

Childhood, War, Refugeedom and 'Trauma': Three Core Questions for Mental Health Professionals

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This article first appeared in the journal of Transcultural Psychiatry, September 2000, 37 (3): 417-433.

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Derek Summerfield

Abstract The rise of the discourse of 'trauma' as a major articulator of suffering within Western culture is a facet of the medicalization of life that has gathered pace in the last century. In recent years, Western mental health professionals have been increasingly involved in services addressing the plight of war-affected populations - largely non-Western - in war zones or as refugees. Querying the extent to which their experiences can be reduced to a matter of mental health, this article addresses child refugees from war via three questions that go to the heart of the debate about how they are to be understood, the implications for their future maturation as individuals and citizens, and the role of psychological therapies aimed at catharsis of 'traumatic' memory.

Key words childhood . medicalization . mental health . refugee . social world . trauma . war

BACKGROUND

In the last 50 years there have been nearly 200 wars and armed conflicts, and a steady increase in the number active at anyone time - the current figure is nearly 40. Almost all of these have been in the non-Western world, and internal rather than between sovereign states. The poorest sectors of society and marginalized ethnic groups have frequently been the targets, as have those speaking up for their interests. There has been a six-fold increase in the number 1% of the global population. Only a minority seek asylum in Britain or other Western countries and over 90% are displaced internally or in neighbouring countries, many among the poorest on earth. Around 2.5% are unaccompanied children. 'Total' war at the grassroots level means that over 90% of all casualties are civilians, an intended effect, with little or no distinction generally made between armed or unarmed men, women and children, the elderly or the sick. UNICEF (1996b) says that in the last ten years 2 million children have died in war, 4-5 million have been wounded or disabled, 12 million have been made homeless and 1 million have been orphaned or separated from their parents. During conflict only 5% of child deaths result from direct violence and 95% from starvation or illness (Southall & Abbasi, 1998).

Modern conflict targets not just people but their ways of life, the social, economic and cultural activities that connect them to a particular history, identity, traditions, values and livelihoods. A key element is the creation of states of terror meant to penetrate the entire fabric of grassroots social relations as a means of control. In countries like Guatemala, Iraq or Algeria, silence is a survival strategy. Many such wars in Africa, Asia and Latin America have been played out on the terrain of subsistence economies.

War is seldom a clear-cut event. It is played out in settings attended by environmental degradation and exploitation, chronic poverty, entrenched social injustice maintained through the gun, pressure on the nation state, falling commodity prices, a global increase in food insecurity and a widening gulf between the wealthiest 20% and the poorest 20% in the world. Imposed structural adjustment packages reflecting Western neo-liberal economic orthodoxy can undermine the social fabric no less effectively than war has done, for example in Cambodia or Mozambique (Boyden & Gibbs, 1996). The World Health Organization (1995) is warning of a health catastrophe, with life expectancy in the poorest nations falling by the year 2000 and one-third of the world's children undernourished. It may be somewhat arbitrary to talk of the trauma of war but not the trauma of poverty.

Children are shot dead, maimed, tortured, raped, witness the murder or mutilation of those closest to them, and - no less terrible - the collapse of their social worlds. Those seriously injured often go without analgesia, anaesthesia or proper surgical attention. Three-quarters of deaths from anti-personnel mines are among children. Children were coerced, or volunteered, into active involvement in 33 conflicts during 1995-1996 alone (Brett, McCallin, & O'Shea, 1996). Some undergo military training, may be killed for trying to escape or expected to commit atrocities alongside adult soldiers and guerrillas, sometimes against their own families and communities. An estimated 250,000 children under 18 years of age are currently serving in government armies or armed opposition groups. In El Salvador, Martin-Baro (1990) described how children had to grow up in socio-political and dehumanizing oppression. He described how the developmental processes and social norms of such children had to accommodate this social 'normal abnormality' a climate of unremitting state terror, the militarization of social life and institutionalized lying. In Brazil, Columbia, Guatemala and elsewhere, off-duty policemen regard the elimination of street children as a form of social work (Summerfield, 1998). Such children are also vulnerable to sexual exploitation and drug abuse.

