplan has extensive research experience in the field of children with extreme traumatization. She is affiliated to the Programme for Holocaust and Genocide studies, Uppsala University.

Stockholm in March 2005

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# Acronyms and Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
AMREF	African Medical and Research Foundation
AOCM	Association of Orphan Heads of Households in Rwanda
BASICS	Basic Support for Institutionalizing Child Survival Project
CAFS	Centre for African family Studies
CBO	Community Based Organisation
CCF	Christian Children's Fund
CCP	Centre for Crisis Psychology (Bergen, Norway)
CRC	The Convention of the Rights of the Child
CSSP	Child Survival Support Project
CSVR	Centre for the study of violence and reconciliation
ESPPER	Ensemble pour soutenir les projets et programmes en faveur des enfants de la rue.
HHRAA	Health and Human Resources Analysis for Africa
HIV	Human Immunodeficiency Virus
HSRC	Human Science Research Council
IBUKA	The coalition of Rwandan associations of genocide survivors and the Group Project for Holocaust Survivors and their Children.
IRCT	International Rehabilitation Council for Torture Victims
ISTSS	The International Society for Traumatic Stress Studies
MRC	Medical Research Council of South Africa
NAI	The Nordic Africa Institute
NCPTSD	The National Centre for Post Traumatic Stress Disorder
NGO	Non-Governmental Organisation
OASSSA	Organisation for Appropriate Social Services in South Africa
PTSD	Post traumatic stress syndrome

RSC	The Refugee Studies Centre. Queen Elizabeth House, University of Oxford
SAIRR	South African Institute of Race Relations
SAITS	The South African Institute for Traumatic Stress
SAREC	Department for Research Cooperation at Sida
SASPCAN	The South African Society for the Prevention of Child Abuse and Neglect
SAT	Southern African AIDS Training Programme
Sida	Swedish International Development Cooperation Agency
SSRC	Social Science Research Council
STD	Sexually transmitted disease
TCSVT	The Trauma Centre for Survivors of Violence and Torture
UCT	University of Cape Town
UNAIDS	Joint United Nations programme on HIV/AIDS
UNDP	United Nations development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organisation



# Executive summary

## Background

The African continent has been ravaged by internal conflicts and insurgencies in the past decade. Eighteen of the fifty-three countries on the continent are currently involved in, or emerging from armed conflicts. Children in these war-torn countries are often direct or indirect victims of violence, and/or witnesses to various horrors associated with war and are thus so called *war affected* children. Children as young as seven or eight years old are *child soldiers*.<sup>3)</sup> There are also children that are perpetrators, and minors who are in prison. These children are also victims of war and genocide. More than 120 000 children under the age of 18 are currently fighting in African conflicts.

The genocide in Rwanda 1994 resulted in an estimated amount of 400 000 orphans. A majority are *child survivors of the genocide*. Children living in the streets are a consequence of the unimaginable trauma and poverty and the lives in the streets mean additional traumatic experiences. The children are continuously exposed to insecurity and violence. It is important to underline that girls as well as boys suffer, some being forced into sexual abuse at early ages with HIV/AIDS as one of the consequences.

The estimation is that by 2005 nearly a million South African children will have lost their mothers to AIDS before reaching the age of 15. The numbers of AIDS orphans are alarmingly high and needs our attention. We know that the civilian population are not only victims but also are used for strategic purposes when whole villages are affected. The rate of violence in South Africa is amongst the highest in the world. In some areas children become victims of *trafficking*, sexual exploitation.

With the background of the increasing traumatization of children in different war zones there is great need to refine the theorizing about the after-effects of the victims when taking their emotional state and character of the trauma in consideration. The relevance for the PTSD-diagnosis (post traumatic stress disorder) is therefore increasingly questioned. Children affected by war must not be stigmatized as permanently damaged (Summerfield 1998). Within the psychological realm the main efforts today are to find structures for the reintegration of vulnerable children.

## **Aim**

This study has been commissioned by Sida in order to assess important research relating to children with massive trauma in Africa; identify research gaps as well as promising research groups and individual researchers within this field. Current trends in research concerning models for trauma treatment and reintegration of vulnerable children in Africa, as well as scientific methods used will be illuminated.

## **Findings**

A major conclusion is that research concerning trauma treatment models developed for children in Africa is extremely limited. Research groups with this focus are few. The main part of research is carried out in South Africa where a more developed infrastructure and a higher number of academic researchers exist in a wider range than most of the other African countries. Moreover research has so far, with few exceptions, been concentrated on descriptions of post-conflict living conditions with the aim of mapping out the situation for children exposed to violence, illness and death. Models for prevention of violence e.g. preventive projects at schools, has a high priority and psychosocial programmes with this focus have been carried out in some areas. Violence against girls in schools needs special attention.

Regarding AIDS there is a need for longitudinal studies and it has been stressed that it is inadequate to simply assume a direct relationship between a parent's AIDS-related illness or death and the psychosocial health of their children. There is clearly a need for more rigorous and systematic research aimed at establishing (1) whether AIDS orphans are in fact at risk for psychosocial adjustment difficulties, (2) the lines of causality or mediating processes for any symptoms we see, and (3) the protective factors that might facilitate resilience and successful adjustment in children and can be targeted in intervention programmes (Wild, 2001).

There is a growing interest for interdisciplinary aspects of understanding the roots of genocide as well as the consequences for the traumatized. Studies of affect regulation of the victims and specifically the mental experiences of children are underrepresented in research. Literature on risk factors shows that growing up in poverty is the single most powerful negative influence on psychological development (Donald, Dawes & Louw, 2000; Staub 1999).

There is also a lack of research concerning children and youth exposed to sexual abuse. There are major gaps both in terms of prevention and intervention research.

## **Recommendations**

Realistic and non-prestigious research on evaluating and integrating "western" trauma therapeutic models and African "traditional healing" methods to improve the psychological health of vulnerable children in Africa should be emphasised.

There is a need for longitudinal follow-up studies for at least 10 years, to evaluate treatment models for trauma afflicted children and to be able to see the consequences for the next generation.

Six main areas of research can be recommended as priorities for African research on trauma treatment. Examples of promising research are given.

1. *Integration of treatment models* – western psychotherapeutic and traditional healing. Psychologist L. Wamba (Maputo, Mozambique)

has worked therapeutically with child soldiers in post-war Mozambique ('Rebuilding hope' 2004) and B. Efraim Junior and I. Omar (Maputo, Mozambique) focus on *effectiveness of psychotherapy* with former child soldiers ('Rebuilding hope' 2003–2005). The results of these research projects could also be useful as models for other countries and might lead to development of new projects with child victims of violence, not only military, but also rape, sexual violence and criminality. Building networks with western researchers presented in the special paragraph about child soldiers (below) might be fruitful.

2. *Developing structural interventions* in schools are of great importance. Works of E. Jacobs (TCSVT, South Africa) and J-P. Dusingizemungu (Université Nationale du Rwanda) are promising.
3. *Longitudinal studies of trauma treatment* for child survivors of genocide (Rwanda, Sudan) are of great importance. There are almost no current examples, but Wessel's work in Angola (1996) with war-affected children might serve as a research model. Focus should be on the individual's emotional development.
4. *There are efforts to strengthen the attachment between women and their children* born as a result of rape during the genocide in Rwanda. One project is directed by M. Balikungeri ('Rwandan women community network development'). More research is needed.
5. Concerning *AIDS orphans*, Wilds research (UCT 2001) about the current situation for these children and the need for future research are of importance. *Psychological counselling for children affected by HIV/AIDS* is an important project planned by B. Efraim Jr ('Rebuilding Hope', Mozambique 2004).
6. The areas of *prevention of rape and sexual abuse* of children as well as therapeutical support for children that are victims of rape and sexual abuse are important. B. Efraim Junior (Rebuilding hope projects 2004) project in Mozambique can be mentioned here as a good example.



# Background

## **Children in Africa**

The African continent has been ravaged by internal conflicts and insurgencies in the past decade. Eighteen of the fifty-three countries on the continent are currently involved in, or emerging from armed conflicts. Violent conflicts have devastated countries such as Angola, Burundi, Congo-Brazzaville, the Democratic Republic of Congo, Liberia, Mozambique, Rwanda, Sierra Leone, Sudan and Uganda.

Fifty percent of the population of Africa is under the age of 15. Children in these war-torn countries are often direct or indirect victims of violence, and/or witnesses to various horrors associated with war and are thus so called 'war affected children'. Angola is one of the countries that have an especially high number of landmines relative to its area, with mutilated children as a result. Children as young as seven or eight are often forced to become 'child soldiers' in the countries mentioned above. New technology has provided weapons that weigh less to "suit" these children. The methods used are many times particularly grim. The Henry Dunant Institute (1998) indicates that methods used by military forces include taking the children back to their home villages and forcing them to kill one of their relations and thereby making future reintegration impossible (Nilsson 2001).

Globally there are at least one million children separated from their parents because of war, and there are at least 300,000 children who are currently serving as soldiers and guerrilla fighters. More than 120 000 children under the age of 18 are at present fighting in African conflicts. Under current international law, children can be legally recruited and deployed in war from the age of 15. The Convention of the Rights of the Child (CRC) obligates states to take all feasible measures to ensure that persons under the age of 15 do not participate in war (Taylor 2000).

Children living in the streets are a consequence of the unimaginable trauma and poverty that the high number of African children experience. The lives in the streets also mean additional traumatic experiences, as for children after the genocide in Rwanda. These 'street children' are continuously exposed to insecurity, poverty and violence (Dyregrov, Gupta, Gjestead & Mukanoheli 2000). It is important to underline that girls as well as boys suffer, some being forced into sexual abuse at early ages leading to massive trauma often with HIV/AIDS as one of the consequences. In many cases they become victims of 'trafficking', sexual

exploitation of children, as in Cape Town, South Africa (Koen, Van Vuuen, Anthony 2000).

There are more than 12 million 'AIDS orphans' in Africa today due to the AIDS epidemic. It is stressed that children who have lost one or both parents to AIDS also face more problems than other orphans. They have to grapple with stigma and discrimination often associated with AIDS. According to UNAIDS, these children are at greater risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes. But this conclusion is strongly questioned. Longitudinal studies are required to get a broad picture of the long-term effects of AIDS orphan hood on the well-being of these children and youth (Brey 2004).

The overwhelming number of needy children has meant that earlier support structures no longer cope. Traditionally, children in many African countries would be taken care of by relatives if their own parents passed away, but this is no longer the case. There is often no longer a family network available into which they could reintegrate. In recent years, UNICEF, USAID, researchers from western psychiatric units and many private, voluntary organizations such as 'Save the Children' have developed various types of psychosocial programs to assist children affected by war in the countries mentioned above and/or who have been orphaned due to AIDS.

