

# Children, torture and psychological consequences

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## Abstract

Torture is a strategic means of limiting, controlling, and repressing basic human rights of individuals and communities that is often covert and denied by authorities. Deliberate infliction of pain and suffering or intimidation or coercion on children to obtain a confession or information, for punishment of real or perceived offences on the basis of discrimination about race, ethnic or political affiliation, is practiced in many places around the world. Impact of torture on children may vary depending on the child's coping strategies, cultural and social circumstances. We at Refugee Therapy Centre provide psychotherapy and associated treatments to people who have been tortured, giving priority to children. While our main objective is provision of clinical services, our focus is also to influence policy and practice by searching for evidence and demonstrating solutions to improve the lives, homes and communities of children disadvantaged by torture and the services that support them. We seek to provide some remedies to children of refugees who are suffering the consequence of trauma that they experienced and demonstrate good practice. In this paper I will give a brief introduction of our work at the RTC. I then discuss and reflect on children and torture. I will present a vignette and some examples of clinical intervention.

*Keywords:* children, torture, trauma, refugees, psychotherapy, associated treatment

## Introduction

The Refugee Therapy Centre was established in 1999 in response to the growing need for a therapeutic service which respected, and worked with, the cultural and linguistic needs of refugees and asylum seekers who suffered torture and other forms of human rights violation. We offer psychotherapy, counselling and associated treatments. We offer individual, couple, family and group therapy based on an assessment of need.

The majority of the Centre's therapists has a refugee or immigrant background and brings with them a wealth of linguistic, cultural and shared experiences. Patients have the choice of receiving therapeutic support in English or in their own language. We are aware and respect the fact that some people prefer not to see a therapist from their own cultural background because of feelings of mistrust, guilt, shame or embarrassment about what has happened to them, and also due to feeling rejected by their own country or the intensity of feelings of pain when talking in their own language.

Based on evaluation and feedback we have developed:

- Bi-lingual Support Workers: providing a more active style of support which suits

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people coping with practical issues related to the processes of resettlement.

- Mentoring: providing weekly, one-to-one language support to clients in the process of adapting to their new environment, to help people improve their English and to help newly-arrived children and young people with their school work.

Our priorities are always refugees and asylum seekers. Children are supposed to play, to laugh, to look forward to their future and have hope; and above all to be a child. They are not supposed to be abused for food, chained to a wall or be in any way tortured. Children need care and protection. It is not acceptable to simply watch the way children are treated around the world; we have a social responsibility to say loudly and repeatedly torturing children is wrong.

### **Children and torture – overview**

Amnesty International<sup>1</sup> reported that child torture remains widespread in the world including Afghanistan, Algeria, Angola, Brazil, Burundi, China, Colombia, Democratic Republic of the Congo, Ecuador, Eritrea, Ethiopia, Georgia, Honduras, Iran, Iraq, Israel/occupied territories, Lebanon, Mexico, Moldova, Mongolia, Nepal, Paraguay, Saudi Arabia, Serbia, Sri Lanka, South Africa, Sudan, Swaziland and many others. We need to act to put a stop to this and save children from torture.

The largest group of tortured children are amongst refugees. There are high numbers of unaccompanied children, mainly from Latin America, Africa and the Middle-East. Amongst them, child soldiers, those affected by armed conflict street violence, living in extreme poverty, abandonment and child labour.<sup>2, 3</sup>

The UN Secretary General's report on children and Armed Conflict in Sudan has

highlighted that in 2007 and 2008 internally displaced children in Darfur faced the highest risk of rape and sexual violence.<sup>4</sup> One third of the 34 reported incidents which the UN verified were perpetrated against internally displaced children or occurred within the vicinity of an IDP camp. Girls were reported to be particularly at risk. One example of evidence was a 15-year-old girl who was raped in January 2008 while collecting firewood with a group of women on the outskirts of their camp in Western Darfur. The report raises concerns over the abduction of children in Darfur.

In general, the extent of these types of abuse and cases of sexual violence go unreported because of the social stigmas attached to rape; therefore although some cases are confirmed as the result of investigations by the UN, the extent of the problem goes beyond this. Lack of research is one of the main factors which conceal such tortures and atrocities that children suffer. Recognition and exposure of torture and abuse should become priority for the IRCT, indeed all other organisations respecting and working towards implementation of human rights. Monitoring of violation of children's rights should be encouraged and commissioned to be carried out by the local, regional and international humanitarian and rehabilitation organisations. As clinicians, we must also affirm a commitment to protect people's rights, indeed rights of children.