Another facet of contemporary conflict is the increasing likelihood that children will be separated from their families. Before the genocidal events of 1994, there were 20 children's homes in Rwanda. In 1995 there were 70 centres housing 12,000 children (a figure that had halved by the end of 1997, following family tracing work). There were also many households headed by children. Institutionalizing children, however well intentioned, may mean the loss of a family name and place of origin, and thus the links needed to establish a foothold in the adult world (Petty & Jareg, 1998). These trends may be exacerbated when women too become soldiers. In Eritrea in the late 1980s, 30% of troops were women; their children often went to institutions such as orphanages. Unaccompanied children are turning up regularly as asylum-seekers in Western countries.

The three questions in this essay may provide a backdrop for potential or actual encounters between a refugee child, with or without the family, and mental health professionals in Western countries in particular. They are questions which reflect resonant themes and assumptions that run through the contemporary debate and literature. They require critical reflection because of their influence on the mindset of the professional, which matters not least because of the disparity of power in their clinical encounters with refugees. From the point of view of refugees, the professional has everything - a fixed place in society, a voice, status, money, etc. - which has been

lost to them. Most encounters are also cross-cultural. The professional can ask the questions and the refugee only answer them, answers that will be interpreted or assigned in accordance with how the questioner reasons.

Those assessing a refugee child should, firstly, have basic knowledge about the war from which the family has fled, to complement their firsthand and personal accounts. It is then important to have as sophisticated a view as possible of the complex and evolving realities in which this child is currently embedded. In a clinical encounter one of those realities is the professional gaze and what informs it - however natural and self-evidently appropriate this may seem to be. As much from their cultural upbringing as from their training, mental health professionals will carry general assumptions about children and the nature of childhood. So too about what it might be like to come through firsthand experiences of violence without limits, of sudden loss of a parent or other family and of whatever was normal and familiar in day-to-day life, and of landing up in a strange country with strange customs. Few professionals have actually had these experiences. It does not follow that these conceptualizations are uniformly relevant to refugee children in all their diversity.

HOW CAN THE PREDICAMENT OF REFUGEE CHILDREN BE FRAMED AND WHEN CAN THEIR DISTRESS OR SUFFERING LEGITIMATELY BE SEEN AS MENTAL PATHOLOGY?

Children, with or without their families, reach Western cities and seek asylum after journeys that have often been difficult, and sometimes protracted and dangerous. Some of them have been in refugee camps. They bring with them the sense of a broken social world which is the experiential lot of the asylum seeker. The new arrival must contend with what is usually a strange culture and society largely shorn of allies and points of reference. Naturally, those who come from an urban, middle class or Westernized background may find a city less disorientating than do others. There may be comfort and advice to be obtained from refugee community organizations, although some asylum-seeker families are wary since such organizations may reproduce the political splits of the home country.

Practical issues present most urgently - housing, legal advice, social welfare entitlements, schooling and mental health professionals may be valued more for their advocacy than anything else. Insecurities over the ultimate fate of asylum applications may be pervasive. Beyond that, refugees must negotiate disrupted life trajectories, loss of status, sense of place and culture shock, as well as the attitudes of the host society - ranging from accepting to discriminatory. In his study of Greek Cypriot refugees from the Turkish invasion of 1974, Loizos (1981) described the loss of customary daily rhythms and what he called the duality of persons- and- things, the material element of relationships. Parents had nothing to give to their children, neighbours no longer interests in common or tasks to share. Refugee families are not necessarily 'lonely' but are often short of relationships with people who share the same pattern of meanings.

The experience of the child will also be shaped by the attitudes of parents and family to their new situation. Some families seek to hold tight to traditional values and take a conservative attitude to the new social milieu; others want to assimilate. There may be pressure on values that, until then, had been unquestioned. Traditional hierarchies-in

particular the relations between generations- are subject to new forces and persuasions. For the refugee child, the school may offer a potentially potent setting for building a new 'normal' life, though one in which the attitudes of non-refugee peers can be influential for good or ill.

The classic study of Freud and Burlingham (1943) gave a convincing demonstration of the positive effects of family attachment and of wider social supports in combating the influence of violence and disruption. The anthropological literature has similarly shown that uprooted peoples do well, or not, as a function of their capacity to rebuild social networks and a sense of community. The social world is thus pivotal-both what refugees bring with them in remnant form, and what they can reconstruct in exile. These collective resources, however buffeted, continue to embody the capacity of survivors to manage their suffering, adapt and recover.