### **Point of departure**

My point of departure is psychodynamic with an accent on mentalization (Winnicott 1971, Fonagy 2002), i.e. creating a psychic space in order to express trauma related emotions and – social psychology as when investigating factors preceding genocide (Staub 1989) and factors facilitating reintegration (Verhey 2001). Working through both feelings of desperation and thoughts of revenge may change the self image and attitudes of vulnerable youth. In my view, symbolizing is needed to diminish anxiety driven behaviour. Research background concern children growing up with experiences from genocide (Kaplan, 2002, 2005).

I have assumed that extreme traumatization at the occasion of the traumatic, unexpected abnormal event is *experienced* in similar ways, regardless of culture. Each individual's vulnerability, personal life history and culture nevertheless has bearing upon how one *regulates anxiety* in connection to the traumatic moment and afterwards. This view applies especially to man made trauma and to a lesser extent natural catastrophes. Sgoifo et al.(1999 in Schore, 2003) write about how social stressors are far more detrimental than non-social aversive stimuli, and therefore attachment or "relational trauma" from the social environment has more negative impact upon the infant brain than assaults from the nonhuman or inanimate, physical environment.

There is an increasingly accepted view of memories as something not stored statically, but as something changeable. Central terms within current research are *symbolizing* and *mentalizing*, understood as mental processes, transforming bodily/affective experiences into mental representations. I value contributions from cognitive memory research (Damasio 1999, Schacter 1996). Experiences from Holocaust survivors show that from time to time survivors suffer from their memories. Schacter (1996) emphasizes the impact of "memories that keep coming back". Emotional traumatic memories can be "vividly, intrusively, and repeatedly recollected" (p.195). The feeling of being constantly controlled

by memories in this context probably even contains aspects of introjection of the persecutor's attitude towards the survivor. "Failures to forget can sometimes be even more disabling than forgetting itself" (Schacter 1999, p.38). Survivors either want to be able to work with their memories or to be able to forget them.

Traditional healing rituals such as purification bring together a series of symbolic meanings aimed at cutting the child's link with the past (the war) – i.e. the past is locked away which might go together with Schacter's (ibid.) conclusion. Simultaneously a space for a retelling of traumatic events and contents of dreams is provided, that may go together with western psychotherapeutic practices that emphasize verbal exteriorization of the affliction.

In carrying out this desk study, information has been gathered through searching data bases, via internet and visits at data centres (NAI, ICRT).<sup>ii)</sup> Interviews have been conducted with researchers to get updated information in this important field of research that seems to be in its very beginning. I am grateful to their contributions<sup>iii)</sup> as well as those who have given me extensive answers per email. The report does not claim to give the whole picture and there are most likely research that have not come to my attention. Only few research reports concerning trauma treatment models for children in Africa have been found on the well established PubMed and Cochraine search engine. My hope is that major themes will be enlightened and may serve as a guide to further investigation. I will start with some general considerations on psychotherapy research (Introduction to the research area) that I find relevant to bring forward in this context.

# Aim

This desk study concerns psychological health of African children related to post-war trauma and AIDS. It has been commissioned by Sida to assess important research relating to children with massive trauma in Africa; identify research gaps as well as promising research groups and individual researchers within this field. Current trends in research concerning models for trauma treatment and reintegration of vulnerable children in Africa as well as scientific methods used will be illuminated.



# Introduction to the research area

## **The trauma concept**

During the past 25 years, western psychotherapists have become increasingly concerned about understanding the effects of trauma and violence. The concept of trauma has its roots in the medical term for wound, and mental trauma is a symbolization for bodily injuries and is defined as an event that overwhelms the individual's coping resources. It is generally used for a variety of overwhelming events in everyday life, but also includes natural catastrophes such as earthquakes and man-made violence such as war and concentration camp experiences. It is essential to emphasize that man-made trauma especially evokes feelings of *humiliation*.

The three main characteristic symptoms of post traumatic stress disorder (PTSD) are (Michel, Lundin & Otto, 1992):

1. Re-experiencing, so-called 'flashbacks'
2. Avoidance of everything reminiscent of the trauma
3. Exaggerated vigilance and loss of memory

A study was conducted with 105 children of school age, who were affected by the terror of RENAMO in Mozambique (Boothby, N, Sultan, A. & Upton, P. 1991, in Hjelm 1997). The following PTSD related symptoms were described:

Nightmares	78%
Recurring nightmares	75%
Concentration difficulties	62%
Mental fatigue	46%
Guilt feelings	54%
Depression	83%

## **Limitations of current concepts**

In recent literature, the concept of trauma does not have a clear and well defined meaning. The concept is used for different experiences of mental strain. Many researchers today also stress the limitation of the concept PTSD saying that other similar syndromes should be recognized. The most fundamental principle is that recovery over time is linked to social and economic networks, cultural institutions, and respect for human rights (Bracken et al.1995).

There is a risk of getting stuck in established diagnostic systems of mental massive trauma. With the background of the increasing traumatization of children in different war zones – where we know that the civilian population are not only victims but also used for strategic purposes when the whole village is affected – there is great need to refine the theorizing about the after-effects of the victims when taking their emotional state and character of the trauma in consideration. Moreover the experiences from using the label PTSD concerning children is limited (Hjelm 1997).

Varvin (2003) gives an extensive overview of the concept of trauma and the key concept PTSD and stresses that trauma has not a clear and well-defined meaning in psychoanalytic and psychiatric theory and that the loose use of the term reflects basic conceptual problems. A psychiatric diagnosis may even be counter-productive for the victims' possibilities of regaining their self-esteem (Becker in selected papers, referred to in Hjelm 1997). Green & Honwana (1999) also stress the problems using the PTSD-concept in this context – especially the notion of post (past). In many areas it is a question of on-going continuous trauma (The Traumatic Stress News 2004). The PTSD-concept is increasingly questioned, especially its relevance for communities in the non-western world as well as the limitations of western psychiatric models used. There is an ongoing debate of the necessity of a reconceptualizing of the sequelae of trauma (Bracken, Giller & Summerfield, 1995; Kagee & Naidoo 2004; de Jong 2003; Igreja, V., Schreuder, M., Wim, Chr. & Kleijn, M. 2004). Wamba & Mahoney (2004) reminds that 'collective trauma like war are more than the sum of their individual effects' and something more than individual help is thus needed. There is today a growing professional interest to learn more about cultural differences as a base for conceptualization.

### **A single traumatic event, cumulative trauma and continuous trauma**

One may differentiate between a single traumatic event, like e.g. when a child is being attacked and humiliated at the school yard by a gang, where caring adults may be available and thereby help the child find words for what has happened – and on the other hand prolonged, repeated trauma where the victim has no access to such psychic space, like in genocide. In the first case it is possible to talk about what happened, to work through the event. In the second case, children could only register what happened in the form of a panicky feeling in the body. "You didn't think" is an often heard comment from the victims. An interruption of thinking occurred. In such cases a perceptual image or sound like the perpetrators voice could be imprinted in the body and it is hard to leave the event behind as a memory in the way we use to think about memories. Instead, it remains as an inexpressible sense of discomfort in the body (Kaplan 2003). To this differentiation we should add the further complicating circumstance – ongoing continuous trauma (Green & Honwana 1999). Many children have no other experience than living in political conflicts and being witnesses of violence and death and this adds a new dimension to trauma theory. Punamäki (2002) underlines how trauma impacts on developmental tasks throughout childhood.

## **Extreme traumatization (cumulative trauma, continuous trauma)**

Extreme traumatization may be described as events in the life of the survivor that are defined by such intensity that the individual cannot encounter them adequately. The mental structure is torn apart during a long time period. Freud (1920) and many of his followers visualize the trauma process by using the concept 'protective shield', a barrier between the outer world and the inner mental life that is perforated from psychic overload. In this context one may suspect that the time concept and the time related memory function also are hurt. It is as if the trauma did not happen a long time ago, but again and again every day. In the war torn developing countries, this is also the reality. Based on years of experience from interviews with survivors, researchers have clearly shown how a split in the self occurs as a result of the difficulties in dealing with massive trauma. Laub & Auerhahn (1993, p. 291) describe this phenomenon by showing how fragments "are recalled without the individual knowing that the 'I', or the subject who experienced the event is different from the one who recalls it" – "there is a collapse of the two at the moment of recall, with no reflective self present". The past and the present exist simultaneously within the experienced self. Hessel & Levin (1995) emphasize the currently established concept dissociation (i.e. split in the self) that often has been described as an effect of breakdown in the time sense of the traumatized person. They mean that the feeling of unrealness that is often described by refugee children who come to Sweden, seems to be relieved when the dissociative material becomes integrated in one's own life history.

## **Western psychotherapeutic methods and traditional healing**

When examining trauma treatment models for children in Africa, you first come across questions about psychotherapy research in general – views on different kinds of western psychotherapy methods as well as research scientific methodology which in its extension might mirror individual views of human beings and the power of cultures.

Western psychotherapeutic methods are characterized by two main ideas. The psychodynamic perspective emphasises understanding connections between underlying themes in one's life history, i.e. context and meaning, while the cognitive perspective underlines changes of maladaptive behaviour via modifications of thought and behaviour.

'Debriefing' as a western therapeutic method is increasingly questioned. Inappropriate exporting of Western culture may cause additional stress, claims Summerfield (1995). Summerfield describes how projects using debriefing as a method, for instance in Rwanda could be like a 'social movement'. It was carried out without prior consultation with the refugees themselves or knowledge of their cultural norms or frameworks for psychological health. He points out that in Africa the experience of war: "is a collective one; processing it is a function of what it means or comes to mean". In the Rwandan case this will be coloured by what previous massacres have come to represent in Tutsi and Hutu social memory and the coping strategies used then. Instead of working on an individual level, Summerfield says: "projects should primarily target the impoverished social context of the survivors". This statement is discussed by Dyregrov et. Al. (2002). They question the validity of this description, and stress the importance of introducing the trauma concept within UN and NGO's. Such concepts increase the understanding and awareness of the effects. They give example from Rwanda's "week of mourning", initiated by UNICEF.

Simultaneously there is evidence for both psychological relief and structural, biological changes already after one session of narrating the traumatic events (Edelman, Damasio & Pennebaker, 1997). Trainees within a project concerning war affected children in Angola were encouraged to talk about their own war experiences before supporting the children. They were asked: ‘What was the worst thing that happened to you?’ Trainees often commented that the opportunity to step back and reflect on their own experiences was one of the most valuable parts of the seminars provided (Weesels & Monteiro in Donald et al 2000). Maybe the main concern is the question of ‘timing’ and a safe context. From a psychodynamic point of view, a good result of the treatment approach is that the victim can feel the pain and that a mourning process has started. This goal may create difficulties in evaluating e.g. finding variables for the effects of debriefing. What appears to be a degradation in health is in fact an improvement. This complication is an important topic that should be further investigated.

The interest in the cultural dimension of psychology is growing. Madu, Ntomchukwu (eds) Baguma, Kakubeire (eds) Pritz (ed) (1996) write about healing in different African countries – Nigeria, Tanzania, Botswana and Uganda. Wamba & Mahoney (2004) shows how western psychotherapeutic research might have knowledge to provide that may serve as an appropriate additional part to approach healing in Mozambique. The authors refer to among others Errante’s work (1999) that has revealed the necessity of rethinking our understanding of trauma and psychotherapeutic intervention.