### *Torture and rape*

Many refugee children suffer appalling violence and have been tortured as part of collective punishments for whole communities, or as a means of extracting information from parents.<sup>5</sup> Some children throughout the world are exposed to physical, mental and emotional abuse and torture and suffer immeasurable pain. In some countries children are tortured as a form of punishment for their parents,

whilst in others children are as likely as adults to be captured, imprisoned and subject to torture. In some Asian, Latin American and African countries such as Congo or Rwanda, for the first time in history children have been imprisoned and are facing trial for genocide.<sup>6</sup> Child imprisonment and ill treatment is therefore an increasing concern.

Sexual violence is particularly common in these ethnic conflicts. In Afghanistan, Rwanda or the Balkans, girls suffered the added trauma of sexual abuse and rape, which can be the most intrusive memory that these girls carry into their adult lives.<sup>5</sup> In fighting in Bosnia and Herzegovina and Croatia, and indeed in Rwanda it has been deliberate policy to rape teenage girls and force them to bear "the enemy's child".<sup>5</sup> Moreover, in Rwanda rape has been systematically used as a weapon of ethnic cleansing to destroy community ties. In some raids, virtually every adolescent girl who survived an attack by the militia was subsequently raped.<sup>7</sup> Many of those who became pregnant were then ostracized by their own families and community; some abandoned their babies, some committed suicide, and some kept their enemy's child, at the expense of losing relationships with all other family members.

Many tortured children have lived in circumstances that most of us could never imagine. There are disturbing incidents, such as the one in the Renamo camps in Mozambique, where young boys, who themselves had been traumatized by violence, frequently inflicted sexual violence on young girls. Children should not be chained to a wall and be raped as these girls were. Even girls who are not forcibly raped may still be obliged to trade sexual favours for food, shelter or physical protection for themselves, their baby or younger siblings. The rise of sexually transmitted diseases, and particularly of HIV/AIDS, is therefore inevitable. One of the common fac-

tors contributing to the high rates of AIDS in Uganda is that some girls had to trade sex for security during the country's civil war.<sup>8</sup> Many of these girls suffer the consequence of such a torture to the end of their life, whenever that would be, given the lack of treatment.

#### *Psychological impact*

The Mental health of refugee children can be affected by experiences of loss, separation, stress and the psychological impact of an uncertain life.

The psychological impact of life in the host country i.e. UK, can be positive and negative. Positive because of the safety, food, shelter, education and new opportunities offered by UK life; and negative because of the stress of asylum application, social rejection (prejudice, racism and xenophobia lack of appropriate care, limitation in language and cultural environment and bullying).

Some consequences of psychological trauma would then include: Post-traumatic Stress (PTS), traumatic grief, psychosomatic illnesses, anger outbursts, academic difficulties, sleep disturbances, regressive symptoms i.e. bedwetting and chewing nails. The person experiences a traumatic event in which both of the following were present:

1. The person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror.

#### *Possible measures for children's services and specifically rehabilitation centres*

Children, most at risk of exposure to torture, include refugee and displaced children, child soldiers, children affected by armed conflict, street children, children in extreme poverty,

abandoned or unaccompanied children and children subjected to child labour. It therefore is possible to establish that there is need for study to identify gaps and to develop appropriate preventions in order to protect children at risk.

IRCT is contributing to the human rights of children and young people. It has been recognised that it is of great importance to meet the increased demand for appropriate campaigns, rehabilitation and prevention services with a wider competency based workforce. The organization need to recognise that alongside the development of expanded services there remains the need for solid core of skilled listening and highly specialised practitioners who are able to support, train and supervise others. Some long term measures to transform children's mental health and improve retention in mental health work could include:

- Secured Children's Centres and the Parent Child Project.
- Provision of supervision, consultation and training for workers to enhance early intervention.
- Tackling substantially recognised inequality by securing local government to commit to consider and accept lack of equality and address the need to enhance provision of services.

Increased knowledge of the situation leads to:

- Identification of status of ratification of relevant international treaties.
- Identification of implementation of international obligations.
- Identification of children at high risk to detention, ill-treatment and torture.
- Identification of perpetrators and reasons for torturing children in specific regions.