While the impact of war on physical health is fairly well understood, its impact on mental health is much more contentious. An overview of the contemporary medical and psychological literature on the subject suggests a relatively polarized field, with little cross-referencing between the 'trauma' school and those querying it. On one side are clinicians and researchers who see Western psychological frameworks and practices as essentially having universal validity and relevance. They regard post-traumatic stress disorder (PTSD), which has assumed an almost hegemonic position in the field, as established scientific fact and see the current challenge as merely to fine-tune treatment technologies. Their articles tend to view 'post-traumatic stress' as a major public health issue. On the other side are those who take a more socially constructionist and culturally relativist approach to 'health', emphasizing the limitations of Western-led theory and practice based on a biopsychomedical paradigm. They tend to a more sober view of the scale of the clinically relevant psychological fall- out of violent conflict.

While any generalizations from one particular situation are problematic, the Northern Ireland conflict - with 3500 people killed since 1969 - is interesting since it is one war zone where comprehensive health, statistics have been maintained throughout. Over this 30-year period there is no evidence of a significant impact on referral rates to mental health services (Loughrey, 1997). Presumably, much of the human pain engendered during this lengthy period has been managed within the family and community.

One marker of the rise of 'trauma' as a health issue comes from the database of the US National Center for Post-Traumatic Stress Disorder. Although their coverage is mostly limited to the English-language literature, and even then is only partial, over 16,000 publications had been indexed by September 1999 (Lerner, personal communication, 1999). Western cultural trends-accelerating in the twentieth century-towards the medicalization of distress, and the rise of talk therapies, provide the backdrop to the discourse of 'trauma'. Medicine and psychology have replaced religion as the source of descriptions and explanations of human experience, and individual psychology has come to be seen as the core of human nature anywhere. Terms such as 'stress', 'trauma' or 'emotional scarring' have come into commonplace usage by the Western general public, frequently denoting candidature for professional help. It is because medicalized and psychologized thinking are now so embedded in popular constructions of 'common sense' that the conflation of 'trauma' with distress

(even after much more everyday events than war) has a naturalistic feel. Accounts that do not use the language of trauma may sound as if what children must endure during and after war is being played down. (They may also sound overly matter-of-fact, stripped of expected pathos, and thus unattractive or even in bad taste - contemporary aesthetics too can be psychologized. These matters touch mental health professionals as citizens, but naturally can come with them into their clinical work.

Torture is not, of course, a noxious phenomenon because PTSD can be diagnosed in some of its victims. Nonetheless, it is testimony to the power of medical frameworks to legitimate outcomes, and to signal severity, that not to use them may be perceived as tantamount to suggesting that victims of atrocity just pick themselves up and get over it.

None of this can be assumed to represent definitive knowledge, valid for non-Western peoples who comprise the vast bulk of the world's refugees. Western psychological concepts and methodologies are a product of a globalizing culture and may risk an unwitting perpetuation of the colonial status of the non-Western mind (Berry, Poortinga, Segall, & Dasen, 1992). Every culture has its own reserves of psychological knowledge, range of attributions to assign to adverse experience, and forms of accommodation, struggle and help-seeking. In many non-Western cultures distress is commonly understood and expressed in terms of disruptions to the social and moral order and no particular attention is paid to internal emotions as items in their own right. Western psychotrauma models, which liken the brain to a machine and see PTSD - the flagship diagnosis - as due to incomplete emotional and cognitive processing within that machine, cannot make much sense to such people (Bracken, Giller, & Summerfield, 1995).

Until the mid-1980s refugee mental health hardly existed as a topic, but since then interest in the psychological dimension of war has burgeoned. There is now a tendency - evident in the media, academic journals and material presented by humanitarian agencies - to conflate 'refugee' and 'war victim' into a general category of the 'traumatized', associated with psychopathology. One consequence of a medicalized idiom is that it reduce complex and still-evolving experience, meanings and priorities held by refugees to a single category- 'trauma'- so that all refugee suffering may be routinely attributed to index trauma events in the past, as the PTSD model directs, with too little attention to intercurrent social variables and background culture (Eastmond, 1998). For example, a UNICEF sponsored child trauma programme in post-war Bosnia reportedly interpreted everything in the bearing and behaviour of subjects in terms of post-traumatic stress, ignoring factors such as family poverty and marital violence. In Sudan, a lorry delivered a substantial load of plasticine to a remote camp for war refugees lacking even basic amenities, its inhabitants near destitute and barely subsisting, A far-off psychologist had decided that the children should use these materials to work through their war traumas (Petty, personal communication, 1996). In a study of their perceptions of violence, South African children gave as much prominence to their experiences at school, on the streets and at home, as to 'political' violence (Turton, Straker, & Moosa, 1990).

