

Health in the Aftermath of Violence: A Critical Narrative Study of Children of War and Children of Battered Women

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De plus en plus d'enfants dans le monde vivent dans des contextes de violence. Ce phénomène ne suscite l'attention des chercheurs que depuis peu. Toutefois, un nombre croissant de preuves démontre que les enfants témoins d'actes de violence souffrent des mêmes maux que ceux qui affligent les personnes subissant directement la violence. Cette étude narrative critique se penche sur les connaissances et le vécu en rapport à la santé ainsi que la relation entre celle-ci et la violence. L'échantillon, composé d'enfants de 10 à 17 ans, était divisé en 2 groupes de participants ayant été témoins d'actes de violence: les enfants qui ont vécu la guerre et ceux dont la mère a été battue. L'analyse des données a révélé plusieurs catégories: la santé en tant qu'absence de maladie, la santé en tant que prérequis à la participation à des activités désirées, la santé en tant que phénomène holistique et multidimensionnel, et la santé en tant qu'élément essentiel pour «se rendre au bout d'une journée». Bien que les 3 premiers concepts s'appliquent aux enfants qui n'ont pas vécu la violence, le quatrième s'applique uniquement à ceux qui l'ont vécue. Même s'ils ne vivaient plus en situation de violence, les participants avaient encore à relever une myriade de défis physiques et émotionnels en rapport à leur santé. Toutefois, plusieurs ont démontré des capacités de guérir. Des arguments sont émis à l'effet que la violence et la santé ne peuvent être dissociées et que l'exposition à la violence entraîne des effets importants et durables sur le vécu des enfants et leurs croyances quant à leur santé. Cet article traite des stratégies d'intervention à court et à long terme.

Growing up amid violence has become reality for many children throughout the world. The health effects of this phenomenon have only recently begun to be addressed by researchers. However, there is growing evidence that children who witness violence suffer many of the same outcomes as those who experience violence directly. This critical narrative study examined the understandings and experiences of health and the relationship between violence and health. The sample, aged 10 to 17, comprised 2 groups of witnesses to violence: children of war and children of battered women. Analysis of the data revealed 4 categories: health as the absence of illness, health as a prerequisite for participation in desired activities, health as a holistic and multidimensional phenomenon, and health as a necessity for "getting through the day." While the first 3 ideas are consistent with those of children who have not lived amid violence, the 4th is unique to this population. Although no longer living in violence, the participants continued to face myriad physical and emotional health challenges. However, many also revealed an ability to heal. It is argued that violence and health cannot be separated, that exposure to violence has a profound and lasting influence on children's health beliefs and experiences. This paper addresses long- and short-term strategies for intervention.

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Violence is a serious health problem in our homes, our communities, and our world. While it is difficult to determine the number of children who grow up amid domestic violence, it has been estimated that one in four assaults on women each year is committed by the male partner (Statistics Canada, 1998). Rodgers (1994) reports that, in Canada, children were witnesses to almost 40% of wife-assault cases and that 61% of these attacks had resulted in harm to the woman.

It is equally difficult to estimate the number of children who witness war-related violence. Figures on the extent of global conflict vary considerably, depending on one's definition. However, the US National Defense Council Foundation (1996) suggests that as many as 70 wars are being waged in the world today, forcing millions of people to seek refuge outside their native countries. According to the United Nations High Commissioner for Refugees (UNHCR) (1993), there are about 17 million refugees and 27 million displaced persons throughout the world. Current Canadian policy is to admit 225,000 newcomers annually. Approximately three quarters of these are women and children.

Given these figures, it is reasonable to assume that many children are growing up in an environment where violence is an integral part of life, where danger is common, and where interactions are chaotic and unpredictable. The carefree life depicted in Norman Rockwell's paintings — children swinging on tires suspended from trees, bicycling along streets lined with white picket fences, lazily fishing in the local creek — eludes many of the world's children. The life phase known as childhood, typically thought to be relatively free from worry, stress, and violence, bears little resemblance to the world portrayed by Rockwell. Many children in the modern world are forced to confront a darker side of life. At a time when they should be attending to their developmental tasks, many are involved in a daily struggle to survive.