- Socio-economic circumstances that children are tortured.

#### *Issues related to refugee children*

We are far from a world without human rights abuses, impunity and torture. The experience of being the subject of torture is often a precursor to psychological distress and psychiatric illness for children. The pervading sense of not being wanted attacks the wellbeing and hope of a child. Especially those young people who live with endemic poverty, sadness, feeling lonely and uncertain, and helpless. Sometimes their relatives cannot help or they were psychologically not well enough to help, and some are simply cruel and abusive to the child themselves.

Refugee children suffer from war and other forms of persecution in their countries of origin. Yet refugee and migrant children continue to suffer human right abuses in countries of asylum especially if they are separated from parents and caregivers.

In the United States, Europe and some other western countries, the immigration services continue to detain a substantial proportion of children, "unaccompanied without parents."<sup>9-11</sup> In the States unaccompanied children are sometimes held in cells with juvenile offenders.<sup>a</sup>

Some refugee children that we work with in London feel that they receive inadequate support from social services, have problems

a) Provisions of the UN Convention relating to the Status of Refugees (Refugee Convention), the International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR), the Convention on the Rights of the Child (CRC), and the Convention Against Torture and Other Cruel, Inhuman or Degrading Forms of Treatment (CAT) all contain provision related to detention, including the use of detention generally, treatment of individuals in detention, the detention of children, the right to legal assistance for detained individuals, and judicial review of detention.

accessing health services and education and have serious concerns about being dispersed when they are 18; and many are subject to problems related to age disputes and detention.

The number of children and adolescents seeking asylum in the UK is rising and one in four people seeking asylum is a child. These vulnerable young people need protection and support. This now seems to be recognised as one of the main priorities of child services in the UK since the acceptance of the UN Convention on the Rights of the Child. But there are still serious shortcomings in the protection of refugee children. It seems that these shortcomings are largely down to lack of resources together with poor management and shortage of systematic research about key issues.

Defective conceptualization of refugees, in particular children, is due to inadequate empirical data and knowledge which leads to serious shortcomings in the protection of refugee children. Some reasons for this include: the influence of western psychological models which bring a lack of understanding across cultures and social contexts that these children come from. Effective policy requires sound theories and sound empirical data, not assumptions underlying western conventional practice. I maintain that the dominant idea of childhood as a universalized and (paradoxically) very individualized construct that is built on notions of vulnerability and incompetence has led to interventions that unintentionally undermine children's resilience and denigrate their capacity.

Many services for refugee children who endured massive trauma and atrocity are led by stereotypical notions of social norms, values, dynamics and power structures. In order to avoid these stereotypes there is a need to contextualize projects and to give greater attention to ethnographic needs of children. This is to assure greater resiliency and sus-

tainability and closer social and cultural adaptation for the people that we set our self to serve.

Refugee children have been exposed to stressors. They are exposed to stressors in their country of origin, flight to safety, during their asylum application and during the process of settlement and integration. Part of this is because children often leave their homes without any knowledge, sometimes without parents or personal belongings. They often do not have any cultural awareness of the environment to which they are fleeing and must overcome the hurdles of adapting to a new language and a new culture during which they live in deprived neighbourhoods with high levels of crime where they can suffer from acute discrimination.

The challenges are enormous. Children's traumatic experiences of war, torture, persecution and the flight from home countries can lead to a sense of constant fear. It is important to note that apart from the risks that all children and adolescents experience; refugee children who have been tortured have the added stress of having to live with distant relatives or foster families whilst taking on adult responsibilities. This can lead to problems with young refugee identities and education attainment which can lead to gaps in inter-generational understanding and disperse family cohesion possibly leading to delinquency, neglect and abuse which ultimately will add to community strain.

Many refugee children, although living in the west, find themselves in difficult situations that undermine their opportunities to grow up as happy, healthy, educated and responsible members of the community in which they live. Those that succeed are a tribute to the resilience, survival skills and hope demonstrated by their potential for adaptability.