Rudnick (2000) presents an overview of how contemporary psychology is linked to traditional healing. He underlines that there has long been a fascination by selected western therapy practitioners in traditional healing, and refers to Straker (1994) and Willis (1986). There are in this method important strivings for therapeutic relief through *purification* (Hjelm 1997; Wamba & Mahoney 2004). The purification rituals include washing away the bad spirits, for instance in the treatment of child soldiers. The meaning of this process might have a symbolic connection to expressions used by Holocaust survivors as well as victims of sexual abuse in the western countries: “I showered for hours – I needed to wash away the words” (wash away the feeling of being humiliated, wash away the voice of the perpetrator). A Rwandan boy said “How do people outside Rwanda see us here – like strange animals?” (Kaplan, 2005) The self image seems hurt. Perhaps in this sense it doesn’t matter whether you were a perpetrator or a victim. It is like having been contaminated by the crime or identified with the aggressor.

Reynolds (1989) as well as Dawes and Honwana (1996) have written about traditional models for understanding mental problems. In the purification process of former child soldiers, people of the whole village gather. Clothes and things the child has carried as a soldier are being burnt and the child is literally washed so that the past is left behind and a new life can start (Hjelm 1997). Telling dreams plays an important role as in psychodynamic western methods. Body treatment is often a part of the healing method. Winnicott’s theory (1971) about a potential mental area that constitutes a bridge between isolation from and closeness to the mother might have a generality across cultures when dealing with children’s reactions to brutal separation from their parents and their community network. In addition to this mental space, to have one’s body taken care of by a person who is prepared to listen, as in traditional healing, might provide an optimal trauma treatment. Western psycho-

therapeutic methodology may have much to learn from healing rituals as we might need more mental (helping) structures of symbolizing to reach what is not always possible to verbalize after major trauma. Bracken et al (1995) claim that the western separation of the psychological from the somatic and cultural is problematic.

Sandell (2004 with ref. to Wampold, 2001) discusses critical factors within the western psychotherapeutic approaches – “technique or relation”? He enlightens two current models, ‘the medical model’ and the ‘contextual model’. In the first model, the idea of the technique is determining the cure. In the second model the technique is also considered but is subordinated to the character of the relationship between therapist and patient in the long run. The ‘allegiance’ – the therapist’s loyalty or attachment towards the therapy model used, proved to be one of the most important factors in both models and has thereby a decisive role even if that kind of factor is seen as irrelevant in the medical model. The question of evidence-based research in the field of psychotherapy is also discussed in this context. One may even question if quantitative research is the most appropriate when psychotherapy effects are studied.

Research on child development in high-risk environments has historically been driven mostly by positivistic forms of inquiries. This approach has recently been challenged by the method broadly known as ‘social constructivism’ (Donald, Dawes & Louw 2000).

Current discussion concerning the constructivistic view on children’s development and mental health in political conflicts show that the concepts ‘meaning’ and ‘context’ are essential (Hjelm 1997) The cultural dimension may be related to the ‘contextual model’ described by Sandell (ibid). A creation of a mental space for the traumatized individuals in groups or separately where a *trustful relationship* based on cultural knowledge is the basis, would be productive. Some authors underline that it is fundamental to consider cultural aspects whilst others are critical to an over-emphasis on the significance of cultural aspects. Donald, Dawes & Louw (2000) note that there are many things in developmental psychology that has universal applicability and “it would be foolish not to incorporate what has been learned in other contexts and it is equally important to search for models that are most relevant in the cultural context of African countries”. Dyregrov, Gupta, Gjestad & Raundalen (2002) raise the question a bit provocatively in their title: “Is the Culture Always Right?”. The authors discuss whether the ongoing critique of western models in the trauma field reflects a continuation of the denial of trauma and PTSD that has been evident for a number of years. They argue that *denial* has become a central concept – parental denial, UN agencies’ denial, psychology professionals’ denial etc. The context has to come into consideration, especially cultural traditions for preventing long-term traumatic stress, but not be over-emphasized. The authors view aspects of trauma as universal, and claim that you have to rely on children’s inborn resilience – “children are hurt just the same”. The conclusion is that one works closely with national counterparts to secure a sensitive application of methods, as well as a mobilization of the culture’s own natural healing system. But on the other hand “Culture is not static; it is a dynamic changing entity”, it is claimed, and we should not adopt a cultural aspect uncritically. There could be aspects that affect children negatively and simultaneously we should also look upon what we see as negative (Dyregrov et al, 2002).

In this context it is important to see that we, as in all war torn countries, mainly have focused on adults and tried to transfer knowledge from

therapeutic work with adults to children instead of developing child focused treatment models (Walaza 2004). Documentation of the fate of the children from previous wars and genocides (Dwork 1991), show that children have been seen as appendages of the mothers and not as individuals in their own right. Both the world at large and the child survivors themselves, paradoxically, do not seem to have viewed the psychological issues of the children who survived (in i.e. the Holocaust) as far-reaching as the adults' problems. Child survivors have only been given any greater degree of attention in more recent years.

### **From describing 'the problems' to finding 'solutions'**

There are an increasing number of research reports today where the focus seems to be on a description of current living conditions for the children exposed to various types of trauma. However, African researchers now stress the importance of going from describing the 'problems' to finding 'solutions' (Donald, Dawes & Louw 2000). Main focus seems to be on *community-based interventions* but there are often major difficulties to conduct controlled studies due to chaotic situations (Dawes 2004). Limitations in field work have been necessary in some cases and some projects are currently on hold due to security concerns. Moreover there is repeatedly an emphasis on taking the cultural context into consideration.

Within the psychological realm the main efforts today is to find structures for the *reintegration* of vulnerable children. Reintegration seems to be the key concept but there is simultaneously a need of focusing on children's emotions within future research (Honwana 2004). This approach coincides with Keilson's results (1992) from studying Jewish child survivors that lost their parents. The most interesting aspect of his results was that the extent to how the children managed life after the war was not dependent on the kind of trauma they were exposed to during the war, but how they were taken care of afterwards.

One major conclusion is that research concerning trauma treatment models for traumatized children in Africa is extremely limited. Research has so far, with few exceptions, been concentrated on descriptions of post-conflict living conditions. During the last few years, efforts have arisen of trying out possible models for reintegration of vulnerable children that also has taken the children's psychological state into account. Many of these reports demonstrate a concern to integrate western models with traditional healing models.

### **Trauma treatment models and the reintegration of vulnerable children**

Green & Honwana (1999) stress that the therapeutic technique is questionable if centered on the individual patient. Such focus may ignore local beliefs and undermines family and community involvement.

Many authors note the difference between western 'egocentric societies' with the focus on 'talk therapy' and other less 'egocentric' or 'sociocentric' societies (Bracken et al 1995). On the other hand we may question whether the so-called western 'egocentric' societies are in accordance with the human beings natural way of acting or if it is a result of structural changes in these societies. Most probably, the basis for a mentally healthy condition is the maintenance of important links to significant individuals – generational linkings ('sociocentric') in contrast to trauma linkings in the cases of war-affected children and AIDS orphans.

These concepts are further described in research about children in genocide (Kaplan 2002). Donald, Dawes & Louw (2000) stress that we

have to accept the need to search for universal developmental processes that are subordinated to cultural differences. At the same time transcultural psychiatry is now well established practice in many western countries.

Green & Honwana (1999) conclude the need of integrating different approaches. Interventions may be cross-scientific with the focus on anthropological, psychological, medical and/or juridical levels. One comparative study concerns the reparation in the light of transitional justice in southern Africa (Buford & Van der Merwe 2004). Important work in ethnography of children and youth related to labour, healing, ethics, state violence and political actions is also carried out (Reynolds 1989, 1996, 2001).

Described below are some categories of interventions found in the literature with possible therapeutic effects from the individual to the societal level:

- Support child-mother attachment, when the child was born as result of rape.
- Psychodynamic child psychotherapy, individual or group – western models
- Cognitive and/or behavioural, individual or group – western models
- Psychiatric treatment/medical model
- African traditional healing rituals
- Psycho-social models/building networks
- Psycho-education/supporting trauma counsellors, radio programs
- Preventive work/prevention of violence
- Education/supporting school teachers/ structural changes of schools
- Reintegration/reunion, resocialization – family and community level
- Reconciliation and reparation/societal level

‘Eye movement Desensitization and Reprocessing’ (EMDR) could also be mentioned. It is a recently discovered treatment method using bilateral stimulation when processing traumatic memories in patients with PTSD. Oras et al (2004) find positive effects of this method in combination with child psychotherapy.

It is, as stressed above, of great importance to clarify concepts, labels and expressions used. There is a range of childhood adversities in Africa and a scale of different interventions by a range from academics to practitioners and the categories of interventions may overlap. The term ‘program’ and the term ‘project’ may be used interchangeably and the term ‘intervention’ connote the actual activity, says Donald et.al. (2000), who stress that ‘the growth of psychological capacities is a highly complex process’.

Western researchers emphasize the discovery of how their preconceptions of the socialization processes in the different African countries differ from what it may look like in reality. Non-western concepts of western mental health are investigated and described by Honwana (1998) which may be helpful in future efforts in integration of different approaches. Furthermore, chosen concepts may tell us something about how we conceive the psychological phenomenon we wish to describe. As an example Wessels & Monteiro (Donald et al 2000) and the CCF/ Angola team they worked with, never spoke of “trauma”. They preferred to use the term war-affected children. Another example comes from Solheim (2003) describing the change from having used “former child

soldiers” in Sierra Leone as the label of her key informants, to “young ex-combatants” that told her more about the common view among the Sierra Leone society. Armed conflicts use children as weapons and/or targets and there are difficult borders to draw, she stresses, between civil war, social exclusion such as ethnic cleansing of political and economic causes and genocide. Another cultural expression is “fighting their brothers” meaning: “they are fighting within the territory of their society and without any structure of rules”.

There are similar concepts used for defining the road to well functioning post-conflict societies. One expression used is “sensitizing” the people, used in Rwanda to reach reconciliation, reunion, reintegration or re-socialization. A teenage boy, whose parents were murdered said with a gesture to his chest: “In my heart, the sadness and the anger will always exist. I will not be able to reconcile, but to accept”. Maybe acceptance is a better word than reconciliation (Kaplan 2005).

Supervision of local trauma counsellors by professionals living outside of Africa without knowledge of the cultural context may raise problems (Perlman 2004). Psycho-educational lectures on the origins of genocide, the psychological impact of trauma, avenues to healing, and the prevention of future violence (Perlman & Staub 1999) may on the other hand be very productive as has been shown in Rwanda. Yule (2002) underlines the different levels of interventions that the ISTSS/UN spells out, among others: Children’s right to attend school, safe play areas, teachers’ new ways of responding to children’s stress and youth leaders getting basic counselling. Radio programs can serve as a channel for psycho-education as has been important in Bosnia and also in Rwanda (Staub & Weiss 2004).<sup>iv)</sup>

## **Research about children**

The main question according to Walaza, HSCR, (2004) is: “What are the models that are appropriate for the child population”. The youth that has received therapeutic interventions could in “retrospect communicate what has been useful to them”, she suggests.