Today, violence is recognized as a problem for all age groups, socioeconomic groups, cultures, and geographic regions. Whether violence is expressed in overt or subtle ways, in the home or on the battlefield, its effects on the health of individuals, families, and communities are becoming increasingly clear. Until recently, violence was viewed and studied primarily as a social and political concern; its conceptualization as a significant public health problem has received attention only in the last decade. The contributions of many nursing leaders (Campbell & Humphreys, 1993; Henderson, 1990; Hoff, 1990; Sampselle, 1991) have helped bring it firmly into the domain of nursing.

Children who witness violence have been described as its "unintended recipients" (Rosenbaum & O'Leary, 1981). Because such children do not bear the physical scars typically seen in those who are abused directly, researchers and health professionals have largely overlooked their needs. However, investigators examining the phenomenon of post-traumatic stress disorder (PTSD) have shown that children may be traumatized by stressful events that they experience either directly or indirectly, including being witness to them (Richters & Martinez, 1993; Saigh, 1991). The disturbing reality is that children who witness violence may face many of the same difficulties and challenges as those who experience it directly (Jaffe, Wolfe, & Wilson, 1990). These effects include physical and emotional health problems, either chronic or transient.

While it is known that many children suffer a multitude of adverse effects of exposure to violence, little is understood about children's constructions of health when violence is woven into the fabric of daily life, or about how health is experienced and understood in this context. If nurses are to help children make sense of events or experiences that have the potential to endanger their physical and emotional health and well-being, we must gain an understanding of the interplay between violence and health.

The purpose of this paper is to address the research question *How is health understood and experienced by two groups who have grown up amid violence, children of war and children of battered women?* The data presented here are part of a larger critical narrative study of how these two groups make sense of their experiences. That study identified common themes and areas of divergence among children who had witnessed violence in these two distinct contexts (Berman, 1996, 1999). In the present paper, data regarding children's ideas about health and their thoughts regarding the relationship between violence and health will be presented and discussed.

Review of the Literature

Health is experienced and learned through individual, family, social, and cultural factors. It may be presumed that these factors are different for children regularly exposed to violence than for those whose lives are relatively violence-free, or that growing up amid violence has some bearing on children's ideas about the meaning of health and their health experiences. In order to evaluate this idea, it is necessary to know how children who have not lived amid violence think about and experience

health. This review reflects a search of databases in the disciplines of nursing, psychology, sociology, and education.

Children and Health

Several researchers have investigated children's concepts of health and illness, utilizing Piaget's stages of cognitive development to describe how children's understandings change over time (Bibace & Walsh, 1979; Nagy, 1951; Perrin & Gerrity, 1981). Their studies reveal a progression in children's ideas about illness, from concrete to more highly abstract notions. For the most part, these studies have been based upon a medical model in which health is viewed as the absence of illness and the focus has been almost exclusively on the development of illness concepts.

In one of the few studies focusing on concepts of health as well as illness, open- and closed-ended interview questions were administered to 100 healthy children aged 8 to 14 (Altman & Revenson, 1985). Personal experiences with health and illness were found to significantly influence their ideas and beliefs. Overall, the vast majority did not consider health a particularly important life concern, a finding also reported by Dielman et al. (1980). The children in this research defined health as "feeling good" or being in good physical or mental condition. Behavioural factors, including eating properly, exercising, maintaining good personal hygiene, and getting enough sleep, were seen as pivotal to staying healthy. No gender differences were noted. The sample in this study was 90% white, from primarily middle- and upper-middle-class families.