The cultural issues incumbent on the refugee child can stem from a family's un-

derstanding of the therapeutic process. First there can be confusion over the parent's vs. an institution's assessment of a child's mental health. Following this, the family's demands and the cultural values are also threatened by the interview process. Language issues are also a problem. This is especially harmful when a child is used as an interpreter by parents, and professionals allow it. A child should not be used as an interpreter or intermediary between the professionals and the parents as this can distort a child's mental health.

Therapeutic intervention is justified by the child's suffering and impairment and is defined by what the child needs and not what the adults may project on the child. The therapist must remember that they know less than the child about the traumatic events and they must dare to ask frightening questions but avoid fascination. Moreover, the therapist must respect the child's pace but should not avoid painful subjects. However, during therapy it is important that the therapist remains aware of the fact that the child may be constructing a narrative in an attempt at describing the indescribable, that the relationship with the therapist may become the prototype for all relationships and that while neutrality is impossible, an excess of empathy can be toxic for therapeutic intervention.

The fragility of the situation therefore begs the need for a suitable framework and from a clinical point of view there are two main questions to be addressed in order to create such a guide. 1) If therapy is primarily aimed at the gentle exposure of one's worst fears, then what purchase can it have on this most ungentle process of a tortured child? 2) What is needed by those who have come finally to rest in some refuge to heal the wounds of external trauma due to torture and their environmental impingement?

### **Presentations and discussions of four cases referred to the RTC**

Here I will briefly refer to a vulnerable young boy that I call Erik, to demonstrate a defensive form of dissociation.

#### *Erik*

Erik, a twelve year old boy from Africa was referred to RTC for assessment and possible therapy. The referrer indicated that Erik was unable to concentrate, extremely withdrawn and did not relate to others. He witnessed his father and brothers shot by officials. He also witnessed his mother and sister being raped, beaten and killed. He was forced from the age of eight to serve in the rebels' camp; beaten regularly and deprived of food and hygiene.

Erik's defence strategy was typical of the autistic withdrawal. He did not talk in therapy for a few months, although at times he became tearful in the sessions. Intensification of sharing his pain was too great for this young boy, indeed became challenging for me in countertransference. I so desperately wanted to help him, and so desperately wanted to work towards strengthening his ego, for both of us to survive the torture he endured. I communicated with him verbally, but I have always doubted whether I was able to convey to him a clearly defined meaning related to his experience. Having said all of this, I was very aware that I didn't know much about him, and that I had to be very careful not to give him the wrong impression that I was intending to explain his truth. His ongoing silences continued with tears session after session with no words, apart from greeting politely on his arrival and his leaving which became a regular exchange from his side (that how much he could relate and cope with). With gentle encouragement, I intended to contain an unprecipitous meaning schematic with projectuality that required his contribution with the

hope to become actual. My intention was to establish a meaning, and not merely confirm, reject or add something. Although he was silent for a long time, I kept talking to him and about him to find words that had meaningful connotations to his experience; he could then express his feelings about them, which would be the beginning of him building some level of resilience to relate to another human being without fears. However, Erik's regular attendance and his tears were confirming that he started gaining some level of relation to me. I assumed that having me as a "listening other" in his ongoing silence was helpful to him as he started to make eye contact. He was looking at me when I was talking to him about our relationship. I could observe his affects in his gaze. I was thinking and talking to him about his lack of response which demonstrates his fear of relating and being let down. Hence, part of him unconsciously at some level related to me by his gaze and tears, and indeed by his coming to every session.

For a tortured refugee child such as Erik, the stress of associating with his memory was too much to bear, so, although longing for relationship, he needed to dissociate himself from the past memory of torture. This type of dissociation is a very concrete and bodily one, which the psychic pain and symbolic representations are denied. Consequently there was no room for him to symbolise his relations with me as his therapist. The defining factor was the experience of reality and representation of reality, and the pain related to it, or lack of it. This is due to the fact that humanity has been denied for Erik as a refugee child who endured severe torture and the pain of losing his carers. As his own humanity has been denied the details of the sensation related to the traumatic experience and the images that could come to be a symbolic representation of the experience was blocked and denied to his conscious function, at least

temporarily due to the fragmentation of his mind.