The overall impression is that research concerning therapeutic techniques for traumatized children in developing countries, remain at a very preliminary stage of development. It is not known to what extent western psychotherapeutic techniques, which were originally developed to treat Europeans and Americans’ would be appropriate and effective for children in Africa. One concern is that the therapeutic techniques used are centred on the individual patient, rather than on the family or community, which might be more meaningful in many countries in Africa.

There are different levels of encountering the children, directly or indirectly: grass-root level, through NGOs, academic research and on a political level. The efforts so far seem mainly to be focused on psychosocial programs and education, working through the adults but seldom with the focus on the child’s emotional state. It is more difficult to receive data from children as you also have to involve the adults surrounding the child. Also, to study results of psychological treatment/healing, you usually have to focus on children who are referred to some kind of psychological treatment, or in other cases reflect upon “what categories of children with what kind of distress does one select for treatment and how may this be communicated in a way that is comprehensible to people outside the profession (clients, third-party, donors etc.)” (Sandell 2004b). This may also connect to the question of research methodology



– quantitative, qualitative or theory generating method. Language is an issue to deal with in relation to communicating the results. A descriptive language might be important. Sandell stresses the following viewpoints:

- How to find a system for clarifying (making visible) something you want to communicate?
- What do you do with the children (interventions)?
- Why have you chosen to do exactly these interventions?
- What progress do the children make?
- What does it cost?
- Who will gain?

Experiences from war affected countries outside Africa may give good examples that can be used also in Africa. Some studies are carried out with refugees in western countries (Hjern 1995, 1997) and the result may be applicable for refugees within developing countries. Some studies are carried out with adults but may be useful for trauma treatment of youth according to Dyregrov (2004).

Most trauma treatment research in Africa seems to have been carried out in South Africa maybe due to appropriate infra-structure and a wider extent of professionals in the psychological field than in other African countries. However, racial segregation might have influenced the previous research possibilities in South Africa. Now, since the middle of the 1980s an increasing number of black psychologists have graduated (Nicholas and Cooper 1990 in Donald, Dawes & Louw 2000). However, the orientation in research has been Euro-American and limited to a small number of university positions and government financed research such as HSCR. Donald et.al. claim that the most urgent need of all is ‘the relationship between research and intervention’ – possible ways of moving forward in the study of child development.

### **Next generation**

The children have in common that they are ‘perforated’, both physically and mentally by being exposed to violence, illnesses and death – the mental shield can be said to be full of holes as a result of an invading of the senses. Mental development may have become complicated, particularly because children were the victims. Many children have been forced to become adults precociously and actually were never able to be children or teenagers with access to parental care that they could internalize and transfer to the next generation in an optimal way. These children are parted from natural role models within the family and in their natural social network. They may have problems in maintaining the feeling of having inner links to significant persons and how these inner links may serve as a life-line to allow the creation of links to the next generation. Another aspect that seems to have a generality, especially for those who were children during the traumatization could be added. Child survivors often communicate of how they felt ‘old’ as children and as young adults taking responsibility for their parents and siblings, and ‘like children’ when they became adults with difficulties in their parenting function. Child survivors have often felt that their age is not their chronological age, what I call ‘age distorting’, which might affect future child bearing (Kaplan 2002). The psychological phenomena age distorting has also emerged in life histories of AIDS orphans. They have become “parents” for their younger siblings for example in South Africa. After the genocide in Rwanda, there are more than 50 000 orphan Heads of Households

where the oldest sibling in the family takes care of the younger ones (Miller D. & L. 2004).

Another aspect is that it seems not to be a part of the culture in many African countries for parents to talk with their children about their emotional reactions to trauma. The children are largely excluded from the grieving process. The younger children may be taken in by relatives “sitting on the mattresses” and indirectly take part of the grieving. Children as old as 10 or 12 years are considered too young to understand. Teenagers that spend more time by themselves do not get such an indirect possibility. They are expected to act as grown-ups which might be a great demand after extreme traumatization and nobody discusses feelings with them (The Traumatic Stress News Letter 2004). Other studies from war affected countries has also shown that teenagers suffer more. An investigation in Cape town shows that pre-school boys and teenage girls suffered the most after an attack of political violence in their neighbourhood (Dawes, A. Tredoux, C. & Feinstein, A., 1989 in Hjelm, 1997).

The psychoanalyst Fonagy (1994) takes as his starting point that a kind of alienated self exists in us all. This is the consequence of normal caretaking with its inevitable deficiencies. During normal development this self is covered by other self-images that a normally functioning person can create from good new experiences. The alienated self becomes most dangerous when later traumatic events in the family or the close surroundings force the child to dissociate, split off a part of the experienced pain by using the alienated self for so called identification with the aggressor – meaning that the pain is replaced by a self-image where the aggressor is taken into oneself in order not to feel so much pain. In these cases the covered deficiencies in caretaking – the empty spaces – will be filled by images of the aggressor and the child will experience itself as destructive and in extreme cases, as monstrous. Mentalization is the mental process within the individual that transforms bodily/affective experiences into mental representations i.e. memories that we can reflect upon. The probability to survive psychological damage/humiliation increases if there is free availability of one’s own thought space to work through the experienced trauma.

To create a mental space for all sorts of thoughts, to work through feelings of revenge, may change one’s self image and attitudes. Working through demands verbalizing and going through fantasies and words that symbolize in order to develop a picture of what one has gone through (e.g. one’s family members’ death and/or conflicts). Symbolizing is needed to diminish anxiety driven behaviour. This psychological work can be done in a layman context but may have to be done within a professional frame. Both kinds of work are necessary. Experiences from trauma work in Rwanda are that this psychological work is somewhat easier to do with children and preferably in their natural environment. Children are more open than adults and do usually not think of the political attitudes of the listener. To create space for expressing all sorts of thoughts is important to eliminate the soil for political extremism. Moreover it is important to identify acts of manipulations from activists towards groups of young vulnerable traumatized victims to avoid the risk of escalation of destructive spirals of revenge (Kaplan 2005).

Stress is personally and socially constructed, underline Wessels & Monteiro (in Donald et al 2000 with reference to Punamäki 1996; Straker, Moosa, Becker & Nkwale 1992) and emphasize that ‘strong ideological commitment, as evidenced in war glorification and defiant

attitudes towards a feared or hated enemy, enables youth to find meaning in political violence and is associated with reduced anxiety and depression'. Faimberg (1988) stresses what she calls "the telescoping of generations", how trauma unconsciously is transferred between the generations. From this perspective, we have to be aware of what will be transported from one generation to the next of humiliating feelings and what the consequences may be (Kaplan 2005). Similar thoughts are presented by Dyregrov et.al. (2002) when he stresses that we may be ignorant of the contribution that trauma might have to the repetition of violent cycles i.e. the participation in violence and massacres by *adults who were traumatized as children* (the author's italics).

On the basis of research from war torn countries outside of Africa Punamäki (2002) notes how objectively similar trauma experience can bring subjectively different messages to victims and survivors and cause different mental health consequences. From an attachment theory perspective (Bowlby 1988), we may observe how traumatised children and young adults experience and interpret threatening cues, and how they regulate their emotions and respond to danger and threat (Dyregrov et.al. 2002). This shows how complex the aftermath of massive trauma is.

# Inventory of research

## **Dealing with psychological treatment of traumatized children in Africa**

### **Different groups of traumatized children**

The psychological trauma that affect children and youth have varying backgrounds and characteristics. There are thus *similarities as well as differences between these groups of children*. They all have in common being separated from their parents at an early age, either by the parents becoming sick or dying (AIDS, genocide) or that they have become child soldiers –including both those who are forcibly recruited as well as those who join voluntarily. There are differences in living conditions among the different groups of children exposed to trauma and how to approach their difficulties. The following sections are based on the differences in trauma exposure that children have endured.

### **War-affected children**

#### *Background*

Children in war-torn countries are often direct or indirect victims of violence, and/or witnesses to various horrors associated with war and thus so called ‘war-affected’ children. As one example, an estimation has been made that show that 500 000 child deaths were attributed to war in Angola and 840 000 children were living in especially difficult circumstances (UNICEF 1993). Many children have an identity as child soldiers. There are also documents providing information about minors in prison in Burundi (Nzeyimana & Nyamoya, UNICEF Burundi 1998). Unaccompanied children are especially vulnerable.

#### *Trauma therapeutic models*

In recent years, organizations such as ‘Save the Children’ and CCF have developed various types of so-called psychosocial programmes to assist war-affected children. As shown in a study in Angola by Wessels & Monteiro (Donald et al 2000), the key effort was to meet the psychosocial needs of the children. Western psychotherapeutic methods combined with traditional approaches to healing are presented both in the paper “Assisting Angolan children impacted by war” (Wessels 1996) and in the paper “A community-based approach in Angola” (Wessels & Monteiro in Donald, Dawes & Louw 2000). The community based approach was a large-scale, multi-province intervention to assist war affected children.

The aim was to prevent re-traumatization and provide material on non-violent conflict resolution. One major goal was to increase the capacity of adults who work with children. In Angola, there were no psychological services for children which created difficulties. A process of building partnership based on local capacities as a step towards possible cooperation was necessary. The scientific method used was ethnographic participatory action research with trainers conducting training seminars. The researcher offered mental and factual spaces for adults to talk about their feelings and experiences, but in the end the child was in focus. In many provinces, unaccompanied children were placed in orphanages that were poorly staffed and constituted bad environments for the children's development. The solution was instead reunification with extended families. The project estimated that by its end, 298 000 children had been reached. How war affect children turned out to be one of the most important pieces of knowledge that western professionals can provide. Another important effect was enhancing local methods for healing that had been weakened for decades by war. The importance of taking both traditional healing and western methodology into consideration is discussed and the authors stress that particularly in the rural areas of Angola, as in other parts of sub-Saharan Africa, spirituality and community are in the centre of life and the visible world is the extension of the invisible world of the ancestors.

USAID, stress the ongoing instability in the Horn of Africa and the Great Lakes Region where there is a large number of displaced people and refugees who are settled in Kenya. There is a special need to develop programs for displaced children and orphans in this region.

Green & Honwana (1999) have shown that an informal partnership between indigenous healers, with their ritualistic therapies and donor-assisted programmes, with emphasis on the family and social adjustment of the child, may provide a model of how indigenous and western-scientific approaches can be pursued together to provide maximum benefit to children in need. Furthermore, such a model of cooperation and sharing of responsibility serves to validate indigenous healing and beliefs, that tend to energize and mobilize local people who, ultimately, need to develop sustainable, culturally acceptable solutions to help themselves.

