Understanding wartime children's suffering in Uganda

Intersubjectivity at the centre

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My research among children in war-stricken Northern Uganda confronted me with emotional and intellectual dilemmas. The central question of this article is how my own proximity influenced my understanding of the children's suffering. Additional questions that I seek to explore are: how is it possible to be a distant anthropological researcher where assessment of suffering is the central issue? How can the author cope with (not to mention work through) empathic enmeshment? How have classical anthropologists studying issues directly linked to suffering come through them without the respondents' experiences affecting them in a fundamental way? Does the answer lie in detached rather than proximal assessments?

[experience, proximity, detachment, subjectivity, objectivity, children, suffering, wartime, Uganda]

The broader concepts for my study are illnesses as experiences, focusing on infectious diseases and psychosocial suffering in wartime. Children who were born and have lived in the context of civil war all their lives were the major respondents, in particular children in child-headed households. Among the 24 cases recruited for extensive study were children whose parents lived in distant camps, but who had rented for them cheap housing within Gulu Municipality for their safety and to avoid child abductions by the Lords Resistance Army (LRA forthwith). Such parents also wanted their children to access formal education in displaced primary schools within Gulu Municipality. A substantial proportion of the 24 children were, however, orphans who had fled insecure areas. Some of them had witnessed the brutal killings of their parents and close kin. A substantial proportion of children in child-headed households were those taking care of sickly parents, kin and guardians due to HIV/AIDS. They were considered to be heading the households because all the traditional adult roles in Gulu, which include caring for the sick, earning an income, reporting to health centres for antiretroviral therapies, also called ARV medicines, and collecting foodstuffs from the World Vision ART programme, were done by these children.

I also include my experience as an insider to contextualise my analysis and discuss the importance of intersubjectivity and detachment in my research. I have historical and symbolic attachments to Gulu. I speak Acholi, and also conducted research in the same district in 1999 in Pabbo camp, 27km west of Gulu Municipality. More importantly, however, part of my childhood experiences as an orphan[1], living in abject poverty and presently my experience of taking care of a close kin member sickly with HIV/AIDS, take centre stage in intersubjectivity and shared subjectivities. With my childhood experiences, I can fully relate to living in a poor, fetid environment; I know how these are core predisposing factors to preventable and curable infectious diseases; I have experienced hunger due to lack of food and lack of basic necessities. In orphanhood I am aware of the emotional and psychosocial suffering, which comes with losing my father at an early age. These are often expressed in symptomatic idioms as persistent headaches and something invisible moving around my body causing a lot of pain and suffering.

In preparing to do ethnography with displaced children in child-headed households I was aware of the importance of these shared experiences. Nevertheless, I tried to evade this issue since I wanted my childhood experiences to be viewed as *sacred* distant history while I assumed a detached stance in assessing the 'other's' experiences, so to speak. This paper analyses why that was not possible, and at the same time emphasises the necessity of distancing and taking an objective stance in analysis and thesis writing.

Techniques in research (methods)

As in any anthropological study, largely qualitative techniques were used in data collection. In researching children, specific techniques more adapted to suit children's participation were adopted. Such qualitative techniques include participant observation (more precisely subjective/insider participant observation as opposed to conventional/classical anthropological experience-distant participant observation). For clarity, central to this research was the idea that as I assessed children's suffering, I was also assessing my own experiences. This is the essence of introspection in research. I will come back to this issue in the analysis.

Other techniques included eliciting life histories, typical days, narratives of illnesses and other severe experiences in a one month recall; home visits; workshops on medicine use and discussing severe experiences in wartime; in-depth interviews; and in general extensive interaction with displaced children. In order to obtain some quantitative data for the thematic areas, I employed two surveys using semi-structured questionnaires. All data (both qualitative and quantitative) needed to be presented *coherently* and *logically* in the thesis. I highlight here coherent and logical because although intersubjectivity in research is essential for gaining valid data, providing experience-near discussion and *truths*, subjectivity poses problems in analysis. Such problems concern how, for instance, to present forms of suffering as severe or not severe. Some children, for example, argued that an experience with malaria or tuber-

culosis is more severe than loss of kin. On the other hand, some children present concrete arguments showing how loss of close kin and dealing with bereavement is more severe than any other illness of an infectious nature.

Since for this paper's question I need to show how my own proximity influenced the assessment of children's suffering and knowledge production, and in which ways might I be able to come out of empathic enmeshment, I will highlight in the next sections some of the vivid experiences as scenes (1-11). The rationale of the scenes is to systematically present my experiences as aligned to the time frames of ethnographic study.

Scene 1: Doing fieldwork at home – intersubjectivity as an analytical tool

Since the inception of the project idea and the writing of a study project proposal, I had recurring (internal) questions about why I needed to study children's suffering in wartime, and in particular orphans and other children in child-headed households. The subject seemed to be so 'close to home'. Close to home is used here in reference to part of my own childhood experiences. In essence I was designing a study to 'extensively' investigate my own experiences. This is, in a large part, what phenomenologists and anthropologists of experience (Fabian 1996, Denzin 1994, Zahavi 1999) call researchers being their *own* research instrument. The role intersubjectivity plays in such research is spelt out by Tankink and Vysma (2006: 2): "Symbolic space is created when two subjectivities meet to *realise* a shared reality, an emotional reality characterised by the conviction/sensation that the 'I' understands and is understood by the other".

Essentially, I regarded studying my orphanhood experiences and suffering as a sacred area, since: (1) By the time of research I wanted it to be safely relegated to 'important history', and to let it rest. (2) I could not come to terms with, or critically look back into, such severe experiences. I had not the strength nor courage, so to speak, to re-examine these issues. (3) I *knew* operational plans to ensure that I did not 'study myself'. It is summarily called detachment and experience-distant studying of the 'other's' suffering. With my operational plan, I finally managed to suppress the haunting reflections about my being my own instrument in research.

