A study of the psychological state of former abducted children at Gulu World Vision Trauma Centre

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If the children are not protected from their abusers, the public will one day have to be protected from the children.
Anonymous

Abstract

Psychological trauma can be understood to mean an event that overwhelms a person's sense of control, connection and meaning in life. It causes a person to experience overwhelming fear, helplessness and isolation. These events are the kinds that threaten the person or relatives in the sense of their existence, or by causing the destruction of things that are essential to their lives, such as the killing of their parents or relatives, burning of their houses and destruction of their property. This study reports on the situation in Northern Uganda, where children were abducted and coerced into guerrilla warfare. The strategy used was to "burn the bridges" between the children and their families and communities. To facilitate the rehabilitation process the study was intended to provide the social workers, counsellors and teachers at Gulu World Vision Trauma Centre (WVTC) with a handbook and guide to assess the signs and severity of traumatic reactions and the perception of the current situation among the children to give them an insight into the intervention needs of the children. Seventy-four out of 168 children, aged 8-18 and residents at the centre, comprising 21 girls (28.3%, mean age 13.4) and 53 boys (71.7%, mean age 14.2), were randomly selected for the study. The children were not only exposed to horrendous wartime events but were also forced to participate in heinous and ghastly activities while in rebel captivity. They manifested a broad range of signs of physical, emotional, cognitive and behavioural traumatic reactions. The categories of traumatic reactions were: almost normal (11, 15%), mild traumatic reactions (34, 46%), moderately traumatic reactions (26, 35%) and severely traumatic reactions (3, 4%). The perception of the current situation among the children was that of hopelessness, lack of trust in the adults in the community, sometimes including their parents, and a bleak future. They were preoccupied with the fear of retribution, reabduction, absence of a source of livelihood, and when the war would end. The majority could not understand why it had all happened and why it had happened to them in particular. Rational Emotive Behavioural Therapy, in addition to a holistic agenda sensitive to the cultural, psychosocial, emotional and developmental needs of the children in the context of the community, are recommended as intervention programmes. In addition, organised and appropriate tension-relieving activities such as games and sports, dances, culturally appropriate counselling and therapy are recommended, in addition to the establishment of community support networks and an education system cognisant of their special individual needs. Above all, technical and entrepreneurial skills training and micro-credit facilities are proposed as part of the intervention.

Key words: psychological state, abducted children, traumatic reactions, wartime events

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Introduction

For the past fifteen years, Northern Uganda has been engulfed in an atrocious and violent conflict between government forces – Uganda People's Defence Force (UPDF) – and rebels of the Lord's Resistance Army (LRA). This conflict has resulted in large-scale internal displacement of people, abductions of over 14,000 children (Table 1), deaths and the destruction of homes, basic infrastructure and services such as education and health.[1] Subsequently, the very core and fabric of the society have broken down, and the people affected have lost hope and suffer from a range of psychological problems.[2] This large-scale abduction of children is the most tragic aspect of this conflict, forcing the vulnerable and innocent to become part of the conflict as child soldiers, human shields, hostages or as coerced sexual slaves of rebel commanders. Children as young as seven have been abducted; however, the majority are between 10 and 18 years of age. Many of them have either escaped from rebel captivity or were rescued from battles with the rebels. This has attracted the attention of international non-governmental organisations (NGOs), which help provide psychosocial services and reintegrate them into their communities.

World Vision is a Christian-based NGO operating in many parts of the world, including Uganda. Their areas of operation, among others, include: education, micro credit, poverty alleviation and psychosocial support. The World Vision Trauma Centre (WVTC), in Gulu, Northern Uganda, was set up in 1990 to help rehabilitate and eventually reintegrate formerly abducted children who were rescued or had escaped from rebel captivity back to their families and the community. Rehabilitation at the centre ranges from six to twelve weeks, depending on the degree of severity of the psychological reactions they manifest. After rehabilitation, the children are reunited with their parents and reintegrated into the community with a possible follow-up. The therapies employed by the centre include: tension-relieving games and dances, art therapy and individual and group counselling.