Sleet and Dane (1990) describe the perceived components of health among adolescents aged 12 to 17. Thirty-nine attributes are described under the categories of physical, social, and emotional health. The authors conclude that health cannot be narrowly defined, stressing that adolescent health status is dependent upon social and emotional adjustment as well as physical growth and development. They also recognize that the context in which adolescents live provides an important backdrop for wellness. Similarly, they emphasize the role of the family as nurturer and the need for adolescents to feel loved and content in their home settings. They provide no descriptive information on the adolescents studied.

Researchers who have examined gender-based differences in health beliefs report contradictory findings. Dombek (1991) found no gender differences in his sample of 79 healthy children and 108 children with

chronic illnesses aged 5 to 12. In contrast, Farrand and Cox (1993) report notable differences in their research with children aged 9 and 10, with girls demonstrating a more positive health self-concept and engaging in health practices to a significantly greater degree.

Finally, several investigators have examined personal characteristics that influence children's health beliefs and behaviours, and have observed that self-esteem has a strong, direct effect on positive health practices (Lau, Quadrel, & Hargman, 1990; Yarcheski & Mahon, 1989). These researchers also note that family structure and parents' child-rearing practices influence children's health beliefs and practices.

Violence and Health

The precise manner in which exposure to violence affects health is not well understood. However, several researchers suggest that repeated exposure to violence may result in long-lasting or even permanent negative effects on brain organization, including impulsive behaviour, increased anxiety, and sleep disturbances (Richters & Martinez, 1993; Schwarz & Perry, 1994). Older children and adolescents may act out with suicidal behaviours, substance abuse, delinquency, prostitution, truancy, violent crime, and self-mutilation in an effort to relieve intense emotional pain. Other, less tangible, consequences of growing up in dangerous environments include developmental impairment, emotional trauma, fear, hatred, and fatalism (Garbarino, Dubrow, Kostelny, & Pardo, 1992).

The effects of childhood exposure to violence appear to persist for many years. Although there is considerable debate about the extent to which violence in childhood contributes to violence in adulthood, there is some indication that men who abuse their wives were often abused as children or had witnessed the abuse of other family members. Similarly, victims of wife assault often report that they had been abused as children or had seen other family members being abused (Jaffe et al., 1990; Widom, 1989).

There can be little doubt that the occurrence of violence has both short- and long-term effects on health. However, little research has focused on how exposure to violence influences children's health beliefs and practices, or on whether the influences are similar among children who grow up amid different forms of violence. Furthermore, while health perceptions and practices are likely influenced by diverse factors, little is known about how understandings of health are shaped when violence has been a pervasive and enduring aspect of childhood.

With respect to nursing research related to violence, a growing number of studies that reflect the unique perspective of nursing have been described in recent years. Consistent with nursing's holistic view of individuals and health, many nurse researchers have deviated from the dominant, pathology-oriented approaches so deeply entrenched in the disciplines of medicine and psychology (Campbell et al., 1993; Hoff, 1990). Instead, nurse researchers have tended to focus on responses to, and characteristics of, survivors of violence, as well as the interrelationships between physical, emotional, and behavioural responses. However, as Campbell et al. observe, most of this work has been with abused women. Few studies have focused on child witnesses of violence, notable exceptions being Erickson and Henderson's (1992) and Humphreys's (1993, 1995) work with children of battered women. In view of current statistics on violence, it is likely that nurses, regardless of where they work, will interact with these children and their families. Developing a means to attend to the health of this group is an important nursing challenge.

Method

Theoretical Underpinnings

The theoretical perspective guiding the investigation was a synthesis of ideas from critical theory and narrative inquiry. Within a critical framework, the researcher seeks not only to understand and describe phenomena of interest, but to question, challenge, and examine strategies for change (Berman, Ford-Gilboe, & Campbell, 1998; Thomas, 1993). In contrast to the aims of control and prediction in postpositivist research, or description and understanding in interpretive research, a primary aim of research conducted within the critical paradigm is to bring about emancipatory change. Such change may occur either at an individual level, as in consciousness-raising, or at a broader structural level, or at both levels.