Scene 2: Reconciling detachment and shared subjectivities in assessing suffering

My research proposal was approved for funding by The Netherlands Organization for the Advancement of Tropical Research (WOTRO) in April 2004. However, I did not go for fieldwork until July 2004. That had effectively given me one year since the conception of the study theme to s*uppres*s and *avoid* the fact that intersubjectivity was essential in my study. What is more, my perception was that I had reached a level where I would remain aware of my subjectivities, and as I engaged in knowledge production I would merge my own subjectivities with the 'other' (see Coelho & Figueiredo 2003: 194). In addition, as mentioned earlier, I had my preferred operational plan to engage in experience-distant knowledge production. Needless to say, I did not succeed in being a distant researcher in my investigation of children's suffering. To a great extent,

I was severely confronted with the children's misery, abject poverty, and suffering in wartime in Gulu, which quickly reminded me of my own experiences.

In the early middle half of 2004, insurgency was again at its peak in northern Uganda. That meant that there were more war-affected people and children within the relatively safer Gulu Municipality. Moving within and outside Gulu Municipality was like moving within one big overcrowded camp or the equivalent of a fetid slum in Kampala. These recent arrivals to Gulu Municipality came from insecure camps and villages, and were people in the lowest economic echelon. The general trend was that the rich had fled Gulu as early as 1986-1987 when the insurgency had just started. Most of these are presently an Acholi diaspora with refugee status in Europe, the United States of America and Canada. In the early 1990s, more economically able Acholi people also fled to safer regions in the world. By 1994, when the insurgency reached another peak and the state was forced to ensure the safety of people in northern Ugandan districts, it was more precisely the lives of the resource-poor at risk. These were people in the lowest economic echelons, largely women, the disabled, children, and more especially children in child-headed households. The state's approach basically followed one regional psychiatrist's description: the use of military means "to smoke out poor civilians from their huts into camps."

When the insurgency was at its peak again in 2004, even these camps were insecure, thus people moved to Gulu Municipality. This is where I came in with the 'operational plan' to *distantly* assess children's illness experiences, whether it be with infectious diseases or psychosocial suffering. To be sure, I even had my questionnaires starting with name of father and name of mother (I later eliminated these questions). The point here is that if my basic aim were to know the names of their parents, of course I would have succeeded. But, I did not want to know the names of parents in child-headed households; I wanted to know if they had parents. How could I have designed such questions in an appropriate way? Should I have just approached a child with the question 'Do you have a father…?' and so on?

In my study in 1999, I felt I had done a disservice to the people in camps by conducting an exclusively experience-distant quantitative study. Nevertheless, at that time I did not know any better given my 'hard science' background. I think also that it was because I had minimal shared or intersubjective experiences with women of reproductive age living in displaced persons camps. In 2004, I almost made the same mistake with my 'operational' plans. I withdrew my earlier *scientifically*-designed questionnaires since they were not capturing the data I needed. These questionnaires were then redesigned to at least assess common illnesses in a last month recall. In addition, largely qualitative techniques were thereafter applied to holistically assess children's perspectives of their illness experiences and quests for therapy.

Scene 3: Coming to terms with the importance of subjectivity and intersubjectivity as a premise in research

In my reflections about the first phase research findings, and the importance of being my own research tool, I decided to unmask all previous 'operational' plans in data

collection. I decided that if my own childhood experience of orphanhood and living in abject poverty were valid *but sacred* to me, children's illness experiences must overlap with mine. In essence, I recognised the importance of intersubjectivity as a field of intersection between my 'own' subjectivity and the 'children's' subjectivities, or, as Benjamin (1995) puts it, the interplay between two different subjective worlds to define that analytic situation. Other authors who advocate for generating an experience-near discussion in assessing suffering (Kleinman & Kleinman 1998, Denzin 1994) helped to reinforce my decision.

Subsequently, I made a deliberate choice to confront my sacred past to be able to validly represent children's experiences – as in generating an experience-near discussion of their life-world and suffering. This is a central issue, constituting intersubjectivity and subjectivity in research. As Fabian (1996: 9) states,

> If an anthropologist does not want to use intersubjectivity – that is: to actively gain insight into his(her) own not fully conscious part of the interaction between him(her) and his(her) subject – s/he runs the risk of producing mere categories of social facts with doubtful historical and intellectual significance.

In investigating issues directly linked to suffering in wartime with the purpose of generating an experience-near discussion, I used my 'home gaze' to view children's experiences. I looked at children in wartime through my own self as a child. In particular, I assumed that stage of orphanhood as an authentic prism for seeing and assessing children's life-worlds. Coelho and Figueiredo (2003: 194) further assert that we can only understand another person in terms of ourselves, and ourselves in terms of another. Husserl (1925) also discusses that a person can only know the other through his (her) own consciousness, thus in a mediated form. Since intersubjectivity is a basic element in experience researches as an intrapsychic quality, I become aware that I am one among others; I become aware of my own subjectivity, making it possible for me to come to know myself and others.

Following that reflection, I wrote a piece about 'un-stated assumptions' as opposed to working assumptions. The un-stated assumptions were distributed to a strictly closed group. This action also tells us much about anthropology as a discipline. I will come back to this crucial issue concerning the espoused positions in conventional anthropology to study the 'exotic other', the primitive, the historical, the African, through experience-distant participant observation and other techniques. This espoused anthropological position is what Fabian (1996: 199) calls a negative starting point because the accent is on 'being different', which denies equality. Such a stance has a tendency to deny coevalness by seeing the 'other' in an earlier state of development and/or technology. In the same critical vein, Tankink and Vysma (2006: 8) propose that the moment intersubjectivity is acknowledged, it becomes more difficult to deny coevalness and equality.

Perhaps, for me, I could not take the 'espoused position' because I was already an insider, the 'other' in a sense. And when the 'other' is studying medical anthropology, it is, mildly put, very difficult to come to terms with *historicising, objectifying*, *exoticising*

and *othering* assessments. Intersubjectivity therefore took centre stage in re-designing the study, selecting literature and facilitating awareness in the research of mine and the children's subjectivities. Through becoming aware of the concept of intersubjectivity, I understood that my experiences (and re-experiences) overlapped with those of displaced children, together creating our intersubjective or interspatial reality.