Narrative exposure therapy (NET) is a short-term approach based on cognitive-behavioural therapy and testimony therapy that has been evaluated in a randomized controlled trial with Sudanese refugees living in Uganda who were diagnosed as PTSD. Compared to other methods (supportive counselling, psychoeducation), the results indicated that NET is a promising approach for the treatment of PTSD for refugees living in unsafe conditions with continuous trauma (Neuner F, Schauer, M., Klaschik, C., Karunakara, U. & Elbert, T. 2004). The authors stress that in spite of the promising treatment effect found in this trial, this study does not fully prove the usefulness of any psychotherapeutic approach for war-torn populations, as the treatment was carried out by well-trained European psychologists.

There are a limited amount of follow-up studies. One is a five-year study about the Orphans in Eritrea (Wolff & Fesseha 1999). RSC, The Refugee Studies Centre, Queen Elisabeth House, University of Oxford, England, conducts research about coping strategies and rehabilitation of refugees outside Africa that may add important knowledge to the understanding of suitable treatment models also in war torn countries in Africa. One programme is 'The Experience and Management of

Displacement' carried through by a network of researchers such as Loughry, Hart, Chatty and Boyden. Agger (2004), Queen Margaret University College, Edinburgh, outlined psychologists' humanitarian interventions and research in conflict zones.

#### *Research needs*

The need for retroactive studies is emphasized by Walaza (2004). It would be important to, in retrospect evaluate psychotherapeutic interventions that have been directed towards the young population. Psychotherapeutic methods are often based on experiences from adults. There is a need for increasing the number of longitudinal follow-up studies for at least a period of 10 years to get good evaluations of trauma treatment models. However, the problem may often be the cycle of violence and war. "Peace education had been a prominent theme initially, but communities became, understandably reluctant to talk about peace on the eve of war" (Wessels & Monteiro in Donald et al 2000). One major conclusion is that an integration of western and non-western approaches may be the most important future challenge.

### **Child soldiers/Ex-combatants**

#### *Background*

*A child soldier is any person under eighteen years of age who is part of any regular or irregular armed force or group. This includes those who are forcibly recruited as well as those who join voluntarily. All child or adolescent participants regardless of function – cooks, porters, messengers, girls used as "wife's", and other support functions – are included as well as those considered combatants. (Verhey 2001)*

Child soldiers constitute a special group of war-affected children. Worldwide 300 000 children are currently used as child soldiers. More than 120 000 children under the age of 18 are currently fighting in African conflicts. There is an informative overview of Africa's young soldiers by Twum-Danso (2003) who stresses that child soldiering has become a disturbing characteristic of modern conflict but it is not a recent phenomenon.

Derluyn, Broekaert, Schuyten & De Temmerman (2004) show that the former child soldiers in northern Uganda are often blamed and stigmatized for the atrocities and that reintegration can be seriously complicated, but they also acknowledge the risk of transcultural errors when using psychological measures in other than western contexts. One major finding was the supportive role of a parent that can be very important for the recovery of the child. The authors describe the difficulties in travelling while carrying out research – research has to be restricted due to the security situation in northern Uganda.

Loughry has conducted a project 1999–2004 aiming to construct a research instrument that has meaningful and relevant indicators for adjustment of former child soldiers. This project investigates the differential effects, if any, of various rehabilitative interventions on medium and long-term psychosocial adjustment. It is stressed that the project has to be on hold due to the security concerns.

There are different views on how much the child/youth voluntarily gets involved in civil wars. Utas (2003) shows Liberian ex-combatant youth's coping strategies – how their lives became affected by a civil war that raged in the country between 1990 and 1997 and focuses on the experiences of the children, motivations, and reflections. The daily prospect of poverty, unemployment and marginalisation effectively blocked the paths to a normal adulthood; directing them instead into a

subculture characterised by abjection, resentment and rootlessness. Utas stresses that their enlistment into one of the several rebel armies of the civil war became an attractive option for many. He describes and analyses the young people's own accounts of their involvement in the civil war; their complicity in atrocities, their coping strategies in the context of armed conflict, their position as ex-combatants in a post-war environment, and their outlook on their past, present and future. One chapter focuses specifically on the role and predicament of young women in the civil war. Whilst some became active fighters, most participated as auxiliaries in various capacities. Their accounts convey not only the tremendous hardship and suffering, but also reveal mechanisms which helped at least some to survive. Utas discusses the question of a post-war reintegration of ex-combatants into peaceful society and shows that the prospects of different groups depend primarily on their social and geographical situation, rather than on the negligible effectiveness of aid programmes routinely executed by international organisations and NGOs (Uppsala University 2003).

#### *Trauma therapeutic models*

A Culturally Mediated Model in Mozambique is based on the pioneering work of Errante (1999). The program uses the cultural world view of child soldiers themselves as a starting point for treatment. Recognition of culture in what constitutes a traumatic experience and how people explain and understand the sources of trauma are of main importance. In the program special attention is given to the "individual in context". Errante (1999) stresses that a psychotherapeutic intervention is defined as "anything that helped the child elaborate his/her experiences, give meaning to them and build a bridge necessary for integrating those experiences".

Wamba (2004) has shown, within the project of 'Rebuilding hope' for child soldiers in post-war Mozambique, a uniquely collaborative process, based on mutual respect for both western and traditional disciplines of healing that seems very creative with concrete and enlightening examples of therapeutic interventions. The traditional healers would purify their patients and send them to the psychologist for additional support. The result was a symbiotic model of psychotherapeutic interventions, taking into account the local knowledge and culture.

Solheim (2003) has conducted an extensive study of the reconciliation process in post-war Sierra Leone, with a particular focus on the young ex-combatants. She came to look for the coping mechanism among the people and within the culture which enables them to "forgive and forget". However she questions whether the great emphasis laid on education is enough to teach the youth how to live peacefully together in the future.

#### *Research needs*

Solheim (2004) notes that few are working therapeutically with these traumatized children, and certainly research on this topic is quite scarce. She says "one of my personal reasons for choosing to work with young ex-combatants was exactly the lack of research in the area". Most of the focus has been on the background of these youth and their experiences during the war, not so much on the times after war, when most of them have experienced being traumatized. Solheim concludes (2004):

- Additional research is needed – follow-up studies of young ex-combatants within a few years' time, to see how the situation develops after the intoxication of peace has evaporated.

- A particular focus should be on girls and women who are returning from the armed forces. They are most probably experiencing a greater stigmatization upon return to civil society than the men.
- There is an importance of integrating the redeeming features and the coping mechanisms found among the people and the traditional culture of each place. Sierra Leonean culture, like other African cultures, finds itself distant from a western therapeutic treatment model to address the needs, especially of the youth, who have to deal with their experiences of war.

Swartz, S. (2004) concludes that the Youth ministry in South Africa is in desperate need for accurate and current youth research. Although much research does exist it is often hidden between academic disciplines and in the archives of both non-profit and profit making research agencies. A critical absence exists in understanding and documenting the experiences of youth and religion. Chris Smith's multi-year National Study of Youth and Religion (Christian Smith, 2003a, 2003b, 2003c; C. Smith et al., 2002; Christian Smith, Faris, Denton, & Regnerus, 2003) has much to teach us, she says. Ongoing research into contextualising the developmental assets investigating after-school programmes for youth is also necessary (Noam, 2003; Perkins-Gough, 2003; Roffman, Pagano, & Hirsch, 2001 in Swartz 2004).

### **Child survivors of genocide**

#### *Background*

*We live in a time where genocide, mass killing, and other violence by groups of people directed at groups defined by their ethnicity, race, religion, culture, or political affiliation is widespread. Because the differentiation between groups that engage in such violence can be of many kinds, I will refer to such violence across group lines simply as collective violence* (Staub 1999).

In Rwanda, every Tutsi was a target for murder in a similar way as every Jew during the Holocaust, stresses Melvern (2000). Perhaps the most devastating consequence of the genocide in Rwanda is the hundreds of thousands of children who have been orphaned or otherwise left without parents since 1994. Human Rights Watch has published an informative and valuable report about children in Rwanda (Rakita 2003). It is reported that some 400 000 children – more than 10% of Rwanda's children- are estimated to be orphans today. This is because of murder but also because of HIV/AIDS, as a result of rapes committed during the genocide. What the children have in common is that they are deeply traumatized and experience a lack of protection.

The extreme poverty in Rwanda – the lack of possibilities for the majority to satisfy basic needs – probably plays a large part in how the population deals with their emotions. Staub (1989) sees this factor as central for the start of a genocidal process. Böhm (1993) describes the development of prejudices which also seems to have great importance in this process.

Today the youth struggle to rebuild their lives with little help in a society that has been completely devastated. There are now 26 centres in Rwanda for unaccompanied children housing relatively few children. To try to trace possible family members of the children proved extremely difficult. Children have been absorbed into families not their own, so called spontaneous fostering. They are assumed to be the family's own children or domestic workers. Some consider a foster child as interchangeable with a free live-in domestic servant.



In Kigali 2001, an historic international meeting of survivors and descendants of survivors of the Holocaust, Rwanda and other genocides took place with a decision to establish the international Network of Holocaust and Genocide Survivors and Their Friends. This was convened by IBUKA, the coalition of Rwandan associations of genocide survivors and the Group Project for Holocaust Survivors and their Children. There are today also ongoing networks specifically for unaccompanied children to adjust to the current situation that can be viewed as very important for generational linking processes. One of these is AOCM project, where the oldest sibling in the family takes care of the younger ones. This project has been documented through interviews conducted by the children themselves and they are also being photographed which is especially important, since there are hardly any photos left from the time before the genocide (D. & L. Miller 2004).

An assessment of the cross-culture validity and reliability of a standard psychiatric assessment instrument was carried out by Bolton (2001) as apart of a broader assessment of the mental health effects of the 1994 genocide in Rwanda.

#### *Trauma therapeutic models*

Jensen et.al. (1997) has conducted an informative project for “Understanding, Prevention and Healing of Traumatization” with the focus on Rwandan children and their families. Important work is carried out to understand the consequences of the trauma exposure and psychological reactions to genocide among Rwandan children (Dyregrov et.al. 2000). A total of 3030 children age 8–19 years from Rwanda were interviewed about their war experiences and reactions approximately 13 months after the genocide. Analyses showed that reactions were associated with loss, violence exposure, and, most importantly, feeling their life was in danger. Dyregrov et al (2002) point out some important steps in understanding children affected by war and genocide. First, it is necessary to talk to children while visiting war torn countries – to document effects of trauma. Sensitive care takers may continue the process started in such interviews. Secondly it is most valuable to return to the same group of children that again stresses the importance of follow up. Thirdly, positive therapeutic effects from such research interviews are known from several areas (Balk 1983; Dyregrov, Dyregrov & Raundalen 2000; Reich & Kaplan 1994, Kaplan 2005). Chauvin, L.et.al. (1998) has made an evaluation of the ‘Psychosocial Trauma Recovery Programme in Rwanda’.