Upon admission to the centre, the children showed a variety of traumatic reactions such as withdrawal, fear, anxiety, affect and conduct disorders, aggression, intrusive thoughts and a hoard of other posttraumatic stress disorder (PTSD) symptoms such as nightmares, lack of concentration, hypervigilance, sleep disorders, depression, deep sadness, abnormal reactions to situations, as well as attachment disorder (AD), attention deficit hyperactive disorder (ADHD) and apathy. This study initially aimed at providing social workers, counsellors, health workers and teachers at the centre, to facilitate the rehabilitation process, with a handbook and guide to assess the signs of traumatic reactions severity of traumatic reactions and the children's perception of the current situation. This was subsequently intended to provide focused and appropriate measures of intervention and rehabilitation to generate healing, development and subsequent reintegration of the children into their families and community.

Table 1. *Persons abducted by district in Northern Uganda (N = 14585).*

	APAC (n)	Gulu (n)	KITGUM (n)	LIRA (n)
Not returned	597	2610	3161	131
Returned	1442	1842	4631	171
District total	2039	4452	7792	302

Source: UNICEF, 1998.

Trauma

Trauma has a broad definition. In this case, it could be understood to mean the conse-

quences of traumatic events that overwhelm a person's sense of control, connection and meaning in life; or events that cause a person to experience overwhelming fear, helplessness and isolation. These events are the kinds that threaten the person or relatives in the sense of their existence, or by causing the destruction of things that are essential to their lives, such as the killing of their parents or relatives, burning of their houses and destruction of their property. Such traumatic events include: war, natural catastrophes, accidents, deaths and exposure to violence. The consequences of these traumatic events include: nightmares, extreme fears of objects that remind them of the traumatic events, intrusive thoughts, anxiety, isolation and withdrawal. In Northern Uganda, children were abducted and coerced into guerrilla warfare, and one of the strategies was to "burn the bridges", that is, to completely cut, alienate, detach and destroy the bond between the children and their families and communities as a means of keeping the children in the rebel ranks and preventing them from escaping from rebel captivity. One way of doing this was to force the children to be part of a group that attacked and looted their own villages and possibly killed their own families. Another strategy was to tell the children that their parents and all their relatives, whom they had left behind, had already been killed and their homes destroyed. In addition, while in captivity, the children were also informed that if they came back to their homes, they too would be killed and that even those who were admitted to hospitals were injected with poison.[3] They were brutalised and sometimes forced to kill or be killed. They wielded life-and-death powers over adults, often in their local communities, and sometimes over fellow children who disobeyed the orders of their older rebel mentors. The children who tried to escape and were caught were tortured and often killed by fellow children as an example to those with intentions to escape. They were highly traumatised and dehumanised as a consequence of widespread exposure to violence through this strategy.[2,4]

Methodology

Sample

The sample in this study consisted of 74 children: 21 girls (28.3%, mean age 13.4) and 53 boys (71.7%, mean age 14.2) out of 168 children aged 8-18, residents at WVRC Centre, selected in a stratified random sampling to ensure that the proportion of boys to girls in the study was the same as in the target population.

Procedure

Permission was obtained from the centre and the children's parents to conduct the study, and an initial period of two weeks was allowed for familiarisation with the children to build rapport. Each child was assigned a number, which was subsequently placed in a box and shuffled, and the required number of children drawn from the box. The participants were grouped according to gender and a one-on-one interview was conducted. For in-depth interviews, two or more research assistants interviewed the participants. In all the cases, the questions in the questionnaires and interview schedules were read out aloud to them. Female and male research assistants led the female and male groups respectively. To ensure anonymity and confidentiality, the names of the participants were not recorded.

Measures and analysis

Two sets of questionnaires were used. The questionnaires were crosschecked by various NGOs working in related fields, pilot-tested and found to be reliable. The first questionnaire, an 18-item War Experiences Checklist, made for the purpose of this study, dealt

with general information about life in rebel captivity and the kind of traumatic events they experienced, and was rated on a scale of 0 (no) and 1 (yes). A sum score was obtained by adding up all the positive endorsements of events a child experienced while in rebel captivity and descriptive statistics was used to analyse the results. The second was a DSM-IV-based 30-item self-rated traumatic reactions questionnaire rated on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit) and 4 (extremely) of what their reactions were concerning their traumatic experience.[5-6] This questionnaire was aimed at recording the severity of traumatic reactions among the children. Scores were classified as: 0-12 = almost normal; 13-48 = mild traumatic reaction; 49-80 = moderate traumatic reaction; and 81+ = severe traumatic reaction. The overall score is indicative of the severity of traumatic reactions of the participant. The semi-structured interview was used to obtain information concerning the children's perception of the current situation as well as life in captivity.