In my working assumptions I reconciled intersubjective and experience-distant viewpoints. I acknowledged the importance of intersubjectivity in my research and my own experiences as a basic premise. I drew from my own childhood experiences and subjectivities in order to put across ideas which could reflect displaced children's experiences. For coherence and the logical flow of ideas, I combined proximity and detachment in analysis. What is more, a large part of my analysis had bases in shared subjectivities – where I viewed my experiences as shared with those of children in child-headed households.

After working through these reflections, I went back to Gulu Municipality to do the second phase ethnography. I should say here that these reflections were fundamental in unearthing, confronting and coming to terms with the sacredness of my childhood; and also concretising the shared meanings and suffering between my childhood suffering and displaced children's suffering. It was therefore quite difficult to pretend anymore to be a distant participant observer. It was even more difficult to *other, historicise* and *exoticise* displaced children's suffering. I was part and parcel of the children's life-worlds.

Scene 4: Empathic enmeshment as a consequence of intersubjectivity in research.

When my principal supervisor visited Gulu in August 2005, we had one particular discussion about my experience as a researcher. In that session we analysed my experience and extreme involvement in assessing the illness experiences and suffering of displaced children. She suggested that I recognise and problematise my over-involvement, since this intersubjective process was affecting my work as a researcher. In problematising that experience, she suggested ways to accommodate the issue, making it explicit how the 'insider' experience influences the production of knowledge and anthropological fieldwork. She then suggested that acknowledging empathic enmeshment was a starting point in dealing with it, and that there were advantages and disadvantages of each position taken by the anthropologist.

I was overwhelmed by the suffering in Gulu. I could not come to terms with talking to a hungry child and leaving him or her hungry, not knowing where his/her next meal would come from. I was also financially constrained in 'solving' these enormous problems. To give one quick example, if I interviewed a child with enormous daily problems, and at that moment had only 1,000 shillings (0.43 Euro cents), I would give it to him. However, I would feel guilty for not being able to do enough to help with the many problems they faced. Another supervisor suggested the importance of detachment and doing research as a 'psychotherapist' to the displaced children. This would help in dealing with issues of transference and counter-transference. In short, if the issue at stake is the assessment of suffering, and there is transference, then the

researcher becomes a psychotherapist and the displaced children become clients. In this interactive dynamic, it is necessary for the researcher to handle emotions and possible disruptions brought to her. This is accomplished when the researcher becomes aware of the transference role she is placed in by the clients, through listening to their stories (Van der Veer & Van Waning, 1998: 192). Meanwhile, stories told by the clients can evoke all kinds of emotional reactions, sometimes called counter-transference reactions, in the therapist/researcher. These reactions can include rage, horror, guilt, shame, grief, and mourning (Daniel 1984, Van der Veer and Van Waning 1996: 193). Whether or not these reactions become harmful depends on whether the therapist engages the clients to transform and work through these experiences of horror and violation. The therapist needs to be able to contain their feelings, discriminate if his or her own emotions surface because of the projections of the client, and know when to discuss these projections in an empathic way.

In the Wilson and Lindy (1994: 15) scheme, I had reached empathic enmeshment bordering on over-identification and personalisation. I had lost boundaries with my respondents' (clients') suffering. Tankink and Vysma (2006: 11) state that in empathic enmeshment, the personal history of the researcher plays an important role. In essence, I had (unconsciously) re-enacted personal issues through contact with the displaced children, thus ran the risk of blurring the boundaries and becoming a helper. Therefore, to assume my researcher role again, I needed to distance myself, redefine my boundary; but at the same time not *deny* the realities of the children's experiences.

Scene 5: Dealing with extreme involvement in assessing suffering

In one of our discussions about empathic enmeshment, my principal supervisor inquired if I thought a one-time donation of a substantial amount of money would suffice in dealing with my extreme involvement in assessing the children's suffering. My response was ambivalent. Here is the reason why: monetary assistance would greatly minimise the children's suffering, however it also created new challenges. I had been told by some children that my frequent visits to their homes, and my intervening where I could in solving their problems, was a source of jealousy and slander from neighbours. In one instance, the landlord had drastically raised the monthly hut rent for one child-headed household when I met the charges. The landlord argued that since the children were now beneficiaries of an NGO (referring to my research), it was likely that they could now afford to pay for the rent at its exact value. I was disturbed by this incident. The dilemma here is that I am not by any means a representative of an NGO. In fact, I cannot even claim to be in a position to financially support the children for a long time. Yet I perceived myself as prompting or generating more problems for the displaced children. Nevertheless, I could not come to terms with the children's likelihood of being evicted due to non-payment of hut rent. In short, in attempts to solve life problems and core issues related to suffering, there are no panacea solutions.

My principal supervisor donated a substantial amount of money to alleviate the displaced children's suffering and I was to administer these funds. My first impression was that she understood my realities, spatial subjectivities and my employing

subjectivity in research to assess suffering in wartime. It would be an oversight not to recognise her intervention. In a larger part, proximity and related experiences of suffering are not issues which are only addressed through *awareness* and *sensitisation*. In contrast, numerous NGOs in Gulu promote sensitisation seminars for many of life's challenges. For example, when an epidemic of a severe skin infection struck virtually all night commuters' shelters, a substantial number of NGOs alternately conducted awareness workshops and sensitisation seminars about *scabies* to the affected persons. Here is my point of departure: (inter)-subjectivity is a concept that is learned and developed over a long time, and is reinforced by contexts the client is submerged in. To put it in another way: if my supervisor had *sensitised* me about *distancing* as clearly as she did, and then left me to 'implement the knowledge', I am doubtful whether that would be a concrete intervention. I had the impression that a gradual administration of her donated funds would be most appropriate, and when they finally ran out I could tell children that I was actually not able to do much more about their needs at that time. I was slowly distancing myself from 'their' experiences.