Staub (1999) and Errante (1999) both describe how healing trauma may act to prevent further trauma since it helps to restore the social bonds that were destroyed during a conflict. When traumatized, people often feel isolated and split off from others, trauma healing work helps them feel reconnected with the social groups they had before the conflict—where most people have their sense of identity.

There are also private initiatives with therapeutic effects. Dr. A. Jahn, a German paediatrician working at a hospital in Kigali is supporting 71 teenage boys since 2003 with accommodation and going to school, a most important preventive work. The boys had lived in the street since the genocide in 1994. There is an international association for specifically street children, ESPPER that support such private initiatives.

Balikungeri (2004) emphasizes efforts within a developmental project (‘Rwandan women community network development’) to strengthen the attachment between children born as a result of rape and their mothers.

An estimated amount of 500 000 women were raped during the genocide in Rwanda.

### *Research needs*

There is an accelerating interest for interdisciplinary aspects of understanding the roots of genocide as well as the consequences for the traumatized. The importance of reconciliation is repeatedly emphasized. In Rwanda, Hutus and Tutsis should be able to live side by side again in the same country. Studies of affect regulation of the victims and specifically the emotional experiences of children after genocide have however been underrepresented until now in research. Even if we know that there might not be possible to fully work through experiences of massive trauma and leave the memory images behind, there is a necessity to find therapeutic methods of learning how to continue living with genocidal experiences in one's life history.

One major research need concern the repetition of violent cycles of revenge among vulnerable traumatized youth. Dyregrov et. al. stresses (2002) "Although an area not well researched we know that the propensity for violence is increased in victims of violence. In Rwanda there are anecdotal reports that child victims of previous massacres have been central as perpetrators in new massacres. War may make children more vulnerable to political forces that instigate violence". Dyregrov emphasize one serious issue in interviewing. Interviews may be seen as threatening to the warriors and great care must be taken to protect and provide security for those interviewed. This discussion may serve as an addition to what Verhey (2001) stressed in her paper (above). Moreover trauma work is difficult in places such as Rwanda where, as Staub noted, many groups are geographically intertwined and people can not walk in their communities pretending that the 'enemy' lives in another country. People who were 'on the other side' will be living in the same community. Before people can be open to any type of reconciliation, there must start a healing process or people will not be able to participate in the hard work of reconciliation, he stresses. The Rwandan situation is potentially dangerous, complex and urgent. Single-focused solutions are not possible or desirable and some environmental conditions that hinder the healing process include poverty and the lack of physical and social amenities. The legacy of colonialism and post-colonial exploitation has severely limited self-reliance. Current political realities are not stable enough for on-going co-operation with government organizations. Culturally, further development of the partnership must take into consideration differences in western and African approaches to care giving (Rwanda healing March 2000 survey Report).

Wessels & Monteiro (in Donald et.al 2000) underline that "intervention is needed to interrupt cycles of violence and transform the situation in the direction of peace". These statements are stressed also by Volkan (1997) and in accordance with experiences from follow-up interviews with 'street children' in Rwanda (Kaplan 2005). To create a mental space for all sorts of thoughts, to work through feelings of revenge, may change one's self image and attitudes. This could be done in focus groups within a secure frame.

### **Violence, rape and trafficking**

#### *Background*

The work by Donald, Dawes and Louw (2000) may be the very first extensive work to address the psychological consequences of childhood

adversity in South Africa, specifically by psychologists about disadvantaged children. The rate of violence in South Africa is amongst the highest in the world. Political violence as a structurally generated form of adversity is responsible for the generation of widespread fear, hatred and despair. Why so many African children in the African education system drop out of school have been insufficiently researched, Dawes & Donald (1994) claim. Apartheid, poverty and girls dropping out of school and taking care of younger siblings are not sufficient answers, according to these authors.” The developmental issues facing this sector have, with few exceptions hardly begun to be examined” they say. Their book serving as a guide, aims to stimulate the development of effective community-based interventions in the field of childhood adversity and to contribute to the growing theory of practice in this area.

Many cases of child abuse and neglect are not reported. The growing incidence of this is attributed to the breakdown of families, a legacy of apartheid (‘Save the children’ 2004). It is estimated that 480 000 rapes occur in South Africa each year. Investigations of the effects of violence on psychological development have increased in numbers during the past years.

#### *Trauma therapeutic models*

The urgent need of psychological help for children exposed to extreme violence demands quick interventions. Waiting for a research design and funding as a base for these interventions may be difficult. As an example, in South Africa there is a ‘Child crisis center’ attached to almost every police station where there is a possibility for a child exposed to violence, to stay 2–3 days and then get support. Special detectives are doing the investigations and then referrals are carried through by NGO staff. This approach has turned out to be very successful. TCSV, continuously conducts research projects. The Children and Violence Programme is currently busy with a seven-year longitudinal study on violence prevention interventions in schools. This research will be published once complete. A contact person is E. Jacobs who directs an ongoing project investigating resilience factors among school children that could serve as an important base for preventive work (Levin 2004).

The research team, Efraime Jr & Omar, Maputo, Mozambique (2004) do research within the area of prevention of rape and sexual abuse of children as well as therapeutical support for children that are victims of rape and sexual abuse. The research will be a independent part of an intervention project with two main components:

- 1) Psychotherapy – psychological and legal counselling and medical care (including HIV/AIDS prophylaxis or/and treatment in all rape cases)
  - 2) Training of the different groups of people involved such as police, officers, judges, psychologists, social workers, community leaders.
- A cooperation with traditional healers is also planned.

MRC, South Africa, the ‘Unit on Anxiety & Stress Disorders’, has an adolescent youth stress clinic that provides a free research-based assessment of posttraumatic stress disorder (& other trauma-related psychopathology). They currently have a study on a medication/pharmacological intervention for youth diagnosed PTSD. The clinic is also in the process of broadening its scope to focus on secondary trauma prevention and carries through a trauma psycho-educational service/program offered to schools (teachers, scholars, parents). Seedat (2004) has carried through research in schools and is now planning to start a study to look at the

benefit of an early group psychotherapeutic intervention in female adolescents who have been raped, to investigate whether this is effective in lowering rates of PTSD and depression over 1 year period.

Another study is carried out to get an understanding of what accounts for the increase in child prostitution. The main question is: “what are the key causal factors for trafficking of children in South Africa?” (Koen, K., Van Vuuren, B. & Anthony, V. 2000). As “trafficking children do not voluntarily engage in the exchange of sex for money or luxury items” this report therefore does not regard them as ‘sex workers’. The report deals with specific themes, as political initiatives, conceptual and methodological issues, overview of international literature, causal factors that give rise to the increasing of trafficking of children, indicators of cross border trafficking, legal issues, case study and recommendations.

A preliminary exploration of theoretical and therapeutic aspects of extra familial child rape is carried out by CSVR in South Africa (Lewis, Sharon, Braamfontein 1997). Liebowitz-Levy (2004) Conducts research where she explores the interventions available for working with children. She underlines that interventions usually focus on exploring the story without integrating it into the child’s life experiences. She proposes a short-term model, which uses both the exploration of the story and its integration.

Dawes & Donald (1994) describes a project carried out in Nicaragua that may serve as a good example for trauma treatment. Mental health workers and non-professionals so called ‘Promoters’ (pioneered extensively in Nicaragua by Metraux 1992) are trained to deal with trauma in the family following violence. A precondition is that the non-professionals have had the opportunity to deal with their own experiences of trauma. The influence of psychodynamic approach is clear in this approach.

### *Research needs*

The annual conference Critical Methods (hosted by ‘Themba Lesizwe’ South Africa) had one specific theme year 2004 (Durban 2004) concerning traumatized children– ‘Child sex workers in sub-Saharan Africa and motivation for change’ (Gokan, 2004). It considered the social condition of children trapped into sex work. There is a need, according to the author, of considering alternative models for treatment, such as motivation theory to change behaviour both for children and adults. Field studies within this project are ongoing in South Africa, Ghana, Uganda and Ethiopia.

Seedat (2004) stresses the lack of research concerning children and youth exposed to sexual abuse. There are major gaps both in terms of prevention and intervention research. With the high rates of youth violent trauma that exists in the country, studies testing early interventions are indeed needed. This could be coupled with work identifying risk and resilience factors to trauma and PTSD. According to Seedat, in terms of treatment, very little work has been done on demonstrating efficiency of established psychotherapeutic and pharmaco-therapeutic interventions for youth diagnosed with PTSD.

## **AIDS orphans**

### *Background*

More than 13 million children under the age of 15 have lost their mother or both parents to AIDS (UNICEF 2001). Currently, the vast majority of these ‘AIDS orphans’ are living in sub-Saharan Africa. In 1998 the

Ministry of Health in South Africa estimated that by 2005 nearly a million South African children will have lost their mothers due to AIDS before reaching the age of 15, and this number can be expected to increase to more than two millions by 2010. This exponential increase in the number of orphans has aroused fears that the AIDS pandemic will result in a new “lost generation” of dysfunctional and delinquent South African youth who have been inadequately cared for, educated, and socialised (Burnett, 2000 in Wild 2001). Whether in real or relative terms, these are alarmingly high numbers that deserve our attention and we have to reflect upon preventive work, Brey stresses (2004). Brey and Wild have both been studying existing literature, material from across the continent of Africa, to find out what is known about the impact of children’s lives over the short and long term. There are predictions of social breakdown, cultural collapse and other costs to the wider society, but there was remarkably little material documenting the effects of orphan hood on children, their families and communities.

Wild (2001) adopt a broad definition of AIDS orphans as uninfected children and youth up to the age of 21 who have lost either or both parents to AIDS. Orphans who are themselves infected with HIV are not included in her review, as they are thought to have unique needs and challenges which warrant separate consideration (Siegel & Gorey, 1994).

The purpose of Wild’s valuable article (2001) is twofold. First, it aims to integrate, summarize and evaluate current knowledge regarding the psychosocial adjustment of AIDS orphans, which is likely to be of use to mental health professionals, researchers and others working with families affected by AIDS. Second, it is designed to identify limitations and gaps in the current literature with the aim of stimulating and facilitating further – and more sophisticated – research into processes of risk and resilience in children who have lost, or will in due course lose, a parent due to AIDS. She identifies the stressors which commonly face AIDS orphans before and after the death of a parent and the psychological impact of these adversities. In focus groups conducted in Zimbabwe (Foster et al 1997) some evidence was provided that there are multiple stressors associated with losing a parent to AIDS. Accumulated clinical experience suggests various ways in which AIDS orphans might feel and behave in response to the stresses they experience, although there is no standard response: reactions are likely to vary depending on the child’s developmental level, personality and particular circumstances (Dane, 1994; Lewis, 1995). Wild’s literature search revealed 6 published and 2 unpublished studies which appeared from 1995 onwards and were designed to investigate the psychosocial adjustment of children. She describes four empirical studies which investigate whether AIDS orphans and children of HIV-infected parents do in fact show heightened levels of psychosocial adjustment difficulties compared to other youngsters in their communities.