Data was also obtained from the records and files of the children at the centre documenting the physical, emotional, cognitive and behavioural signs of psychological distress manifested by the children. This was tabulated and presented as signs of psychological distress. Social workers and counsellors at the centre made these records. Case stories were obtained through the semi-structured interview that dealt with the children's perception of the current situation and life in captivity. Records of responses from the structured interviews with the children and data from the records at the centre were carefully analysed and transformed into meaningful broader content categories in order to analyse the intensity of traumatic reactions among the children through group discussion and analysis by the counsellors, health workers and social workers at the centre. The records were again cross-examined by different research assistants, the principal investigator and the counsellors at the centre for cross-validation of the interpretative thematic analysis; a careful multistage analysis was used in which information collected was transformed into meaningful broader content categories, and later discussed and analysed until particular themes emerged. All the recordings by the different research assistants were later compared, and a common position arrived at. In analysing the perception of the current situation, records of interviews by the different research assistants were compared, discussed and carefully analysed and transformed into meaningful content categories to arrive at the perceptions of the children on the current situation.

Results

Signs of traumatic reactions among the children

The children showed an array of signs of traumatic reactions and symptoms as a result of exposure to a broad spectrum of violent activities and experiences. Table 2 shows the affirmative endorsements of the 18 items on the War Experiences Checklist specifically made for this study. The mean total score on the War Experiences Checklist for the whole sample was 10.8 (SD = 2.8, range = 4-6). Among the experiences highly endorsed by all the participants were long-distance treks, death threats and thinking that they would be killed. Other experiences, such as seeing dead bodies and body parts, were witnessed by 90% of the children, while 47% participated in killings and 20% saw family members or close relatives being killed. To corroborate these findings, records from the files of the children at the centre were studied and found to be consistent with the war experiences.

Table 2.
War experiences checklist (N = 74).

Events	Yes (%)	No (%)
Walked very long distances without rest to avoid rebels	100	0
Saw other people being abducted	100	0
Slept in the bushes to avoid abduction by rebels	100	0
Witnessed people being flogged	100	0
Thought that you would be killed	100	0
Threatened with death	100	0
Had to hide sometimes to protect oneself	100	0
Saw dead bodies or parts	94	6
Saw killings and injuries with machetes, pangas or knives	90	10
Saw someone shot	87	13
Heard people shouting or screaming for help	80	20
Escaped narrowly from rebel abduction	78	22
Escaped narrowly from battles	78	22
Witnessed village raids	70	30
Saw someone blown up in a landmine blast	55	45
Participated in killing their own relatives	47	53
Participated in beating or killing a fellow child who tried to escape	40	60
Saw your family members or close relatives being killed	20	80

The signs and symptoms were categorised as follows: a) physical, b) emotional, c) cognitive and d) behavioural signs, and are listed in Box 1. All the children showed at least one of these signs and symptoms. The majority of the children were malnourished, emaciated and had numerous dermatological complaints, such as rashes, scars and wounds. They also had eye problems, muscle aches, sores, pains and diseases such as cataract and conjunctivitis. Many of the girls who had reached menarche were having irregular menstrual cycles. Three of the girls who had already reached puberty, and had started having their menstrual periods, had stayed for over a year without menstruating. They were severely depressed and expressed fears that they would not have children in the future because of their condition. The common emotional signs were sadness, fears, irritability and numerous phobias, especially those associated with their experiences while in rebel captivity. A few, especially the younger ones, were prone to crying. The common cognitive signs included: lack of concentration, confusion, intrusive thoughts, absentmindedness and incoherent speech patterns. Bedwetting, nail biting, thumb sucking, sleep disturbances, repetitive play and failure to comply with rules and regulations were also common among the children. Many of the children (29, 39.1%) had nightmares quite often and others were withdrawn and engaged in reckless and self-destructive activities. Many were also very suspicious and found it difficult to stay in one place for a long time.