Nevertheless, in administering the funds I was confronted with numerous other challenges. One such challenge was that on one occasion my research assistant and I gave each of the twenty-four children extensively participating in the study money for rent for three months. Since we had no smaller denominations, a substantial amount was given to them in groups of four so that they could find the smaller denominations themselves. In one such group there was a girl and three boys. Shortly after their departure, they came back to where we were. The girl was crying, and the boys complaining bitterly. This is because at the shop where they had requested smaller denominations of money, the attendant had confiscated it. He threatened them that he would call the police if they persisted in their demands, since children of their age cannot have such large amounts of money. He suggested that he would order their arrests since it was likely that the boys were paying for sexual encounters with the girl. We approached the shop attendant to demand the money back, which he did reluctantly. Clearly, at this time, I am unable to concretely talk about what solutions there are for suffering, living in abject poverty, unmet basic needs and problems in wartime.

The professionally established disciplines to help people *cope, distance,* and *work through* their problems and subjectivities are psychology and psychiatry. In the next scene I will share various experiences with professionals in these fields.

Scene 6: Coping with subjectivity, empathic enmeshment and re-experiences in research

At the end of my supervisor's visit, she recommended that I visit a professional counsellor to help me deal with my 'empathic enmeshment'. Since in Gulu there is an over-use and misuse of the term counselling (See Akello et al. 2006), following the advice of my country supervisor it was decided that I visit the student counsellor based at Makerere University students' hospital. I mention over-use and misuse of the word counselling in Gulu since evidence suggests that all humanitarian agencies (both national and international) recommend counselling for mental wellbeing in wartime.

To operationalise this intervention, nurses, primary school teachers, religious leaders, camp leaders, support staff in non-governmental organisations (NGOs) and sometimes school drop-outs are trained for a short period of two to three weeks to *make* them counsellors. The term *counselling* is variously used when organising games and competitions, telling children to assemble in a particular place to practice traditional songs and dances, distributing food items and household utensils, and telling children stories of long ago, to mention a few examples. To avoid this confusion, I left Gulu for Kampala for a two-week break to seek the services of a professional counsellor.

I thought that by the end of the session or sessions if recommended, I would have *worked through* consequences of proximity in research and become a researcher *not* a helper; I also hoped to deal with empathic enmeshment. I was mistaken, to put it mildly. Owing to the counsellor's experience in seeing what he called 'real cases', he dismissed my need for counselling. After a long hard look, he asked again whether I was not just doing a study about counselling and that was why I want to interact with him. I answered that that was not why I was there and explained my situation a second time. He reluctantly gave me a form to fill in. In it were questions concerning my marital status (most women of my age are distressed if not married), my educational level (for a PhD researcher, there is absolutely no likelihood that I could be distressed), where I lived (it is not a resource poor neighbourhood), and whether I had children. Yes I had, 2 boys (infertility can be distressing, or for some if they have only girls). The university students' counsellor, having dismissed or analysed my life in such a way, asked again why I needed counselling. I declined to go through the entire story for the third time, concerning how I was having difficulties with intersubjectivity in research. In essence, I felt guilty, helpless, and overwhelmed with the experiences of displaced children in child-headed households. This is because in reality they are my experiences.

He instead preferred to give me synecdoche cases of some Makerere University students he often counsels. One such student was on the verge of committing suicide by jumping from her third floor residence. She was brought to him in chains. By the end of three sessions she had a smile on her face. Her difficulties in paying university fees were solved through his recommendation to register her in a particular scholarship fund. More clients (often female), who were married but childless, also came to him for counselling, and he sometimes saw clients with difficulties in finding employment.

However, for a case like mine, firstly he believed I was not like other cases; nevertheless, since I had struggled so much to get an appointment, including going through my country supervisor, he agreed to tell me some *basic information.* After one hour of telling me how I needed *KAMPPALAA* (which stands for *K*nowledge, *A*ttitudes, *M*anage (self-management), Purpose, Punctual, *A*cquisition of skills, Loyalty to *A*chieve goals, and *A*ssessment of level of Achievements) and *POSDCRB* (for *P*lanning, *O*rganising, *S*taffing, *D*irecting, *C*oordination, *R*eporting and *B*udgeting), I left the hospital. Since I was not a 'real case', I was not given another appointment. Perhaps he had helped me to *work through* my subjectivities already! Until now, it is still confusing to me what the session was worth. Was it essential in helping me to come to terms with my re-suffering and empathic enmeshment since I had unearthed my 'previously sacred' experiences relegated to history? Was it worthwhile that I met

him, so that he could tell me *real* cases? Is it possible that this session had helped me in dealing with re-experiencing my severe childhood experiences? How would I apply this vast information, in *KAMPPALAA* and *POSDCRB*, to suit my 'minor' problem of having to do research with children in extreme circumstances?

In passing, the counsellor told me to consult with the numerous NGOs (up to 150 in 2005, and 263 in 2006) in Gulu to directly *help* 'my' children. In fact, he was surprised that a researcher could go that far having 'feelings for subjects'. I was supposed to do my research and leave. I should focus on achieving my goals, which were to complete my research and not become involved emotionally.

Following the professional counsellor's advice, I made a specific written request for assistance with the children's basic needs to international NGOs, focussing on the wellbeing of displaced children. In response, the United Nations International Children's Emergency Fund (UNICEF) made it clear that it only works within its mandates, and does not acknowledge proposals from academics. UNICEF also stated that it only acknowledges proposals from its partners, who are sister NGOs and not children, because I had asked the coordinator if children should not be their basic partners. Save the Children in Uganda (SCiU) responded three months later by giving each child a blanket. World Vision also responded, four months later, by giving each child a pen, three pencils, and four exercise books. When I made it clear that they had needed these items during the school term when the request was made, their reply was that they could still use the scholastic materials for the next year. In short, it was too little, too late, coming from the major institutions who claim to alleviate the suffering of children in wartime. I was exhausted and tired by the end of this exercise.

Earlier I mentioned how *counselling* is considered a professional way of dealing with any form of distress and psychosocial suffering. Briefly, I will give two examples of children's interactions with professional counsellors in order to show the ultimate ambivalence I have about the process of counselling in alleviating psychosocial suffering in wartime.