Although narrative research has not played a major role in the development of nursing science, there is growing recognition of the merits of storytelling both in nursing (Meleis, Arruda, Lane, & Bernal, 1994; Sandelowski, 1991; Stevens, 1993) and in the social sciences (Mishler, 1986; Polkinghorne, 1988; Van Maanen, 1988). For Maines and Ulmer (1993), narrative is a human and social act designed to make sense of our experiences. While it may take many forms, the narrative generally consists of a chronological ordering of events and an attempt to bring cohesion to those events. In *Tales of the Field*, Van Maanen uses the term "critical tales" in describing narrative approaches within a crit-

ical framework. The aim of such tales is to give voice to individual experiences and meanings but to examine them in a social and political context. This intersection of critical and interpretive approaches was at the heart of the current investigation. By participating in interviews, the children engaged in reflection and critique as they examined the meanings of health in their own lives and contemplated the relationship between violence and health generally.

Sample

A purposive sample of 16 children of war and 16 children of battered women, aged 10 to 17, participated.

The children of war group comprised 11 girls and five boys from 14 families who had fled to Canada from Bosnia ($n = 7$), Burundi ($n = 2$), Somalia ($n = 5$), and Liberia ($n = 2$). The children from Bosnia were Muslim and those from Burundi were members of the Tutsi minority group. Ten families had incomes below \$20,000; all except two were dependent on public assistance. While many of the parents were highly educated and had held professional positions in their native countries, few had found jobs in North America.

The group of children who had witnessed woman abuse comprised nine girls and seven boys from 12 families. Ten children were Canadian-born and could not identify their ethnic background; two had emigrated to Canada from Eritrea as young children; one was First Nations (Ojibwa); and two were second-generation Eastern European. Like those of the children of war, the majority of families (9) in this group had incomes below \$20,000; all except three were on public assistance.

All participants had witnessed violence. Some of the children of battered women had also been abused themselves. None of the children were living amid violence at the time of the interviews. The children of battered women were no longer living with their mother's abuser, and all the refugee children had been living in North America for between 1 and 5 years. While all the children spoke English, the letters of explanation and consent forms were translated into the family's first language.

Several strategies were used to recruit participants. The children of battered women were identified primarily through two agencies in southwestern Ontario. One of the agencies offered a group program for child witnesses of woman abuse of which I had been a volunteer facilitator. With the assistance of the agency director, potential participants

were identified and approached by the program coordinator. The other agency was a transitional housing project for women who had left abusive relationships, the director of which served as a recruitment support.

The recruitment of children who had been witnesses to war proved more difficult. The elimination of federal funding for many immigrant and refugee programs precluded the cooperation of key agencies. I therefore contacted several cultural and ethnic groups directly. As a result, leaders from the Bosnian, Burundian, Somali, and Liberian communities endorsed the study and agreed to contact families and to translate letters of explanation and consent forms into the family's first language. Informed consent and assent were obtained from the parents and children. Often, the families assisted in the recruitment of additional participants. This "snowballing" sampling technique proved extremely effective.

Procedures

All participants took part in two autiotaped interviews. In the first interview they were questioned in order to elicit stories about their lives before, during, and after their exposure to violence. Specific questions concerned their perceptions of their past and current state of health, the meaning of health, strategies to become or to stay healthy, and perceived impediments to being or becoming as healthy as they would like to be. Probes were used to encourage elaboration, and, when appropriate, I shared information about myself. All participants were given the choice of being interviewed alone or in groups of three or four. Most preferred to be interviewed alone. Four group interviews were conducted. With the exception of two girls from Bosnia who asked to be interviewed together, the groups consisted of siblings. Two weeks after the interview, I met again with the children to share and discuss emerging themes.