There may be risks that the host society offers refugees a sick role instead of what is really sought: viable opportunities for social integration and meaningful citizenship as part of the rebuilding of a world. Indeed, Western psychological models have never

really acknowledged that social action directed at the conditions of one's life might be a strategy for improving mental health. Psychotherapy promotes an ethic of acceptance: it is the individual who has to change, not society.

Consider the role of work: men made redundant when whole industries are shut down describe how life loses shape and colour, and how in the end this loss of the role of breadwinner, of social identity and standing is corrosive. Unemployment is associated with early death, divorce, family violence, accidents, suicide, higher mortality rates in spouses and children, anxiety and depression, disturbed sleep patterns and low self-esteem (Smith, 1992). It is undoubtedly harder for refugee families in Western countries to settle down now than it was when work was plentiful, up to the end of the 1970s. It is a hypothesis worth testing whether child refugees in families where the father is employed do better.

Psychological trauma is not akin to physical trauma: people do not passively register the impact of external forces (unlike, say, a leg hit by a bullet), but engage with them in active, problem-solving and social ways. What events mean or come to mean is at the heart of this process and those for whom events remain incomprehensible may well be disadvantaged in their attempts to regroup and rebuild. A child still perplexed or angry at the disappearance or murder of his father in Somalia may well make heavier weather of settling into a school and the other challenges in a new society. So too if her or she is in family carrying high levels of distress or tension in exile, or if a parent is depressed. Professionals have a role here in some cases, although for the majority the process of coming to an understanding of what has happened can only take place in the context of the family and social group. In some settings, refugee children develop strong attachments to each other and become mutually supportive. Discussions with parents must take account of the fact that every culture has its own construction of 'family', including the duties, entitlements and behavioural norms applied to each of its members. Family harmony may well be more valued than individual autonomy, with containment of emotion and adaptation to social circumstances viewed as signs of maturity (Kirmayer & Young 1998).

Most refugee distress is normal and an adaptive communication. Nonetheless, there will be some refugee children whose demeanour or behaviour may suggest something more. The child sits in a web of historical, cultural, political, socio-economic and familial realities, the distress he or she is embodying being both personal and social. Against the backdrop of a damaged social world, the challenge is to understand when and how a damaged mind (presumably the core rationale for the entry of a mental health professional) might usefully be identifiable, and to keep refugee understandings and frameworks at the heart of the engagement.

CAN IT BE ASSUMED THAT WAR AND REFUGEEEDOM RENDER CHILDREN PSYCHOLOGICALLY VULNERABLE IN THE SHORT OR LONGER TERM?

Every culture has its own ideas and constructions of the nature of childhood. In Western societies the involvement of professional psychology in child-rearing has tended to promote predominantly middle-class ideals and aspirations. Such prescriptions are in part self-fulfilling prophecies, an instrument by which a standard

and desired form of childhood is 'produced' (Ingleby, 1989). Boyden (1994) has pointed out that many interventions with child survivors of war in non-Western societies are based on Western constructions of childhood, which emphasize innocence, vulnerability and dependence, and on Western understanding of what is desirable and what pathological in child health, welfare and development, all assumed to be universal. The idea that the early emotional experiences of children, particularly with their parents, powerfully shape adult personality functioning is taken as self-evidently true in the West but not elsewhere. This portrayal tends to a view of children as passive victims and not active survivors. The child labour that is common in many poverty-stricken parts of the world is deplored in the West because what we understand by a proper childhood appears to have been 'lost'. But some child labourers do not see themselves as victims, and take pride in what they are doing to keep their family fed. Not only do constructions of childhood vary from one culture to another, they vary over time within same culture. After all, small children were working long hours in British coal mines well into the nineteenth century.