Children's experiences with professional counsellors

In one of the workshops organised to discuss severe experiences in wartime and explore how children minimise them, one fourteen-year-old, Ojok, extensively discussed how he had sleep disturbances. For five years, since Ojok witnessed the brutal murder of his father by the LRA, he had had nightmares of his deceased father's *cen* (evil spirit) constantly disturbing him, demanding that he perform *guru lyel (*last funeral rites). Nevertheless Ojok indicated that he did not have the money for such an expensive ceremony. Besides, his ancestral home in Pader was still a conflict zone. In the meantime, however, he used *atika (*Labiate species) plants to ward off such demanding spirits. Each night he crushed leaves and seeds of *atika* plants to smear on his head, his mat, and hut walls before going to sleep. He also burnt branches of the same plant on a partially broken pot every night in order to ward off such *cen*, and placed branches of *atika* at his doorpost, roof and window. He disclosed that his mother and neighbours had advised him that such a practice would ward off spirits, however the ultimate solution would be to perform the ceremony which the *cen* demanded.

I organised a counselling session for Ojok at Caritas. Caritas is a Catholic church's development arm, presently implementing projects to alleviate psychosocial suffering of people in wartime. In Gulu, one of the activities which this institution frequently advertised on local FM radio stations during the time of my research was that "all war-affected persons need to go to the centre for free services of counselling".

At the centre, Ojok was privately counselled as I interviewed another professional counsellor. Here is what Ojok had to say when I inquired into the entire procedure and how he felt about its ability to help with his deceased father's *cen*:

> Those people at Caritas know how to talk to people. When you just listen and without responding, the lady even dances and ululates for you in order to make you laugh. She also told me that she had exactly the same problem like I had, but she had called charismatic people from a nearby Catholic church to chase off the *cen.* When I told her that the *cen, which* disturbs only needs *guru lyel,* she advised me to go and perform that ceremony. The problem is that I do not have money to organise it. When it is holiday time [end of the school semester] I will try to organise for the *guru lyel* if I have money. But still I will continue using *atika* plants.

In another spectacular ceremony, I invited Caritas to conduct a counselling session at two displaced primary schools. I did this because a substantial proportion of children had shared their severe experiences of sleeplessness, nightmares, living in misery and abject poverty, difficulties in caring for their sickly close kin affected by HIV/AIDS, disturbances by *cen* and some had heard about, witnessed or experienced other severe experiences in wartime.

In that group counselling session, three counsellors took turns to counsel the traumatised children. Concerning the problem of nightmares, *cen,* and disturbed sleep, one counsellor went through a '*dream analysis procedure'* where she told the children reasons why they had nightmares:

> It is because children had imaginations about deceased persons' talking to them and such related problems. It was because they had seen, heard about or witnessed such scenes. Nevertheless, that is just in the '*mind*' and therefore, children should stop fearing, disturbing others or waking up those who are having nightmares. It is a normal *re-play* process, which children should not be afraid of.

I observed that by the time she had completed her presentation, the majority of the children were instead talking to each other. In follow-up interviews, the children instead reaffirmed the importance of *atika* plants, while others indicated the need for *guru lyel* as the only effective way of dealing with *cen* of close kin and persistent nightmares.

In yet another attempt to professionally address the children's problems mentioned above, another counsellor elaborated upon the topic of 'problems of growing up', in which he discussed extensively bodily changes in adolescent girls and boys, much to the children's amusement.

In subsequent individual interviews with the children, no child particularly linked the professional counselling session to addressing their psychosocial distress.

In principle, evidence points to counselling sessions to help children to become joyful, play and listen to stories for a short time. Here is my point of departure: I am doubtful that such counselling sessions in essence addressed core distressing problems such as *cen* (evil spirits), which the psychiatrist termed Post Traumatic Stress Disorder coupled with anxiety and other a-specific somatic symptoms. What is more, the children suggested more concrete ways of dealing with their distress, including performing *guru lyel*, using *atika* plants, doing income-generating activities, and attending healing services at Pentecostal churches.

Scene 7: Contemporary biomedical approaches to coping with distress and suffering in wartime

The first stages of my interaction with a psychiatrist in northern Uganda were at the northern Uganda regional psychiatric unit at Gulu regional referral hospital. I observed that the main clients were epilepsy cases coming for prescription refills. Occasionally, children who had been arrested for committing various crimes including rape, theft, defilement, and severe assaults would be brought to the psychiatrist for assessment prior to being remanded to Gulu district's juvenile prison. These were mainly former child soldiers and ex-combatants. The basis for bringing the assailants for assessment to the regional psychiatrist was to find a link between the trauma they had experienced in captivity and crimes they had committed. The regional psychiatrist, however, often found no link between the crimes and trauma flashbacks.

Since the psychiatrist's unit was put in place to address all mental illnesses in wartime, I specifically asked him to let me know if he saw any clients (especially children) for Post Traumatic Stress Disorder (PTSD). As a child, I remember having nightmares, emotional suffering as a result of loss of close kin, persistent headaches and daily distress due to a lack of basic needs and living in abject poverty, but I did not seek specialised help. I thought that this was perhaps because I was not exposed to the *trauma* discourse at that time. However, children in wartime Gulu have grown up in an environment where they are told about mental ill-health at numerous sensitisation seminars, on radio talk shows, and in discussions at churches and displaced primary schools. They are *counselled* to relieve their *traumatised* memories if they have seen, experienced or heard about extreme events. They are therefore supposed to go for counselling at the regional referral hospital's psychiatric unit.