Data Analysis

The narrative data were analyzed using methods described by Riessman (1993) and Mishler (1986). As well, the NUD*IST (Non-numerical Unstructured Data – Indexing, Searching, and Theorizing) software program was used in organizing the data. The audiotapes were transcribed verbatim. Because narratives are often long and may contain many comments not germane to the research, narrative reduction is necessary (Riessman), resulting in what Mishler calls the "core

narrative." Labov's (1982) framework was employed to identify story components, namely orientation, plot, evaluation, and resolution. The narratives were read several times, with attention to the children's thoughts, experiences, feelings, perceptions of what occurred, and responses to these events. Similarities and differences among individuals and sample sub-groups were noted. Ideas concerning health were content analyzed for common themes.

Lather (1991) suggests that negotiating meaning helps build reciprocity. In the current study, the children were given an opportunity to review their narratives and make additions or changes. Emerging analyses and conclusions were shared and discussed, individually and in the groups, thereby allowing the children to participate in the construction and validation of meaning.

Results

The question "What does health mean to you?" elicited a wide array of beliefs and images. Frequently, I was asked what I meant, and typically I replied that health can mean different things to each of us and I was interested in knowing what it meant to them. The children required time to articulate their ideas, but through the processes of dialogue and reflection they shared thoughts that were perceptive, sometimes poignant, and always honest.

The comments of the children of war were similar to those of the children of battered women, and in some respects were also similar to the ideas attributed to children who have not grown up amid violence. However, for the participants the experience of violence was interwoven into their thoughts and feelings about health. A small number depicted health as a reflection of their physical state and several spoke of health as a holistic and multidimensional phenomenon. More commonly, however, they discussed health as a necessity for everyday survival. Four categories, or themes, emerged: *not being sick, being able to do what you want to do, being mentally healthy and happy and stuff like that, and just getting through the day*. In the following passages, all of the names are pseudonyms, many of which were chosen by the children.

Not Being Sick

A few participants described health as the absence of disease or sickness. Included in this category was the belief that health is the absence of illness or symptoms, the absence of the need for medications, and being "normal." This perspective is apparent in the description of

health articulated by 13-year-old Andrew. "You know, needing medicine and being sick and stuff like that. Is that the sick that you mean or the health that you mean? Well, what I think about, I just think of being sick and getting better."

Medina, a 15-year-old girl from Bosnia, also described health primarily in terms of the absence of physical illness. She identified behaviours that might prevent illness. "Well, I don't know. Health is kind of like being normal or something. People who are normal are not sick. It's very important, because everything you can do when you are healthy you can't do when you are sick or having some problems or something." She viewed health as valuable and desirable, as well as the "normal" and expected state of affairs. Similarly, Monique, from Burundi, stated that being healthy meant being "in good condition, with no disease."

Being Able to Do What You Want to Do

The idea that health is a prerequisite for participation in recreational activities was expressed by almost all of the children. As Medina succinctly stated, "Without it, we can't do the things we'd like to do. With it, we can." They described their participation in sports and other recreational pursuits, and noted such measures as eating well, maintaining good hygiene, and getting sufficient sleep as strategies for achieving and sustaining health.

Stjepan, an 11-year-old from Bosnia, related a poignant story that illustrated for him the meaning, and the importance, of health. Stjepan's identification with children still in Bosnia added to his appreciation of his own good health.

It means a lot to me. If I had no legs or arms I would just have to sit here in the house. Last week me and my mom were watching this show about some guy from our country who was bombed and had no legs and just one arm...and that's how he went to school and stuff. It was a small child, like 3 years old. So that made you think about being healthy and the kind of things that you can do with two legs and two arms.

Several children described various activities that they currently enjoyed, adding that if they did not have their health they would not be able to engage in them. Thus these children viewed health as necessary for participating in sports, social events, or other recreational pursuits.