War-affected children need attention but the primary basis for this should be social and educational. Both the subjective well-being and objective fortunes of children are a function of those of their parents or other caregivers and anything that is pro-family and pro-community must bolster their psychological resources and give them the chance to accept and adjust in the context of a more positive day-to-day reality. There may also be a lesson in the work of Eisenbruch (1991), who addressed what he called 'cultural bereavement.' He pointed out, for example, that Cambodian adolescent refugees in Australia, where there was less pressure to conform to local norms and where there was access to some traditional ceremonies, did better than those in U.S. Lastly, it should be noted that poverty is perhaps a more pervasive determinant of the longer term fortunes of refugee children than war per se.

In recent years refugee reception in Western countries, and humanitarian programmes in war zones, have been increasingly influenced by pronouncements by mental health professionals as consultants to UNICEF, WHO, and leading aid agencies. The trend has been to portray war-affected children as psychologically 'vulnerable' or damaged. The focus has often been on child soldiers or orphans, but some consultants have tended to portray children en masse in these terms, to the extent of references to a 'lost' generation (Summerfield, 1999).

What, for example, do child soldiers actually say? A series of interviews in Sierra Leone was instructive. Typically from impoverished backgrounds, " what the children provided were clear, rational reasons for joining a militia or army. In one rebel movement, half of all combatants were aged 8-14 years. Many became intensely loyal to their units, which may have played a quasi-parental role. They fought with open eyes, to defend their communities and take revenge for attacks on their families, to make a living from loot, to reverse educational disadvantage. Neither dupes nor straightforward victims, they sought to stay alive with the best of their strength, and ingenuity. Rated highly by officers, they could fight without inhibition and kill without compunction, sometimes as an extension of play. Although many rated their experiences negatively, this was perhaps as much a consequence of loss of family and normal life as of the violence per se (Peters & Richards, 1998). Elsewhere too - from EI Salvador to Palestine to South Africa - children have actively identified themselves

with social and political causes at stake in unjust and oppressively ruled societies (Dawes, 1990; Punamaki & Suleiman, 1990).

It is simplistic to see children only as recipients of experience, unable to act on their environment- whether war zone, refugee camp or in country of asylum. A telling example of just how resilient and adaptable war- affected children can be (or have to be), and of the dangers of a Western clinic mindset, comes through in a study by Jeppsson (1997) of Dinka children who fled the Sudanese civil war. He found that though largely without the presence of adults, they had managed their experiences remarkably well over the following five years or so, drawing on culture- specific coping skills. Fewer than 5% reported their experiences of war and violence as reasons to be unhappy, although nostalgia and a longing for missing family and friends were common. There was little evidence of mental ill health. What is interesting is that an internationally known UNICEF psychologist had previously reported on these same children. His findings were that over 50% of them had 'disabling' PTSD which threatened to be a lifetime problem without psychological intervention. This had clearly not been borne out.

Claims about mass psychological casehood among war-affected children may reflect the prior mindset of Western professionals - who find what they expected to find - and the use of psychological questionnaires on populations for which they have not been validated. A striking example was a UNICEF (1996a) survey of 3030 Rwandan children aged 8-19 years using the Impact of Events Scale and a Grief Reaction Inventory. Their conclusion was that there were high levels of post-traumatic stress requiring urgent treatment to 'restore a sense of hopefulness about their future and to prevent long term sequelae such as depression and anxiety disorders.' This seems a poor empirical basis for a generalization which risks stigmatizing whole populations of children as sick or permanently damaged.

What, then, of long term effects? Because in the West many believe that, for example, childhood sexual abuse, incidents of criminal violence and even persistent bullying at school are all experiences that may have enduring psychological effects, it seems natural that war and atrocity would do this to virtually all children exposed to them. This tends to be reproduced not just in mental health publications but in the world's most widely distributed general medical journals, as if it was established, universal fact. UNICEF (1996b) states that millions of children worldwide have been psychologically traumatized by war and that addressing this must be a cornerstone of their rehabilitation because 'time does not heal trauma'.