Moreover, the regional psychiatrist featured every Saturday on a local radio station, Mega FM, from August to December 2005, to advise people to seek specialised help (read: counselling) for such disorders including persistent headaches, nightmares, hyper-vigilance and emotional distress. For the six months and more where I kept in close communication with him, no child came to the psychiatric unit due to distress. I need to mention here that in reflecting on my own emotional pain and distress, and my living in abject poverty, I am ambivalent that seeking someone for story telling, singing peaceful songs, participating in debates of peace, and NGOs which give footballs

and toys to play with, would help alleviate such severe suffering. For clarity, numerous aid agencies in Gulu argue that story telling and counselling, and getting 'traumatised' children to perform such activities which make them become cheerful, albeit for a few hours only, helps them 'become children again'. It is argued that children need to play in order to become children. If evidence suggests that children in wartime are still children, but are distressed children, then while it may be true that facilitating creative play makes children joyful, it is also a fact that the very displaced children are living under very distressing conditions and they need material support. Perhaps that is why, when there are organized *counselling* opportunities for them to play and sing, sometimes they state that they would have preferred to participate in income-generating activities.

Scene 8: Intellectual dilemma: neglecting socio-economic factors in assessing mental distress in displaced children

The other specific intellectual dilemma I was confronted with is this: there has been a major survey in two camps, namely Unyama and Awer, to assess the mental distress of displaced children in Gulu district. This was conducted through the use of the Acholi Psychosocial Assessment Instrument (APAI), the validated questionnaire for the Acholi ethnic group. By looking closely at the entire procedure, the basic argument is that in administering the instrument all problems of socio-economic nature, including living in abject poverty, should be ignored. In my experience, living in abject poverty, striving to access basic needs, hunger due to lack of food, and being predisposed to various infectious diseases due to living in a fetid environment, are important (mentally) distressing factors. This premise forced me to re-adapt the validated instrument to reflect the children's life world. As discussed elsewhere (Akello et al. forthcoming), there were major contradictions in the findings and subsequent interpretations of the results. It was quite difficult to conclude whether or not particular displaced children were experiencing mental distress from the scores obtained.

Scene 9: Exemplary case of transference and counter-transference in research

On one particular day I was visibly distressed after a day's fieldwork. I had visited one thirteen-year-old boy heading a household. In a virtually empty house, where they were struggling to pay rent, (although recently three months rent had been paid with the help of the donated funds from my supervisor), I found five more people. Oketch's aunt, together with her four children, were presently living with him in Kanyagoga surburb. She and her children had left them seven months earlier to live with a soldier. Nevertheless she had come back to live with Oketch – her nephew. She disclosed how she had had a misunderstanding with 'that man'. She now wanted to focus on raising her four children. To begin with, she needed me to also register her four children in my NGO (read anthropological research). One neighbour had recently visited Oketch's aunt and told her about the NGO 'representative' frequently visiting her nephew.

Oketch, in response to the new development in his household, complained how his returned aunt had told them to go and sleep at Noah's Ark night commuters' shelter

since there was virtually no space in the hut. In addition, since the family was large, the food they had bought for the month was already finished.

I found myself very angry and outraged. I could not comment about the complex issue, nor respond to Oketch's demands anymore. When I met the psychiatrist that afternoon, he summarily told me to stop getting emotionally involved with the displaced children. It was not healthy for me. He mentioned how in this whole phenomenon he could see transference and counter-transference occurring. Was this because I had a similar experience in my childhood of close kin taking advantage and exploiting me? Through Oketch's experience, was I therefore *re-experiencing* that particular severe episode in my childhood? Was it that I still had not dealt with *empathic enmeshment* and that was why I could be affected in such a fundamental way? If the solution to such severe re-experiences lies in distancing, becoming *less involved* with the informant, how can a researcher acknowledging shared subjectivities and intersubjectivities deal with such scenarios?

Scene 10: Proximity and the sharing of emotional phenomena with respondents

Earlier, I mentioned having to take care of a close kin with HIV/AIDS. I have also lost a substantial number of close kin and friends to HIV/AIDS. Perhaps, indirectly, choosing to assess the experiences of children taking care of close adult kin with HIV/AIDS related symptoms had a basis in this. Each of the visits to such children's homes was an emotional experience for me. At first I could not muster the courage to meet the clients themselves, but simply talked to the children either at World Vision food distribution points or at displaced primary schools where they attended. When this was not an option anymore, such as during end-of-semesters, I had to visit these children and their special but sickly kin. In one such scenario, I discussed with Anek's mother, recently discharged from Lacor hospital, what she thought of her daughter. On our way to visit her mother Anek had told me how, instead of using the money she was given for three months' rent, she had set it aside to buy her mother milk, oranges, and any nice things she wanted to eat. In turn, Anek's mother talked about her worries about whether Anek would continue studying after her death. Anek's mother died two months after this conversation. Here is my point: in these ethnographic conversations are vivid emotional ideas that the person you are talking to is close, special, but sooner rather than later, they will be no more. S/he will be dead due to HIV/AIDS. If anyone knows how to 'distantly' assess such suffering, I urgently need assistance. I need assistance not only for my own subjectivity and shared suffering, but also to help me deal with the particular suffering which comes with assessing 'others'' suffering, which at the same time constitutes spatial subjectivity. I could call it emotional pain which is of an individual/specific and shared/ collective nature.

I visited the mother of another twelve-year-old girl, Adokorach. She had had *aona opiu* (tuberculosis) for three months. Presently, she had diarrhoea. Her two older sons had started spending nights at the night commuters' shelter due to persistent warnings and sensitisation from persons taking care of TB patients about the highly contagious

Tubercle bacilli. Adokorach, however, insisted that she would take care of her mother since it was especially at night that she needed someone to get water for her, to light the lamp, and to give her medicines. When at the World Vision food distribution centre, children taking care of clients currently enrolled for ARVs were instructed to avoid sharing basic utensils with people with *aona opiu,* Adokorach responded that she could not do such a thing to her mother. Besides, they often had insufficient food; hence they could not throw away what their mother left. Unfortunately, Adokorach's mother died five months after this interaction in March 2006. In a follow-up visit in May 2006, I found other people where she had previously resided. The new tenants told me how, following the death of Adokorach's mother, the landlady had ordered them to vacate her hut. All efforts to trace Adokorach and her siblings were fruitless. Inside, I still blame myself, while thinking, perhaps, that I was too emotionally involved with 'my' children in child-headed households.