Being Mentally Healthy and Happy and Stuff Like That

Some of the children depicted health as a multidimensional phenomenon affecting everything we do. Andrew said, "I guess it's just like being mentally healthy and happy and stuff like that." Seth's view of health clearly went beyond one's physical state: "I guess just mainly physical and emotional okay-ness. I think people that haven't known abuse and don't know about it would say that health is just about physical well-being. And I know that there is emotional in it too."

Four daughters of battered women described health holistically. One girl described health as "how you view yourself." Another said, "It has to do with, like, how your body is doing, how your stress is taken in. I think it includes your mental awareness and, like, your health affects you mentally and physically both." A third girl observed that health was "being happy, like having a healthy house. Like everything's clean. There's a lot of different healthy things. Like your body could be healthy and everything."

Erica, 14, described her home as a cold and barren place where family members rarely spoke to one another. She viewed her father as domineering, lacking in warmth and affection. Although not physically abusive, he would constantly engage in verbal assaults against Erica's mother and older sister, who ran away at the age of 17 and never returned home. Erica admitted that only in retrospect could she see that, in fact, she had been quite unhealthy during her early years.

I thought I was healthy, but now I see that I wasn't. I had good physical health, but I didn't have emotional or mental health. I can see that I wasn't healthy now. I think violence affects health a lot more than people think. People don't think it's a big deal, but they don't understand that it is.

Monique, 17, had come to Canada from Burundi in 1995. For her, being healthy meant being "in good body." Asked whether she considered herself to be healthy, she replied, "Like, physical, yes. Not emotionally. Physically I'm fine." Claudine, a 14-year-old girl from Burundi, responded similarly: "I think it's when you are not sick and when you are happy. For me it's when you are happy."

Just Getting Through the Day

Most often, however, the children provided more modest depictions of health. Because of their experiences, they felt healthy when they were simply able to get through the day. Health was viewed as necessary for everyday functioning, for being able to sleep through the night, and for

feeling safe. Although no longer living in a violent environment, many still suffered both physically and emotionally. For many years 13-year-old Seth had seen his father physically and emotionally abuse his mother. Although his parents had been divorced for almost 2 years, his family was still enmeshed in court battles over support payments. Seth described how he still became thoroughly immobilized dwelling on thoughts about his father.

A lot of the times I feel so bad that I won't want to do anything. I won't want to go out and run or play sports. I just sit at home and eat. And a lot of the time I don't want to eat healthy stuff because I don't care any more. Like, why bother, I'm so down. Sometimes it's school, I'm really loaded with work or somebody is being a dickhead. Recently it's been the court. I've stayed home six times in the past month. After court I felt so bad that I didn't really want to go to school. Today I didn't feel very good and I needed to work some stuff out.

There's been instances that I didn't feel very well. I felt really tired because emotionally I was exhausted. It's just been overloading me. I haven't been able to do anything. I didn't go to school those days and I didn't socialize with anybody. I sat at home and did nothing, and just sat there and thought about it [his father]. It's really hampered me physically. I haven't shown any signs of it but I've just been feeling really bad, and my stomach ache this morning I think was caused by emotional stress. That's probably happened a couple of hundred times in my life because of emotional stress when I was younger. It's not just a stomach ache, I've just felt not really depressed but kind of motionless and energyless. Not really tired, just not wanting to move, not wanting to do anything. And I haven't.

Seth's comments revealed the profound sadness and loss he continued to feel as a result of his father's violent behaviour and his parents' subsequent divorce. Although he no longer lived amid violence, Seth continued to have difficulty with the routine of everyday life, to the point of feeling thoroughly incapacitated, and continued to endure myriad physical and emotional problems.

Seth's 15-year-old sister, Dakota, added her perspective that health was incompatible with violence. "I don't think that an abusive family is healthy. I would say it's an unhealthy family and if the abuse does go on it's not really healthy because you get hurt, and you usually don't forget it." For Dakota, health entailed "being someplace where you can feel safe and where you don't have to worry about everything all the time. If you're in a safer place, you don't have as much stress and you feel better."