As the leading international child agency, UNICEF's pronouncements are especially influential. Quoting them, a *British Medical Journal* editorial stated that the psychological consequences for children of armed conflict are 'so great that they can rarely be repaired' (Southall & Abbasi, 1998). Another recent editorial was entitled 'Refugee children. May need a lot of psychiatric help' (Hodes, 1998). A recent *Lancet* editorial stated that 'the long-term medical sequelae of a refugee crisis are largely psychological' (*Lancet*, 1999). Does this represent a sober consensus with important implications for mental health service provision, or merely a kind of piety? A recently published article, again in the *British Medical Journal*, about the civil war in Sierra Leone puts it that 'a generation of Sierra Leonean children has been brutalized' (Salama, Laurence, & Nolan, 1999) – not 'treated brutally, objective fact for many of

them, but 'brutalized'. Are the authors really in a position to classify these children en masse-who they have not even met - as having damaged psychologies and moral norms? Isn't this a kind of medical imperialism, even if unwitting, and one that might distort how international assistance to these children - now or later - is prioritized, as well as colouring how society comes to think of them, or they of themselves? Were the millions of children caught up in World War II in Europe similarly 'brutalized' and, if so, what became of it? Arguably these characterizations are not really about far-off children, but about ourselves, Western civilization and its ideals. They seem a kind of homage to 'our' vision of childhood, to the fragile innocence and beauty which we are sure could not survive the enormity of such war, and which are unrecoverable. In short, these are cultural values masquerading as medical facts.

The literature on survivors of the Jewish Holocaust is often held to demonstrate that extreme events such as war and mass atrocity may induce lifelong psychological effects in victims, and that these effects can even be transmitted to victims' children and grandchildren. Krell (1997) alludes to the medicalization of understandable distress in some of this literature, and Solkoff (1992) noted the salience of psychoanalytically orientated studies of relatively few cases whose findings were not borne out in surveys of non-help-seeking subjects.

Studies on refugee children in the U.S. report that serious psychiatric disorder is present and persisting in up to 40-50% (for example, see Sack, Clarke, & Seeley, 1995). How credible is this? It is difficult to draw firm conclusions about the significance of supposedly ongoing PTSD in war-affected children because the diagnosis may say little about capacity to function and to get on with life (Richman, 1993). This is not just the issue of culture: the difficulty the PTSD model has in distinguishing between subjective distress and objective disorder is only one reminder that a psychiatric diagnosis is fundamentally a way of seeing, or a style of reasoning, and not at all times a disease with a life of its own.

Long-term qualitative studies of children following experiences of war and social turmoil are rare. One remarkable exception is a little-known study that traced, over 50 years, the children caught up in the Greek civil war of the late 1940s (Dalianis-Karambatzakis, 1994). These children had witnessed violence at close range, had lost their fathers to flight or execution and had been imprisoned with their mothers, some of whom were subsequently executed. All children reaching the age of two were abruptly taken from their mothers, who remained in prison, and placed in foster homes or orphanages. Here the staff were openly negative or hostile to the political beliefs of the children's parents. Reunions, if they ever took place, were delayed for years and even after that there was ostracization and discrimination. The author of the study, who had herself been a detainee with her subjects in 1949-1950, found to her surprise that although they naturally retained painful memories, almost all the children had grown up into well-adapted adults.

Reducing experiences of children simply to a question of mental health tends to mean more focus on vulnerability in individual psychological terms rather than social ones. Ultimately, it is the economic, educational and socio-cultural rebuilding of worlds, allied to basic questions of equity and justice, which above all will determine the long-term well-being of millions of child survivors of war worldwide. For those for

whom this does not happen, war may indeed turn out to have been a life sentence, but this is not 'trauma'.

SHOULD THE BAD MEMORIES OF REFUGEE CHILDREN BE 'WORKED THROUGH?'

The rise of talk therapies within Western culture has accompanied a gradual revolution in professional, and indeed public, understanding of memory and its meaning. The growth of a science around memory has arguably tended to remove it from the exclusive ownership of those carrying it, passing it on to professionals for their expert pronouncements. As noted above, PTSD is held to be a disease of unprocessed 'traumatic' memory. However, Young (1995) describes how 'traumatic' memory is not a found object but a man-made one, originating in the scientific and clinical discourses of the nineteenth century. There have always been unhappiness, despair and disturbing recollections but no 'traumatic' memory in the sense that we know it today.

Nonetheless, a range of mental health technologies - trauma counselling, critical incident debriefing, etc. - has been developed which trades on this concept of memory. These services are either pitched as preventive (early intervention will reduce the chances of 'traumatic' memory/PTSD forming) or curative (an already formed 'traumatic' memory can be dissipated by a 'working through' with the therapist).