Coming back to my own experience of taking care of a sickly kin: clearly taking care of a terminally ill person can be emotionally draining, let alone the physical aspects one needs to deal with. However, taking care of a person with HIV/AIDS-related symptoms, especially in a resource poor setting, can be even more emotionally draining. My experience may overlap with that of the displaced children, but clearly theirs is more problematic. And clearly, in my ethnographic research, I am assessing the complex issue of suffering.

Scene 11: Importance of detachment post-fieldwork and in thesis writing

In PhD writing, these severe experiences notwithstanding, all data must be presented and analysed in a precise and coherent way. This, in practice, is a complex and difficult task from a purely subjective and intersubjective stance. For example, and in regard to empirical data, which I have, a substantial proportion of children argued that forms of suffering due to infectious diseases like malaria, diarrhoea, scabies, and tuberculosis were the most severe of all. Yet another substantial proportion of displaced children, especially those who had recently lost close kin, those taking care of special and close kin sickly due to HIV/AIDS, children who witnessed the killings of close kin, and those whose siblings were abducted and who had never heard anything about them, vividly showed how such suffering is worse than any form of infection (which, in any case can be dealt with using pharmaceuticals).

In this dilemma, it is only through detachment that I have been able to put structure into my arguments. For instance, I argue that infectious diseases are primary, acute, severe, and require immediate attention, since bodily condition rapidly deteriorates as a result, their prevalence rates are high, and sometimes they reach epidemic proportions in wartime. Infectious diseases also *disorganise* the relatively stable form of suffering in children's lived experience. Concerning psychosocial suffering, I explicitly mention that some is severe, but the bodily condition does not rapidly deteriorate, they are secondary, non-acute, and children learn to *integrate* them into their daily life experiences of psychosocial suffering. Some such suffering needs immediate redress, but since they are complex, ways of addressing them must take a *holistic* approach.

By a holistic approach I mean a combination of techniques largely suggested by sufferers themselves as appropriate ways to minimise such suffering. For instance, such techniques as indigenous ways of dealing with psycho-social suffering, use of pharmaceuticals and acquiring material necessities, negotiating social support systems and designing structures that minimise poor persons' dependence on humanitarian aid, could be combined with techniques including counselling. Subsequently, I will only present children's severe forms of psycho-social suffering in the thesis. I will also, however, critique the contemporary discourse, which addresses the mental wellbeing of children in wartime with only a narrow view of Post Traumatic Stress Disorder (PTSD). Needless to say, I critique even the narrow view that defines infections as a problem of a germ, bacteria, virus or pathogen. It is a narrow view since in wartime, high prevalence rates of infectious diseases and psycho-social suffering have direct links with broader socioeconomic and political factors in disease production.

Discussion of results

I have already mentioned how in my analysis of largely valid, proximal data obtained in my fieldwork I would need to combine experience-near and experience-distant stances. This is in most part an attempt to ensure coherence and the logical flow of ideas. The difficulties I have had to confront are:

(1) I cannot sufficiently distance myself from my own suffering let alone that of children in child-headed households. I cannot even come to terms with 'objectifying suffering' into a distant thing. Nevertheless, I have to minimise any subtle lack of clarity and precision (real or imagined) in order to produce a logical and coherent piece of work in an attempt to bring order to what in reality resists order. That is: suffering.
(2) Although there are existing ways to help the researcher to not become a helper, in a large part I still feel that I am currently enmeshed empathically with the children's experiences.
(3) In some moments, I feel I can distance myself from the children's experiences; however, my own childhood experiences are part and parcel of the complete whole (i.e. myself).

Returning to the issue of intersubjectivity in research, my experience is that for an anthropological insider, and in an attempt to generate an experience-near discussion, it should be accepted as the norm in fieldwork to draw from your own experiences. All perceptions, interpretations and positions taken during research are mediated by 'home' or our own experiences. However, it is argued that being a detached researcher facilitates emotional wellbeing, and prevents becoming over-involved; thereby making research a simpler task when one is not a helper.

Traditional means exist to help the subjective researcher to 'distance' herself from the severe experiences of the informant. It is *counselling.* Until now, however, I am not sure whether if I had visited a different counsellor I would have had fewer difficulties

in reflecting, engaging in detached reporting, and distancing myself from 'own' and the children's suffering in northern Uganda.

Earlier I mentioned how numerous NGOs in Gulu implement and emphasise *counselling* for displaced persons to ensure their emotional and mental wellbeing. Activities in the *counselling* of children in child-headed households include playing football, singing peaceful songs, debating topics of peace, and story telling. A substantial proportion of children participated in these activities. For the most part, however, such projects have registered limited success. Elsewhere I assess a project designed by Save the Children in Uganda (SCiU) to promote mental wellbeing of children in wartime through distributing costumes for traditional dances and also peaceful songs. The school project coordinator complained of difficulty in getting children to participate in the project. Children indicated the need to use their time to instead carry out income generating activities such as *leja leja (*casual farm labour), fetching water for sale, and cultivating their own food crops. Some children preferred to leave school early in order to avoid numerous attacks that occur often at dusk and in darkness by unarmed and armed persons.

Proximity in research is emotionally engaging and acts as a basis for making conclusions. Although I doubt whether *counselling* (as described above) contributes to the mental wellbeing of children in wartime, it could be possible that counselling could restore normality. If not, how then do you explain the fact that numerous national and international NGOs confidently discuss the necessity of *counselling* to restore mental wellbeing? Does such a discourse have fundamental links with the detached assessment of issues of suffering and subsequently recommending interventions?

Closely linked to the foregoing point is the issue of neglect of socio-economic factors in assessing mental distress in wartime. If it is presupposed that it is not distressing to live in abject poverty and lack basic needs, then the same argument is likely to apply for witnessing and hearing about traumatising events. Although witnessing, hearing about and experiencing extreme events can be distressing in wartime, socio-economic difficulties are also central distressing factors. That is why I recommend holistic approaches in ensuring the psychosocial wellbeing of wartime persons. Using the example of my supervisor's *intervention,* financial support is one major aspect; counselling is another. Distancing from experiencing is even the most objective solution of them all. In practice however, subjectivity is not an issue which can be entirely dealt with through acquisition of information, or awareness raising and sensitisation seminars.