Erik's dissociation and consequent disintegration which occurred too frequently resulted in his total helplessness and hopelessness. He could not finish the disturbing memory of torture and trauma he endured, and he could not dissociate with the thought and memory of it either. As a result, his whole existing psychic structure was shattered by re-experiencing the trauma in a fragmented way which could go on for too long without finding direction. I hypothesise that regardless of intensity of the trauma, if Eric has not had a good enough object relation in his early developmental process, although he could dissociate, he will not be able to dissociate in a healthy manner and not be able to turn the attention to something else in positive way, i.e. coming to therapy regularly and cry without feeling under pressure that he has to talk.

Here, we can see that Erik's psyche in its defensive state may at times retreat into dissociation in general to deal with an unbearable situation. This happens because the child has broken confidence and reliance with the consistency and resilience of his core to deal with some of his experience or memory of it. It is as if his core self support systems, agency, continuity, cohesiveness, and affect were temporarily disconnected by dissociation during the actual trauma, when he was tortured and could not be reconnected without psychological disturbances. Despite this, there was an awareness that he has lost the familiar ground on which he stood before atrocities in his life. It has been a sad shift and move of his ordinary everyday life to horror which leads him into a kind of defence that restricts his ability to sublimate his experiences or to be creative. This is partly because memories experienced by him pose as thoughts, feelings, or images that do not reveal themselves as memories. They may at times come to mind, but seem

relatively meaningless. At other times they overwhelm his consciousness and lead him into a vividly remembered past. As he lost his resilience his memories could not emerge into consciousness clearly where there is enough psychic strength that can give him pause for thought.

A periodic, interrupted or broken up representation of a previous state of consciousness could lead him to an intense vivid moment of recollection, without him being able to form self-defining memories in which a previous state of consciousness may be re-instated, which is associated with awareness which unexpectedly place the consciousness in the past. They may cause feelings of revelation, recognition, confusion, and indeed trigger an intense sense of himself in the past. But, the important factor here is that this was not manageable for him. As he lost his resiliency due to being tortured he was not able to dissociate before getting to the state of fragmentation. He did not have the capacity to dissociate in this way which can lead to ego fragmentation. His feelings consequently lead to a state of disintegration, due to the fact that he could not dissociate himself from the memory of trauma and take his attention to another matter, neither was he able to stay with the memory and finish it.

In RTC we appreciate our role as a therapeutic service in the community or as an institution for people who have been institutionally persecuted. We realise that many refugee children come to us having lost their social network supports. Our clinical data from the last two years, April 2007-April 2009, shows:

- 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children and adolescents who have experienced trauma, 3 to 15% of girls and 1 to 6%

of boys could easily be diagnosed with PTSD.

- 90% of sexually abused children presented with PTSD symptoms. 77% of children exposed to violence inflicted on their loved ones in their community also presented with symptoms of PTSD. 35% of refugee children who were exposed to community violence also presented with PTSD.
- These differences are shown to be related to the risk factors of the child and mainly associated with the severity of the traumatic event, parental reaction to the traumatic event and physical proximity to the traumatic event.

Considering that actual or threatened death, separation, loss of fundamental functions, irreversibility, universality and property of leaving things are main characteristics for PTSD.

Very young children (under 7) of refugees that we work with present with few PTSD symptoms, but present with generalized fears such as separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, disorganised attachment and over-dependency and preoccupation with words or symbols that may or may not be related to the trauma. Although young children of refugees do not present with major post-traumatic symptoms, they will display post-traumatic play in which they repeat themes of the trauma they have experienced in play or their drawing. In cases where help is not available, a child can lose an acquired developmental skill (such as toilet training, talking, walking) as a result of experiencing a traumatic event.

However, we observed that the developmental delay very much related to parents mental health or lack of it. This confirms the external vs internal traumas in the process of development. External events happen objectively and internal events happen subjectively.

Internal events are almost always triggered by an external event but the historical fact is negligible compared with the fantasy that it triggers, they are events that are synthesised by the psyche. Internal events can be distressing but don't have the traumatogenicity of external events with the building block being the signifier or representation.

Some events trigger emotions that a child enjoyed in the past which have been worked through and a link is made between the present event and the past i.e. a cuddle in earlier childhood by the loved one (mother or the primary carer).

The events which can not be linked with any previous positive experience can leave the child's psyche vulnerable and psychologically resourceless. Therefore child can not integrate the experience within the course of own internal world.

To capture the effect of torture on refugee children I am going to present the following case examples:

#### *Aran*

Aran was young, about seven, during the initial stages of ethnic cleansing in his country. The police in his village (from the majority ethnic group) had a station next to the village football pitch. Shooting the ball while the children were playing became a favourite pastime, with beatings of any child who protested.