Mardelle was a 15-year-old who had witnessed the abuse of her mother by two men, first her biological father and later her mother's

live-in boyfriend. Mardelle had only vague memories of her life when her parents were still married, and she spoke mostly about the violence inflicted by her mother's boyfriend. She readily acknowledged that the years when he lived with them were not a healthy time in her life.

I used to stay up late all the time, thinking that she was with him, and thinking of what am I going to do if...just thinking of different things. Like if he takes a knife to her or something, and then I'm going to stab him, stuff like that. I'd stay up all night till 6 o'clock in the morning and then I'd go and have my sleep. Now it's like I can shut my eyes at 9 and wake up at 7 o'clock in the morning. To me that's healthy.... Now I wake up and I'm just awake and ready to go.

Donna and Lucy were sisters, aged 15 and 13. Their father was never married to their mother and so had never been a prominent figure in their lives. Their mother's boyfriend, Kenny, lived in their home for many years. Although the sisters liked him initially, both explained that he became abusive shortly after he moved into their home. The verbal and physical abuse was directed towards them as well as their mother. The idea that violence and health cannot co-exist was implied in Lucy's comments.

I feel really healthy when I'm not around Kenny. I feel happier. When I'm around him I always have stomach aches. I feel like when he's around we're all scared and we just sit around and don't say nothing. When Kenny lived with us, I couldn't sleep because I was scared that he'd come in and say I did something wrong. Because we'd have to face the wall sometimes. And if I lay the wrong way I was scared.

Like Lucy, Donna viewed Kenny's violent behaviour as detrimental to her health and well-being. She not only spoke of the effects of Kenny's behaviour while he was still living with them, but asserted that her health still suffered as a result of the years he was in their home.

Well, physically I feel a lot better. I have a lot more friends. I feel more free. But I'm still not very comfortable with who I am. I feel that since I've been through a lot it's just hard to deal with. Because with Melissa and Billy [two younger siblings, the biological children of her mother and Kenny] having to visit him, we are still not through with all the courts and everything. And it just keeps bringing back more bad memories. It just fills my mind. It's hard at school too.

Like the children of battered women, the children of war were confronted with an assortment of day-to-day challenges. Although no longer living in a war zone, they continued to be haunted by painful and disturbing memories. During their years of living amid the conflicts in their homelands, they were engaged in a daily struggle to survive. Now they were secure in the knowledge that they would be provided

with sufficient food and water and no longer lived with the threat of bombs and other forms of terror. Yet that sense of security is fragile and, as they explained to me, easily threatened. For example, during the study Quebec held a referendum on separation from Canada. Several children described to me their fear that this would lead to the outbreak of war. Having just fled from war, this prospect was terrifying to them. Further, despite the relative safety and security they now enjoyed, their nightmares and fears persisted. Seemingly innocuous events like fireworks on Canada Day triggered fear. Intrusive thoughts were commonly described. As was the case with the children of battered women, "getting through the day" was an ongoing challenge.

Monique's family was still in Burundi. For her, concern for them precluded the possibility of health for herself. "I think about the war and my family. It is worse when I am alone, everything comes back, I think and I think, many times I cry and get upset." Monique lived with a young woman from Rwanda whose experience had been similar to her own. Consequently, they were able to empathize and derive strength and comfort from one another.

The interrelationship between health and violence was evident in the words of Claudine, who had cousins and grandparents still in Burundi. "When you are here and there is a war some place, and I think that a person is dying or has died, and you see things on television, to me that is not health." She added that she had recurrent headaches that tended to strike when she was crying. Asked what she cried about, she said, "When I hear my mom saying that it's getting bad in Burundi or something. Or when I think that some people are dying, I think it is a good thing coming here. But I just wish that there wasn't a war and that we didn't have to leave Burundi." Similarly, the persisting challenges in getting through each day were clear in the words of Maja, from Bosnia. When asked if anything interfered with her health, she stated:

Yes, sometimes emotional problems. That's the only thing that bothers me sometimes. Well, sometimes when I think about everything that happened to me, I always start crying. And then I feel like I'm not able to do anything...like, not homework, not anything in the house, not to go out with my friends or something. I just feel like a really sick person. I'm not ready for anything. It always happens in the afternoon. I don't know, it's probably just feelings I have.