Severity of traumatic reactions among the children at the centre

Overall, 11 children (15%) were found to be almost normal, 34 (46%) were found in the mild reaction range, 26 (35%) in the moderate range and 3 (4%) in the severe range. It was observed that many of the children who had stayed for a shorter time in rebel captivity had mild traumatic reactions. The majority of those who were in the mild and moderate categories were in the age group 13-18 years old, and those categorised as almost

normal were in the age group 8-12. The three children who were categorised as having severe traumatic reaction were girls. They very rarely verbally communicated and were withdrawn and extremely suspicious, often had nightmares and messed themselves whenever they answered the call of nature (Box 2). The classifications of the traumatic reactions were consistent with the records on the physical, cognitive, emotional and behavioural signs manifested by the children. Children in the category "almost normal" presented with very few, if any, of the symptoms required to make the assessment. Poor hygiene and a few dermatological signs were present. Among the children in the category "mild reaction", there were symptoms that could be used to make the assessment, and there was one or two minor impairments in social functioning, such as difficulty in complying with rules or regulations, repetitive play and social withdrawal. There were clearly many signs and symptoms (physical, emotional, cognitive and behavioural) that could be used in the assessment of the category "moderate reaction". The functional impairment in this category included: difficulty in complying with rules, extreme suspicion, aggression, repetitive play, social withdrawal and enuresis. Among th children in the "severe" category, there were numerous signs and symptoms in excess of those required for assessment. There were marked impairments such as depressive withdrawal, nightmares and sleep disturbances, daydreaming, aggression, crying, difficulty in staying in one place and reckless and sometimes self-destructive activities (Box 1). Excerpts from some of the outstanding cases are described in Box 2.

Physical signs	Emotional signs	Cognitive signs	Behavioural signs
• Malnourished and emaciated • Dry lips • Poor hygiene: long and dirty nails, dirty, smelly and untidy • Chest infections and bad coughs • Fevers • Amenorrhoea • Dermatological signs: rashes, scars, wounds, etc. • Ear, nose and throat problems • Excessive sweating • Pain related to the muscular-skeletal system • Twitching eyes • Pelvic pains (mainly girls) • Reduced muscular endurance or general fatigue	• Sadness • Anxiety • Fears and worries • Stress • Depression • Irritability • Bitterness • Disillusionment • Hopelessness • Crying, screaming and groaning • Phobias related to experiences in rebel captivity • Pains and body aches without an apparent cause	• Intrusive thoughts • Confusion • Lack of concentration • Absent-mindedness • Incoherent speech pattern	• Crying • Nightmares and other sleep disturbances • Aggression • Lack of body care • Daydreaming • Thumb sucking • Enuresis • Biting • Depressive withdrawal • Difficulty in complying with the rules at the centre • Repetitive play • Extreme suspicion • Reckless and sometimes self-destructive activities • Loss of interest in play/ games • Social withdrawal • Difficulty in staying in one place for a long time

Box 1. *Summary of the signs and symptoms from records and observations at WVRC Rehabilitation Centre.*

Perception of the current situation among the children

The perception of the children of the current situation was mainly based on their experiences during their abduction from the community and in rebel captivity and at the time of rescue or during their escape from rebel captivity (Table 2). Many expressed hopelessness, lack of trust in the adult community and a bleak future. Some of the children had no knowledge of where their parents were, others had committed atrocities

J, girl, 12 years old, was abducted when she was 11 and was in rebel captivity for a year. She and her friend made a daring escape from rebel captivity during a battle when her captors were overpowered and scattered in disarray. While in the bush with the rebels, she was allocated to one of the rebel leaders and was responsible for domestic chores: collecting firewood, fetching water, cooking and cleaning. She was beaten and abused by the wives of the rebel commander. She witnessed her fellow captives severely beaten and on many occasions was made to participate in the beating. In one incident, three of the children who tried to escape were killed. They were cut by machetes and beaten with huge sticks. J participated in burying them and it utterly revolted and shattered her. She says the scene keeps coming back to her. She is withdrawn, depressed and sad. She is also very suspicious and nervous. She fears being abducted again, as the rebels are still operating in the area. She feels that she has to undergo traditional rituals to cleanse her.

D, boy, is 15 years old and was abducted together with his sister on the way to school one morning. His sister was badly injured in a battle during which government soldiers intercepted the rebels as they were taking their captives across the border. He learnt that she later died. D confessed that he is sad and does not have any hope for a bright future for himself because he learnt that the rebels beat his father to death, and there is no one to pay his school fees. He does not have the same feeling he used to have for his mother. When asked why, he kept quiet as he looked down. He has problems with his sleep and finds it hard to concentrate on anything for a long time. He fears he might be abducted again because the rebels are still active in his home village to which he loathes to go back. D is sometimes very aggressive and plays repetitively. He says he participated in many battles and was forced to kill his friends who tried to escape. He also believes that he might have killed many during the battles. He actually confessed that his commander loved him because he was daring during battles. He feels a deep sense of insecurity and guilt and fears he might be abducted again. Like J, D feels that he has to undergo traditional rituals to cleanse him.