When Aran was about ten, he and other children from their ethnic group were forbidden to go to school. His elder brother (intelligent and politically aware) had been warned not to attend any meetings. On his way to a meeting in defiance of this, he was shot dead and his body was kept in the street under guard in the midsummer heat for four days, after which the family were allowed to bring the body home. The stench was terrible, making the wake very difficult.

Meanwhile life was made increasingly

difficult for the minority population. A curfew was imposed, young men were forced to fight in the army (most of whom were killed, so constant funerals), and sniper fire in the streets made it impossible to stand near windows or bring in supplies safely. Then the army arrived at their door.

Aran witnessed his sister and aunt being raped by at least fifteen soldiers. His older brother was rifle-butted in the face when he protested. The family had to leave the house, men and women were separated and the younger men removed.

The rest of the family escaped to a refugee camp in a neighbouring country where conditions were very bad with little food and extreme cold. Aran's uncle was very ill and could not help the family. Meanwhile Aran met other youngsters and decided to return with them to his village to dig up some valuable items the family had buried. The house was an unrecognisable burnt shell, though he found some money. Fighting prevented his return to the camp.

Aged fourteen, he joined the militia where he witnessed many further atrocities. At fifteen he came to this country in the back of a lorry.

When we first saw him at the Refugee Therapy Centre he was unable to sleep at night, suffering from frequent flashbacks and having suicidal thoughts and coming increasingly to the attention of the Youth Offending Team. Like many young people who have experienced violence, he would be very quick to act out aggressively, with little empathy for the person receiving it. During the two years he was in therapy here, he felt contained enough to talk about the events he had experienced, frequently gripping the sides of the chair with white knuckles.

As therapy progressed, his nightmare and flashbacks diminished and his sleeping improved, he stopped behaving aggressively

and did well at college. He was also able to contemplate the fact that he may never see his family again. Eventually he felt well enough to say that he could manage on his own, while assured that he would be welcomed back at any time if he felt he needed support.

#### *Ivan*

Ivan started attending the Refugee Therapy Centre at the age of fourteen, with a history of aggression and violence and an already lengthening criminal record of assaults and attacks in this country. He also could not sleep and suffered flashbacks. His level of communication was extremely poor.

Through therapy it became clear that, although he had arrived from a war zone using the usual refugee routes, he had been deeply traumatized by his family, in particular by a brutal father. From an early age he had virtually lived as a feral child, with food left out in the yard for him, and sleeping in the barn with animals or in a van.

Ivan never attended school and had to be educated alone in this country, due to continual conflicts with other children. Eighteen months after starting at the Refugee Therapy Centre he was able to attend college successfully, started a part-time job, developed empathy with others, and began to realise that no child should be treated as he had been. He also learned to handle difficult situations without resorting to violence, and has not been in trouble with the police again. He continued to do well and is now an articulate thoughtful young man with well-developed insight.

#### *Misha*

Misha started attending the Refugee Therapy Centre when he was ten, following a referral from his primary school teacher. He was presented as being deeply depressed and hard to engage. Through drawings we managed to get a picture of a pleasant early life in a lake-

side African town which was suddenly interrupted by the arrival of militias at his school where some of the older boys were randomly selected, made to lie down in front of the others, after which their limbs were hacked off with machetes.

As the violence worsened his family fled, but Misha and his mother were captured by the militia. Whilst in captivity Misha was forced to shoot an older child and his mother was killed. Following a courageous rescue by his father, the remaining family eventually sought sanctuary in the United Kingdom.

Misha is starting to talk more, and is learning to cope with aggression at school, which he finds deeply traumatising. He is also learning to be more pro-active in searching out help from staff. Young people who have been traumatised by aggression and violence, though initially numb and unable to defend themselves, can frequently start acting aggressively at a later time. It is hoped that through therapy, discussing past events and associated feelings, and working on strategies for present-day difficulties, Misha will be able to further control unacceptable behaviour.