Reviewing this field, Raphael, Meldrum, and McFarlane (1995) concluded that there was, to date, no objective evidence of the efficacy of psychological debriefing after trauma, but that such services were being widely instituted anyway. Wessely, Rose, and Bisson (1998) reviewed the available literature on one-off debriefing interventions. They found the quality to be generally poor, but on the basis of a study of six published trials they concluded that there was no evidence that debriefing reduced general psychological morbidity, depression or anxiety. There was a suggestion that some clients were upset further by the experience.

The subject in these studies were generally Western adults who had experienced a single, clear-cut, peacetime event, and the question is whether there is a place for this or other types of trauma work with non- Western refugee children whose adverse experiences have been multiple and are still not over. Indeed the reification of 'traumatic' memory- a private, static, circumscribed, universal and pathological entity which reveals itself in 're-experiencing' and 'flashbacks' - risks being a caricature of reality. Memory is fluid and multi-faceted, with dynamic and indeed dialectical interplay between personal and public realms (Skultans, 1998). Any act of remembering is interpretative, driven by the concerns or ideas of the present. What a war survivor remembers will not represent a single, definitive narrative, will skip between victim and protagonist modes, will be shaped by the context in which the telling takes place and the purpose to which it is to be put.

A study of 3-9-year-olds during the civil war in Lebanon found that war was the major topic of conversation for 96% of subjects, of play for 86%, and of drawing for 80% (Abu-Nasr, 1985). In the 1980s the drawings of Ugandan children revealed their preoccupation with firsthand experiences of violence, death and starvation: pictures of soldiers shooting their mothers, infants lying bleeding to death, dogs eating corpses, people crouching in forests with ribs jutting and bellies swollen (Harrell-Bond, 1986). In Guatemala children enact public executions in their play, and there have been similar observations in many war zones (and by me in Nicaragua). Much of this is normal and even useful, an attempt to achieve some mastery of an unstable environment, It is not 'post-traumatic'. Children will naturally take bad memories with them into exile but care is required before these can be assumed to warrant management as an entity apart. Many non- Western cultures have little place for the revelation of intimate material outside the family circle and consider 'active forgetting' as a normative means of coping (although it might be said that mankind in all epochs and cultures has had to deal with its woes by putting them to one side and getting on with life). There is little basis for a universalist assumption that a child exposed to war and atrocity should ventilate emotionally or 'work through' all this if they are to recover properly, with recovery defined as the 'processing' of 'traumatic' memory.

Some children referred to mental health services do engage with a verbal or other exploration of their concerns, including the associations and memories they have of life - in war and peace - in their own country. One important element of such work may involve the child's attempt to grapple with questions like: 'Why did they do this to us?' or 'Why did we lose everything?' or 'Why have those responsible not been punished?' This is the realm of the kind of moral knowledge provoked by manmade disaster and loss. It is worth nothing that the psychological sciences have been competent at addressing the 'how?' of a patient's questions, but not the 'why?' or 'why me?' (Taussig, 1980). Moreover, the traditions of the clinic are for its outputs to be detached and technical, morally and politically neutral. This begs basic questions about how far professional notions of 'healing' as an expert-led process aimed at emotional catharsis - independent of back- ground, current social situation, the availability of wider societal recognition or justice - can go.

CONCLUSION

How pain and suffering were to be understood has always been at the heart of the relationship between human consciousness and the material world. The religions of the world traditionally provided frameworks to capture pain, and the terminology with which to express it; over the last century in the secularizing West, this role passed to medicine and psychology. But human pain is a slippery thing, if it is a thing at all. Mental health frameworks, and the discourse of 'trauma', can contribute to its elucidation, in particular when it is too much for a person as a biopsychological organism to bear. Nonetheless, the transcending reality is that counting the human costs attached to adverse experience invokes not technical considerations but philosophical and socio-moral ones: these differ radically across cultures, but also do not stand still over time in one culture or indeed in an individual life course. Whatever their pain, the vast majority of refugee children seem competent to live on without breaking down, mourning or, putting aside their losses and seeking creative accommodation with their present circumstances. It might be said that the imperatives of life leave little choice, that this is the lesson of history. With a few exceptions,

these trajectories are scarcely visible from the clinic: tracking them is principally the work of historians, anthropologists, sociologists, political economists), poets, journalists, religious, political and community leaders, and via the verbal and written output of the actors themselves.

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