K is a 17-year-old boy who was brought to the centre by government soldiers who rescued him from the battlefront where many of his colleagues with whom he was abducted three years ago were killed. He lives in great fear and is always suspicious and cannot stay in one place for a long time. He washes his feet several times a day. When asked why he keeps quiet. When pressed to explain this behaviour, he becomes very nervous and begins to stammer. Later on, he hinted that he was forced to repeatedly kick a friend to death after he tried to escape. K is usually withdrawn but easily irritable and aggressive. He does not want to go back home after the counselling and fears that he might be abducted and killed by the rebels. He frequently has nightmares and wets his bed every night, a situation he describes as humiliating and degrading because his friends laugh at him and he fears his wife will not tolerate this kind of situation.

B, girl, 16 years old, was abducted when she was 14 years old and had already started her menarche. She has not had her menstrual period for the last four months and yet she is not pregnant. She was diagnosed with gonorrhoea and syphilis upon admission at the centre. She fears she might not have children in the future. Her tasks while in rebel captivity were to do domestic chores: walk long distances to fetch firewood and water, cook and clean. Sometimes the commander would come to the hut in which she slept and ask her to come out. When she remembers this, she cries all night long. She does not feel safe at the centre and says she does not want to go back home. Loud noise frightens her and makes her tense.

S, a 14-year-old boy, cannot follow what he is told to do. He is always very angry and irritable and quarrels a lot with his peers. Sometimes he wakes up shouting in the night. He was abducted one night from his home village. He participated in raiding villages, looting foodstuff and brutal killings and was made to amputate the legs of villagers who did not follow rebel rules and regulations. He feels very guilty about all this. He is hyperactive and unable to concentrate on any activity, and is unable to stay in one place for long.

Box 2. *Excerpts from cases showing the degree of traumatic reactions among the children at the time of the study.*

against their communities, including torching their houses, looting their foods and sometimes killing their relatives. For fear of retribution, they did not want to go back to their communities. Many of the children were very suspicious of the communities and facilities they were indoctrinated against while in rebel captivity. For instance, they avoided accessing health facilities for fear of being poisoned, and those who had not yet met their parents feared that they may be dead. Another source of great fear among the children was the possibility of reabduction by the rebels who are still operating in some of the areas from which the children came and into which they are to be reintegrated. The grinding poverty in the communities made it unconducive for the children to want to go back. Many of the children had also lost their parents, either as a result of the war or natural causes, leaving the children without any support. The majority of children of school-going age expressed the desire to go back to school or be trained in some skill that would be a source of livelihood for them in the future. Also very prominent was the worry about when the war will end.

Discussion and conclusion

Exposure to wartime events is generally associated with a variety of traumatic reactions. This can take the form of physical, emotional, cognitive or behavioural signs and different levels or degrees of trauma. The present study sought to examine the signs and severity of traumatic reactions, in addition to the children's perceptions of the current situations, with the aim of finding an assessment tool and an insight into the intervention needs of the children at the rehabilitation centre.

The children at the centre manifested a wide range of traumatic reactions. Most of them were exposed to very gruesome activities, such as raids on villages, participating in killing their relatives and fellow children who attempted to escape, etc. Many were threatened with death and thought they would be killed. Signs of traumatic reactions were clearly evident in the majority of the children studied. Previous studies recorded similar findings in populations exposed to violence in which life in captivity consisted of activities and scenes involving very strong mental imprints such as in this study.[7-8] The majority of the children showed signs of physical, emotional, cognitive and behavioural psychological distress associated with exposure to traumatic events and a range of other mental health problems, including PTSD symptomatologies (Box 1). These findings are consistent with previous studies conducted in Palestine, Sierra Leone and Rwanda.[7,9-12] In Sierra Leone and Rwanda, 99% and 79% of the children reported clinically significant levels of PTSD respectively. The limitations here, as in the Sierra Leonean and Rwandan cases, are that the number of experiences depended on self-reports and records at the rehabilitation centre, that the environment at the time of the study is still fraught with war and that there was no psychiatric assessment. In a climate fraught with war, fear of retribution, shame or guilt, the children may have underreported their experiences. Sometimes, health and social workers, if not sufficiently trained in dealing with traumatised children, may fail to recognise and record signs. However, in spite of these limitations, this study clearly shows that the children had a high degree of psychological distress.