### **Conclusion**

If children are to be helped to overcome highly stressful experiences they have endured, their views and perspectives need to be treated as a source of learning and strength, not weakness. We need to use children's negative experiences to create positive outcomes. It is important to acknowledge the painful, humiliating and profoundly debilitating experiences that many children suffer during periods of war, torture or other forms of political violence. It must also be recognised that the dominant discourse of vulnerability, sickness, crisis and loss has the potential for seriously undermining children's current wellbeing as well. The physiological experience of suffering undoubtedly has universal characteristics for

human beings that have a limited repertoire of responses to catastrophic experiences but different responses recur across cultures.

In assisting children who have been tortured, we, as campaigners and service providers need to have access to in-depth information about cultures, the nature of trauma endured, family dynamics and any special needs they may have. Most importantly, though often most overlooked, we must listen carefully to the child.

Our task as campaigners and service providers should drive us to include culturally and linguistically appropriate workers in the team; provide opportunity for children and adopt methods with philosophical and anthropological reorientation and adjustment to take into consideration the cultural and linguistic differences as well as different phases in children's lives. In addition to this, there is the situation whereby some children have considerably been impacted by torture or their time spent as child soldiers. It is also important for therapists to consider the role of words in treating trauma that comes from physical and bodily privation, and the indicators by which we can pick those whose resilience can carry them through.

We need to remember refugee children leave behind a home and become stateless and in many cases have lost their carer/s and everything familiar to them. They often have either been victims of or witness to violence, torture, rape and murder of loved ones. Some watched their homes being razed to ground and suffered pain and physical damage at the hands of perpetrators. They may have walked hundreds of miles seeking a passage to safety. Many may come with physical and psychological scars that run deep. And we know the wounds of the recent past re-stimulate the wounds from long past.

Effects on the family can be destructive. Often there must be an adjustment in the role

division between refugee partners and parent-child relations which can lead to a gap in communication. Indeed, refugee parents may, more than a child, feel socially isolated and distant from their familiar environments which can have adverse impact on the relationship with the child, creating risk of identity confusion. This can limit flexibility of a child to adjust to a new environment.

The development of an effective policy requires sound theories and sound empirical data, not assumptions underlying western conventional practice. There are many shortcomings in the protection of refugee children who have suffered torture and who have had their basic human rights violated. Some of these shortcomings, in our experience, are:

- Lack of resources, which brings with it poor management.
- Shortage of systematic research about key issues.
- The influence of western psychological models which can result in a lack of understanding across cultures and social contexts, which affects policies results in refugee children living in questionable circumstances.
- Defective conceptualization of refugee children, due to inadequate empirical data and knowledge.

I maintain that the dominant idea of childhood as a universalized and (paradoxically) very individualized construct, that is built on notions of vulnerability and incompetence has led to interventions that, unintentionally, undermine refugee children.

We are at RTC constantly seeking to employ ideas in our interventions that respect differences. We are proud to move away from western psychosocial interventions at an individual level and to run projects based on the feedback we receive from the people that

we set ourselves to serve. We focus on social reconstruction, social reconciliation and healing. We work with families and communities in an effort to restore social structures and a sense of normality. Our service is not led by stereotypical notions of social norms, values, dynamics and power structures. We focus on the need to contextualize projects and to give greater attention to ethnographic needs. This assures greater resilience and sustainability and closer social and cultural adaptation for the community that we set our self to serve. Our approach is sometimes criticised to be imprecision and lacking a firm, quantified data of impacts. This is mostly coming from people or services who do not have knowledge of our work and the outcome of our intervention. Contrary to this view, our very existence and our practice is based on evidence and assessments of need. Arguing for a view of children as at least potentially resourceful is not to sanction their exposure to adversity, nor to deny that some children may be rendered very vulnerable. This approach questions normative ideas about childhood weakness and considers whether a focus on children's vulnerabilities really is the most effective way of supporting self-esteem and self-efficacy in adverse environments. The practical value of an understanding of children as resourceful is that it builds on children's strengths, rather than emphasizing their ill-health, vulnerability, weakness and dependency. The physiological experience of torture undoubtedly has universal characteristics for children who have a limited repertoire of responses to catastrophic experiences and a number of responses recur across cultures.

In summary, it is important to develop strategies to prevent torture inflicted on children around the world. While we are working towards that, in our job which is assisting refugee children who survived torture and human right violations, we, as service providers

need to have access to in-depth information about refugee children's cultural environment, the nature of trauma they have endured, family dynamics and their special needs.

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