This brings me to the fact that numerous sensitisation seminars are conducted in Gulu to promote awareness in various issues. One particular example concerns how children taking care of close kin sickly with HIV/AIDS should avoid contracting tuberculosis through not sharing huts, plates, sleeping mats, and often ensuring that the client gets medicines at the same time every day. Drawing from proximal experience, clearly the *experience-distant* adviser is recommending the impossible. These are impractical procedures, since in Adokorach's case, they had just one hut, which they were struggling to maintain due to financial difficulties. How then were they going to avoid sharing the hut? I could also elaborate on the fact that Adokorach saw the World Vision client not as 'a tuberculosis-infected ARV client' *but* as 'a sick mother'. Those two

stances, one *detached* and the other *proximal*, are conflicting in a fundamental way. In fact the detached stance *simplifies* and readily provides simple solutions to suffering. On the contrary, Adokorach had to deal with the fact that someone special in her life was presently in need of medical assistance, suffering from a highly contagious infection; however, as they had few social amenities, they had to share resources, including food. The idea that they must not share these basic amenities was out of question.

What is more, could it be that suffering is in itself a subjective issue to assess? Could it be that in reality we have to confront, or to have confronted in the past, severe experiences 'at home'? That, therefore, when we set out to study 'others'' experiences we are indeed unmaking our sacred, unpleasant pasts, and that it is through our own sufferings that we report respondents' suffering? In that case, is it possible for an 'outsider' to capture the meaning of suffering and intervene effectively to alleviate it?

Coming back to transference and counter-transference in spatial subjectivities, it is my viewpoint that when our 'own' experiences are mediating observations, there might be a danger of 'misobservation' and misinterpretation. According to Wilson and Lindy (1994: 15), in the case of transference and counter-transference, it is possible for the anthropologist to become over-involved or over-identify with the informant. Their effective relationship can become so intense, in a positive or negative way that it can lead to empathic strain. In the example about the interactions at Oketch's home, I can envisage issues of transference to me as a researcher (now helper) in various ways. Oketch's constant portrayal as a vulnerable child exploited by close kin affected me in a significant way. I perhaps needed to assume the role of a psychotherapist to help him work through his experiences in an empathic way. This I was not able to do, partly because of my inability to distance and not become over-involved in his suffering. Now that I reflect on the entire scene, I think I could have handled my own re-experiences and the children's suffering in a more concrete way through detachment and proximity. Wilson and Lindy (1994) describe two basic types of distance and proximity for a therapist with the client. *Type 1*: Great distance, with the following patterns: disavowal of parts of the clients story; minimising of the experiences and feelings of the client; distortion of the content; avoidance of too painful aspects of the story; indifference or reserved-ness to the client; keeping a distance, and withdrawal as therapist. *Type 2*: Reactions are characterised by a strong proximity: being dependent on the client, over-involved or identified with the client; saviour behaviour; overemphasising the role of the trauma in the life of the refugee/client. Optimal distance could mean taking the client's story seriously and keeping present with the client, with an emotional involvement that is embedded in awareness, self-monitoring, and self-reflection.

Wilson and Lindy's (1994: 8) scheme only considers counter-transference reactions in cautionary terms, i.e. when there is potential loss of intersubjective space due to the therapist (researcher) becoming overwhelmed. These same reactions, as well as their normatively positive counterparts such as sympathy or identification, can also be used constructively as a way of exploring what might in fact be taking place in intersubjective space. Counter-transference can, however, be dangerous since the re-experiencing of severe events can be directed to individuals not directly involved in the initial suffering like research informants. In fact, the person to whom these

re-experiences are directed often has no shared intentions with the initial experience whatsoever. Nevertheless, if such a person can be in a position where re-experiencing of suffering occurs, it is likely that in that sense s/he has taken the role of the *distressor* in the initial experience. S/he meets with the initial distressing factor at concrete unity. Thus the person in the re-experienced subjective event is likely to be a distressor in the original severe event.

Another dimension in recognising intersubjectivity in research about suffering is the emotional pain, both (an individual's) 'own' and shared or collective pain. This contrasts with experience-distant anthropologists' claimed abilities to be objective participant observers. Where, for instance, there were sick persons, funerals and burials, their focus had been to capture the exoticness and otherness of procedures. In my proximity, however, emotional pain comes to the fore since I view these sicknesses, funerals and burials as vivid realities and forms of suffering. I cannot even comprehend that detached stance where I am 'distantly' assessing the *exoticness* and rationalities in suffering. Nevertheless, in PhD writing I need to report both an experience-near and the *exoticness* of suffering, hence the need for proximity and detachment. In which case, proximal experiences will constitute a strong basis to 'objectively' report the suffering. That, in practice, is a difficult task. The difficulty could be minimised through distancing myself from children's experiences. But how do I distance *myself* from *myself*?

Conclusions

The central question for this paper is how my own proximity influenced the research process and knowledge production, and in which ways I might be able to coherently come out of the empathic enmeshment. The best approach in research, I believe, is to combine both experience-near and detached stances in data collection and writing. For valid and reliable data, it is recommended that a researcher, as much as possible, take into account people's total experience; their emotions, their core difficulties, their suffering, and draw on these when designing interventions. Nevertheless, subjectivity in research causes emotional pain, re-experiencing of events, and counter-transference. To minimise the suffering of the researcher, there is a need for detachment and objective assessments of events. I, however, am an insider of the 'other'. I would be telling myself to *distance* myself from myself. I will not do the impossible; I will therefore be a subjective analyst: sometimes being close to the 'others', sometimes taking a detached stance to ensure coherence and the logical flow of ideas.

Notes

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1 In Uganda, an individual is an orphan after loss of one or both parents. This is slightly different from the Western context where being an orphan entails losing both parents.

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