One special aspect that Wild puts forward should be highlighted – parents may “alternate between overprotecting their children or distancing themselves from their children as a way of reducing the intensity of their feelings”. In some cases normal parent-child roles may be reversed, a psychological phenomena that I call *age-distorting* (Kaplan 2002). There is also a ‘conspiracy of silence’. The children don’t tell their friends about the parents’ illness. Most probably they associate their loss with a sense of shame (Dane, 1997; McKerrow, 1995; Pivnick & Villegas, 2000 and Apfel & Telingator, 1995).

To comprehend the behavioural dynamics of STD/HIV transmission, it is necessary to understand cultural constructions of women and men's sexuality as well as their socio-economic contexts. There is a clear link between levels of HIV/AIDS and poverty throughout the world, stresses Freudenthal (2002).

#### *The importance of not 'labelling' the children*

There are very good reasons why we should seriously consider the ways in which children are affected by parental illness and death. According to Wild (2001), a member of the National AIDS Coalition in South Africa recently stated that "Children orphaned by AIDS will have no role models in the future and they will resort to crime to survive". The first assumption contained in this argument is that loss of one or both parents will necessarily mean that a child has no other role model. Members of the extended family and local community are all actual or potential role models, she claims. Moreover, there is ample evidence from studies with other groups of children living outside their own family context that adult neighbours and members of their own peer group provide role models. Some research does point to heightened levels of emotional and/or behavioural problems amongst children who have lost parents to AIDS-related illnesses relative to a comparison sample from the same community.

#### *Trauma therapeutic models*

There are ongoing psycho-social programmes, such as improving social conditions, supporting families, strengthening community based support systems, and building capacity in the community for sustaining care over long term and other preventive interventions (Dlamini 2004). Many programs have thus served as guidelines for practitioners and in that sense been very important. With economic support these programs may develop into more advanced research projects. There are also psycho-educational AIDS/HIV programs for young people who themselves are contaminated by HIV, such as 'You and Rape' developed in Rape crisis center in Cape Town (1999). It could also be mentioned that Ashforth (2001) discusses "AIDS, witchcraft and the problem of power in post-apartheid South Africa". Efraim Jr ('Rebuilding Hope' 2004) Mozambique works with psychological counselling for children affected by HIV/AIDS.

#### *Research needs*

The situation of AIDS orphans has begun to be addressed in the past few years, with articles describing the plight of this group of children. This issue has become increasingly common in both the popular press and scholarly journals. Wilds' (2001) paper is designed to identify limitations and gaps in the current literature with the aim of stimulating and facilitating further – and more sophisticated – research into processes of risk and resilience in children who have lost, or will in due course lose, a parent to AIDS. Wild does not know of any research projects on trauma treatment models for AIDS orphans (2001)

Wild (2001) claims that despite the potential importance of the topic, the psychosocial adjustment of AIDS orphans has often been overlooked by researchers, international AIDS conferences, governments, non-governmental organisations and service providers (Geballe & Gruendel, 1995; Foster, 1997). Publications have been based largely on practice wisdom and clinical experience. Rigorous and systematic empirical

research designed to explore and test hypotheses derived from these informal sources of knowledge is still relatively rare. She refers to a 1994 literature review by Siegel and Gorey who found no published empirical studies – and only one unpublished study – of the grief reactions of AIDS orphans, and noted that “only recently have their mourning problems begun to receive attention in the clinical literature”.

The question is raised by Wild – why does argument link AIDS orphans to delinquency and social breakdown and what further implications has this argumentation? When considering the psychological impact of orphan hood and its implications for individual children and society, it is worth looking at long-term studies done with other children in so-called ‘difficult circumstances’ (such as refugees, displaced children and street children). These have shown that children respond to traumatic situations in different ways. Also Brey (2004) stresses the absence of empirical evidence. She claims that even less research has used the longitudinal perspective required to comment on long-term effects of AIDS orphan hood on the well-being of children and youth. The most striking characteristic of the data on long-term impacts of AIDS orphan hood in Africa and Asia is its scarcity. “Without documented evidence of social breakdown in any country, we have to conclude that predictions of a disintegrating social fabric are, at present, unfounded”, she says.

There is also a particular need for long-term, prospective longitudinal studies which are able to assess children’s psychosocial needs and coping strategies at various stages of the parent’s disease and at various periods after their death, to investigate if and how short-term distress in children relates to long-term outcomes, and to evaluate the effectiveness of intervention programs. Ideally, such quantitative research should be complemented by more qualitative studies describing children’s experience of living with AIDS in the family and addressing such issues as if, when and how children are informed of their parents’ HIV infection and of placement and custody decisions, how they obtain emotional support, and how these variables are associated with the child’s reaction to the parent’s illness and subsequent death (Geballe et al., 1995; Siegel & Gorey, 1994 in Wild 2001).

One conclusion is that there is a real danger *that the emotional and psychological impacts of the virus are overlooked* in the efforts to understand and respond to the social and economic issues. As large – and rapidly growing – numbers of children are orphaned by the AIDS pandemic, providing them with care and protection is an increasing national and global concern. We need to know how to identify children who are at particular risk for psychosocial adjustment difficulties, and to develop and improve prevention and intervention efforts for them.

# Conclusion and recommendations

The psychological trauma that affect African children and youth have varying backgrounds and characteristics. There are thus similarities as well as differences between these groups of children. They all have in common being separated from their parents at an early age, either by their relatives becoming sick or dying (AIDS, genocide), or that the children have been taken brutally from their home to become child soldiers. Children in war-torn countries are often direct or indirect victims of violence, and/or witnesses to various horrors associated with war.

A major conclusion is that research concerning trauma treatment models developed for children in Africa is extremely limited. Research groups with this focus are few. The main part of research is carried out in South Africa where a more developed infrastructure and a higher number of academic researchers exist in a wider range than most of the other African countries. Moreover research has so far, with few exceptions, been concentrated on descriptions of post-conflict living conditions with the aim of mapping out the situation for children exposed to violence, illness and death. During the last few years, efforts have arisen of trying out possible models for reintegration of vulnerable children that also has taken the children's psychological state into account. Many of these reports demonstrate a concern to integrate western models with traditional healing models.

Longitudinal follow-up studies are needed of young ex-combatants within a few years' time, to see how the situation develops after the intoxication of peace has evaporated. A particular focus should be on girls and women who are returning from the armed forces. They are most probably experiencing a greater stigmatization upon return to civil society than the men. There is an importance of integrating the redeeming features and the coping mechanisms found among the people and the traditional culture of each place.

Studies of affect regulation of the victims and specifically the emotional experiences of children after genocide have been underrepresented until now. Even if we know that there might not be possible to fully work through experiences of massive trauma and leave the memory images behind, there is a necessity to find therapeutic methods of learning how to continue living with genocidal experiences in one's life history. There is a need for research regarding the repetition of violent cycles of revenge among vulnerable traumatized youth.



There is a lack of research concerning children and youth exposed to sexual abuse. There are major gaps both in terms of prevention and intervention. Violence against girls in schools needs special attention. There is a need for research on trauma treatment models for AIDS orphans. There is also a particular need for long-term, prospective longitudinal studies which are able to assess children's psychosocial needs and coping strategies at various stages of the parent's disease and at various periods after their death, to investigate if and how short-term distress in children relates to long-term outcomes, and to evaluate the effectiveness of intervention programs.

# Notes:

- i) Child soldiers (former) are also called 'ex-combatants' which underlines different views of what this position means (Solheim 2003, Utas 2003)
- ii) Search engines used are: Google; Scirus; PubMed; NISC and Cochrane Library (Nordenström 2004). Special search engines for AIDS/HIV are suggested by Wild (2001) – PsycINFO, Medline, and the Index to South African Periodicals (ISAP), local library catalogues, and the on-line publications of the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNICEF, and the World Health Organisation (WHO). Several organisations focus on trauma intervention and conflict resolution in ethno political warfare such as Psychologists for Social Responsibility (PsySR), that provide resource lists. Scientific journals and newsletters i.e. Journal of Traumatic Stress, Southern African Journal of Child and Adolescent Mental Health and The Traumatic Stress News letter (by SAITS) provide updated information. Human Rights Watch carries through extensive research and provide invaluable sources of information on the internet. Medecins sans frontieres /Läkare utan gränser/ are available world wide and there is also The European Psychoanalytic Federation Trauma Research Group (Varvin & Popovic 2002), based on profession.
- iii) Mary Balikungeri, Rwanda  
Andrew Dawes, South Africa  
Pierre Dusingizemungu, Rwanda  
Atle Dyregrov, Norway  
Alcinda Honwana, Mozambique/USA  
Lilian Levin, Sweden  
Mats Utas, Sweden  
Nomfundo Walaza, South Africa  
Lennart Wolgemuth, Sweden
- iv) There are valuable pedagogical guidebooks available for teachers such as 'Teacher Emergency Packages' with successful interventions in post conflict settings (Miller 2002) and 'Sharing, Playing, Learning Together' (TCSVT 2003) focussing four main themes: our classroom rules, working together, feelings and problems to prevent violence and promote social skills. The TCSVT work is developed within a web-ster-stratton multi systemic program where you focus the whole structure of the school. Moreover there is a 'Counselling Manual'

developed by OASSA (1993) and a 'Manual for interventions' developed by Dyregrov and his colleagues – 'Teaching Recovery Techniques' (Smith et al 1999). The material is "flexible" and could address common early distress reactions among children. At last, a manual is recently developed that clarifies the basis for and evaluation of a psycho-social programme that is profoundly well worked through, available on the internet – "Children in crisis: good practices in evaluating psychosocial programming" (Duncan, Arntson, 2003, Save the Children Federation). The contributors constitute a network of prominent researchers in the social psychology field concerning violent conflicts across the globe. The overall need is to protect children from future violence. Research on reconciliation for the prevention of future conflicts has been integrated and summarized in a beneficial way by Broneus (2003).

Verhey (2001) has conducted case studies in cooperation with UNICEF. The study demonstrates that children and youth involved in armed conflict experience a process of asocialization, but can re-engage in positive social relations and productive civilian lives. She provides the reader with checklists of preventions and preparing for demobilization as well as steps in the reintegration process and an appendix with definitions of terms. She discusses important issues to take into consideration when interviewing child soldiers as well as mobilizing an appropriate network of programs, policy coherence and program strategies. She discusses advantages and disadvantages with special trauma programs and reception centres for the traumatized children and youth that might implicate 'labelling' the children, as will be discussed in the section about AIDS orphans. Verhey highlights important issues about emotions, attachment and definitions of what is the meaning of 'psychosocial'. This report is in many ways thought provocative and could be especially recommended.

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# Annex 1

## **Terms of Reference for a desk study to identify research needs and research groups dealing with children with massive trauma in Africa**

### **1. Background**

The African continent has been ravaged by internal conflicts and insurgencies in the past decade. Eighteen of the fifty-three countries on the continent are currently involved with, or emerging from armed conflict. Violent conflicts have devastated countries such as Angola, Burundi, the Democratic Republic of Congo, Mozambique, Rwanda, Sierra Leone, Somalia, Sudan and Uganda.