The adolescents continue to live in surroundings resonant with wanton violence and amidst a variety of traumatic reminders in addition to communities traumatised by the same war. The "unspeakable viciousness" of the rebels has created anxiety, fear and despair in the population. Loss, grief, hatred, vendettas, societal dislocation, lack of trust,

dysfunctional families, material deprivation, interruption of schooling and social networks, and scarce resources resulting from the war, in addition to the uncertainty about when the war will end, are possible sources of new traumas for the adolescents, catching them between reminders of life in rebel captivity and an uncertain and bleak future. These additive factors might have influenced their perception of the current situation. They do not understand why it happened to them, they distrust society in general and have enormous fear of possible retribution, reabduction and when the war will end, in addition to worrying about their future in such a society. This is in line with previous findings in which additive factors such as these may further exacerbate the situation, influence perception, make it difficult to come to terms with what has happened and delay healing.[7-13] Health workers, social workers and counsellors have to appreciate these additive factors in order to make any intervention meaningful. Alternately, the revulsion and the sickening level of brutality and cruelty associated with this war can only be compared to others with great caution, and statistical computations can never fully characterise the consequences of the war on the adolescents. Considering the limitations of the cross-sectional design of the study, and that the children were exposed to war situations and were aged between 8-18 years, the results of this study will need to be interpreted with caution, and generalising the findings beyond the sample would be possible after several replications with other similar samples and populations.

Implications for interventions

As underscored in this and many previous studies, the severity of traumatic signs and reactions shown in the War Experiences Checklist – the physical, emotional, cognitive and behavioural signs and the perceptions of the current situations – may make the children less prone to process the trauma, and they may develop psychopathology.[14] Rational Emotive Behaviour Therapy, in which the adolescents are taught how to identify their irrational beliefs and behaviours, question them and replace them with rational ones, can be very useful in this regard.[15]

However, it is imperative to note that several factors affect how children exposed to organised violence react. Knowledge of such factors as immediacy, effectiveness and appropriateness of interventions, intensity and length of time of exposure, nature and history of the violence, context in which it occurs, those involved and how adolescents and their parents are likely to react, individual differences, and gender dynamics in the society are very crucial in planning appropriate interventions. Children's needs are holistic: attention to physical and survival needs must be complemented by equal attention to psychosocial, emotional and developmental needs. Likewise, parents, with whom the children are going to live, need the same if not more attention in all the above needs. Awareness of the community into which the children are going to be reintegrated is also paramount.[8,16-18] For any intervention to be meaningful, the following additive factors consequent to experiencing traumatic events should all be adequately addressed in the context of the local culture: low self-esteem and morale, failure to openly discuss what happened, the dehumanising consequences of the war, restoring the severed bonds between individuals and communities, and strengthening the family systems by improving psychosocial support to parents to manage their stress effectively and enhancing community resources that the adolescents will be reintegrated back into, improving the material well being.[11,12]

Social workers and counsellors at the centre should implement a combination of modalities. Such modalities would include family counselling, cognitive-behavioural therapy and other psychosocial interventions such as community reintegration programmes. The length of psychotherapy should depend on the complexity and severity of the problems of each child and should often be informed by the local culture.[19] In Mozambique, for instance, silence about the past has become a way of coping after decades of cruel and horrendous civil war. Therefore, the assumption that verbalisation of emotions is an integral part of reducing psychological distress may not hold for all cultures.[20] If the school and community functioning are affected, appropriate interventions in these areas are needed, too. Problem solving and learning self-soothing, anger management, communication of feelings and social skills are of enormous importance. Organised and appropriate tension-relieving activities, such as games and sports, dances, culturally appropriate counselling and therapy (such as cleansing rituals) are recommended in addition to the establishment of community support networks and an education system cognisant of their special needs.

Above all, what is crucial to the needs of the children is what the future holds for them. The different therapies alone will not restore any hope in the children, who already see the future as bleak and hopeless and the community into which they are to be reintegrated as awash with poverty. Many of the children would like to go back to school, others need training in technical or entrepreneurial skills that would give them a means of livelihood. Therefore, training and microcredit facilities should form part of the intervention offered to the children.

More research, especially case studies, needs to be conducted on individual children to determine the degree of severity of their reactions, how to help individual children cope with their experiences, and the treatment regimes within a clearly defined cultural context.

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