Children in these war-torn countries in Africa are often direct or indirect victims of violence, and/or witnesses to various horrors associated with war. Children as young as seven or eight are forced to become child soldiers in several African countries. For example, in Liberia an estimated 15,000 children served as soldiers and in Sierra Leone more than 10,000 children were soldiers. In Uganda, approximately 10,000 children have been abducted in the north by the Lord's Resistance Army who has been fighting the government since 1989. The list could be made much longer.

Girls as well as boys suffer, some being forced into sexual or other service at early ages leading to massive trauma often with HIV/AIDS as one of the consequences. In conflicts where terrorizing civilians has become a routine means to political and military ends, women and children are deliberately targeted for torture and death. Globally there are at least one million children separated from their parents because of war, and there are at least 300,000 children younger than 18 years who are currently serving as soldiers and guerrilla fighters.

Apart from being exposed to wars or even participating in wars as soldiers, there are more than 12 million orphans in Africa today due to the AIDS epidemic. This overwhelming number of needy children has meant that kin support structures can no longer cope. Traditionally children in many African countries would be taken care of by relatives if their own parents passed away, but this is no longer the case.

Children who have lost one of both parents to AIDS also face more problems than other orphans. According to UNAIDS, AIDS orphans are at greater risk of malnutrition, illness, abuse and sexual exploitation

than children orphaned by other causes. They also have to grapple with stigma and discrimination so often associated with AIDS.

In recent years, UNICEF, USAID, and many private, voluntary organizations such as 'Save the Children' and others have developed various types of psycho-social programs to assist children affected by war and/or been orphaned due to AIDS. Yet therapeutic techniques for traumatised children remain at a very preliminary stage of development. It is not known to what extent western psychotherapeutic techniques, which were originally developed to treat Europeans and Americans' would be appropriate and effective for children in Africa. One concern lies in that the therapeutic techniques used are centred on the individual patient, rather than the family or community, which might be more meaningful in many countries in Africa.

In Sida's recent position paper on health research (2003) it is stated that "Children's and young peoples' health and rights related to post war trauma and AIDS" is an area that will be given a high priority during the next coming years. As a first step in a process to identify important research activities for possible future support, Sida needs to gain a deeper understanding of this field of research. It needs to know where the research gaps are and also what promising research groups and researchers exists in order to formulate a strategy for what kind of support would be most appropriate and cost effective.

## **2. Purpose and scope of the desk study**

The purpose of the desk study is to assess important research relating to children with massive trauma in Africa; identify research gaps and furthermore identify research groups and individual researchers within this field. The findings and recommendations will guide decisions on future Sida/SAREC support.

## **3. The assignment**

The consultant shall describe relevant research findings in the area of children with massive trauma and/or post-traumatic stress disorder and identify research gaps within this field.

The consultant shall present an inventory of researchers and research groups in Africa within the field of massive trauma and post-traumatic stress disorder. The inventory shall contain a brief description of the area of research including latest publications.

The consultant shall present an inventory of international researchers and research groups within this field and with a focus on Africa and give a brief description of their areas of research including latest publications.

## **4. Methodology and time schedule**

The consultant shall write a report that includes 1) a brief background review of relevant research in the area of children with massive trauma and/or post-traumatic stress disorder, including a short discussion of possible research gaps in this field, 2) an inventory of researchers and research groups in Africa within the field of massive trauma and post-traumatic stress disorder, 3) an inventory of international researchers and research groups within this field and with a focus on Africa, 4) suggestions for what kind of support Sida/SAREC could give in the future that would be appropriate and cost effective.

The consultant may need to travel to meet with research groups in Africa and it is the duty of the consultant to make her own travel and meeting arrangements to fulfil the assignment.

The desk study will commence June 1, 2004. A draft report shall be submitted to Sida no later than October 1, 2004. The maximum work time spent on the desk study will be 8 weeks.

## **5. Reporting**

The report shall be written in English. The draft report shall be submitted to Sida electronically and in 2 hard copies no later than October 1, 2004. Within 4 weeks after receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in 2 hard copies.

# Annex 2

## Relevant researchers and research groups:

### AFRICA

- **TCSVT**, Cape Town is a part of a global network, ‘Global Directory of Rehabilitation Centres and Programmes’.  
[www.trauma.org.za/advocacy\\_research.html](http://www.trauma.org.za/advocacy_research.html) email:

Contact person, psychologist, H.O.D. Erica Jacobs [erica@trauma.org.za](mailto:erica@trauma.org.za)

- ‘The Themba Lesizwe Victim Empowerment conference’ is the biggest national coalition for trauma service providers in South Africa. Their last conference took place in September 2004 in Durban with the main theme: “Critical Methods”. In 2003 the main theme was AIDS. Head of the 2004 conference was psychologist Nomfundo Walaza, Executive Director of TCSVT, Cape Town, [nomfundo@trauma.org.za](mailto:nomfundo@trauma.org.za)
- **UCT**, Cape Town develops several research projects. Ass Professor of Psychology Andrew Dawes and his colleagues David Donald and Johann Louw constitute a group of researchers with focus on adversities facing South African Children and their development. There are selections of community based programmes. He is also the Director of Child Youth & Family Development, HSRC (email: [Adawes@hsrc.ac.za](mailto:Adawes@hsrc.ac.za)).
- Lauren Wild does extensive research concerning the psychosocial situation for AIDS Orphans [lwild@humanities@uct.ac.za](mailto:lwild@humanities@uct.ac.za)
- **MRC**, The Unit on Anxiety & Stress Disorders, has an adolescent youth stress clinic.  
<http://www.mrc.ac.za/> Contact person: Professor Soraya Seedat [sseedat@sun.ac.za](mailto:sseedat@sun.ac.za)
- **CSVR**, Dr Hugo van der Merwe is project manager  
[hvdmerwe@csvr.org.za](mailto:hvdmerwe@csvr.org.za)

The staff in the Youth Programme that may be contacted are

Dorothy Mdhluli [dmdhluli@csvr.org.za](mailto:dmdhluli@csvr.org.za)  
or Mosley Lebeloane [mlebeloane@csvr.org.za](mailto:mlebeloane@csvr.org.za)

- ‘Rebuilding hope’ Mozambique has carried through studies about reintegration of child soldiers. Researchers are psychologist Lucrecia Wamba [lucreciaw29@yahoo.com](mailto:lucreciaw29@yahoo.com) and Boia Efraim Junior  
<http://www.aremz.tk/>  
<http://www.newtactics.org/main.php/TraininginPractice/Africa-Workshop>



- **RAPCAN** and ‘Molo Songololo’, South Africa, are dealing specifically with street child victims of violence and abuse.  
<http://www.rapcan.org.za/>
- **University of KwaZulu-Natal** conducts ‘Critical Trauma Studies’ by Anthony Collins who stress that PTSD was developed in social conditions fundamentally different from those in South Africa today.  
[anti@mweb.co.za](mailto:anti@mweb.co.za)/[collinsa@ukzn.ac.za](mailto:collinsa@ukzn.ac.za)
- **Université Nationale du Rwanda**, Faculté d’Education, Butare, Doyen Pierre Dusingizemungu in cooperation with Recteur Emile Rwamasirabo supervises research projects focused on children and youth in Rwanda. [jpdusingize@nur.ac.rw](mailto:jpdusingize@nur.ac.rw)

## USA

- **SSRC**, USA. Alcinda Honwana, Mozambique is Programme director at Children and armed conflict & Africa Programmes’. She has long experiences from research within this field and has a key role in several research networks. [www.ssrs.org](http://www.ssrs.org) Researchers especially recommended:  
Neil Boothby – Columbia School of Public Health  
Larry Abel – New York University  
Andy Dawes – HSRC – Cape Town, South Africa  
Nonfundo Walaza – Trauma Centre, Cape Town  
Boia Efraim Junior – Rebuilding Hope, Maputo Mozambique  
Carlinda Monteiro – CCF Angola  
Marie de la Soudieri – Progr soc issues Uganda (northern),
- **USAID**, [http://www.usaid.gov/our\\_work/humanitarian\\_assistance/the\\_funds/vot/kenya.html](http://www.usaid.gov/our_work/humanitarian_assistance/the_funds/vot/kenya.html).
- **Boston University Medical School**. Bessel van der Kolk, Professor of Psychiatry has been active as a clinician, researcher and teacher in the area of posttraumatic stress and related phenomena since the 1970s. Dr. van der Kolk is past President of the International Society for Traumatic Stress Studies, at, and Medical Director of the Trauma Center at HRI Hospital in Brookline, Massachusetts. 1998–2004 The Trauma Center/Arbour Health System  
<http://www.traumacenter.org>, [research@traumacenter.org](mailto:research@traumacenter.org).
- **Perlman, L.A. & Staub, E.** (2002) Creating Paths to Healing. Trauma Research, Education and Training Institute, Inc.  
<http://www.heal-reconcile-rwanda.org/>

## EUROPE

- **RCT**, Danmark, is connected to TCSVT. Anne Bay Paludan is African Programme Manager [abp@rct.dk](mailto:abp@rct.dk)
- **CCP** Norway. Atle Dyregrov, Director, Center for Crisis Psychology and his colleagues has carried out research project and manuals available for students in African war torn areas [atle@uib.no](mailto:atle@uib.no)
- **Tammerfors University**, Finland. Professor Raija-Leena Punamäki, is internationally known as an important researcher in the field of children and war. Her research field is not Africa – but much is to be learned from experiences in other countries.

- **Network of researchers in Scandinavia** are focussing African youth. Their first conference was held in May 2004 at The Nordic Africa Institute. Among these researchers, Kamilla Solheim, Norway, studying ex-combatants in Sierra Leone, shows a special interest in finding models for rehabilitation of this group of vulnerable youth [kamillasolheim@hotmail.com](mailto:kamillasolheim@hotmail.com)
- **RSC**, The Refugee Studies Centre, Queen Elisabeth House, University of Oxford, England, conducts research about coping strategies and rehabilitation of refugees outside Africa that may add important knowledge to the understanding of suitable treatment models also in war torn countries in Africa. <http://www.rsc.ox.ac.uk/>
- **Universiteit Gent**, Departments of Orthopedagogics. Ilse Derluyn and her research colleagues studies post traumatic stress in former Ugandan child soldiers [ilse.Derluyn@UGent.be](mailto:ilse.Derluyn@UGent.be)).
- **The Joan B. Kroc Institute for International Peace Studies** and Carolyn Nordstrom Associate Professor of Anthropology at the University of Notre Dame conducts educational, research, and outreach programs on international peace. [http://www.nd.edu/~krocinst/faculty\\_staff/fellows/nordstrom.html](http://www.nd.edu/~krocinst/faculty_staff/fellows/nordstrom.html).
- **Innocenti Research Centre of Unicef**, Florence, Italy
- **TPO**, Women's Commission for Refugee Women and Children the Netherlands.



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