Health concerns were also apparent in responses to questions not explicitly related to health. Almost all of the refugee children described being teased and bullied by their new classmates, particularly during their first weeks and months in North America. For most, these behav-

iours were short-lived, subsiding as the children became more skilled in speaking English and more knowledgeable about cultural expectations in the playgrounds and classrooms. However, the children from African countries tended to describe more persistent difficulties in gaining acceptance. Ismahan, a girl from Somalia, spoke openly about racism, while Claudine described ongoing feelings of loneliness and difficulty making friends. Some were inclined to attribute peer hostility to their refugee status rather than the colour of their skin, but all experienced some degree of unwanted differential treatment. The participants were clear about the ways in which the violence they had witnessed had been detrimental to their health and well-being. Although previously they had not given this issue explicit consideration, and initially seemed surprised by the questions, their interest in exploring the topic was evident. They took their time as they considered the issues and articulated their ideas, and appeared to genuinely welcome an opportunity to think about the relationship between their own experiences, health, and violence.

Discussion

The findings of this study reveal that children's constructions of health are sophisticated and intricately woven into their experiences of violence — that living in a violent environment has a profound influence on how children understand and experience health. The participants viewed health as the absence of illness, as having physical as well as emotional dimensions, as necessary for engaging in pleasurable pursuits, and, most commonly, as a prerequisite for getting through the day. While the first three ideas or themes are consistent with those reported in the literature as expressed by children who had not grown up amid violence, the latter notion is unique to this group. In the context of the lives of these children, it is a profound idea, and one that has important implications for nurses and other health professionals.

The participants in this research depicted health and violence as incompatible. They conceptualized health as vitality and desire, as enabling them to move, act, make decisions, and participate in community life. Violence had rendered them inert and immobile; almost all of the children spoke about ways in which their health was compromised as a result of the violence in their lives. The problems they described, which persisted after they had been removed from the violent situation, included: (a) loss of sleep, (b) intrusive thoughts, (c) eating disturbances, (d) difficulty carrying on with daily routine, including school, (d) lack of energy, and (e) self-doubt and lack of confidence in them-

selves and in the world around them. These symptoms are consistent with the DSM-IV diagnostic criteria for post-traumatic stress disorder (PTSD). In addition, some children reported feeling excluded and racially discriminated against, although they did not typically construe such feelings within the realm of health.

Despite the similarities, there were fundamental differences both between and within the two groups of participants. The children of war endured their experiences collectively, with family and friends sharing the same bewildering and frightening emotions. In contrast, the children of battered women were forced to suffer alone, and in silence (Berman, 1996). While wars are carried out in the public arena, woman abuse typically occurs in the privacy of the home. For the children of war, during the most intense fighting all semblance of normal life came to an end. Schools closed and they could not go out and play. In short, there was no pretext of life as they had known it. For children of battered women, on the other hand, life did not come to an end. They had to get up each morning, attend school, and develop elaborate schemes to ensure that no one found out what was occurring in their homes.

Among the children of war, important differences are also noteworthy. The refugee children who participated in this study came from four countries, bringing with them diverse cultural beliefs, practices, and traditions regarding health, different from one another and, frequently, different from those embraced by Western society. The inclusion of children from such disparate countries in a single study might seem questionable. However, as Meleis (1996) cogently argues, understandings and experiences of health are derived from many contexts, of which culture is just one. When cultural heritage is the unit of analysis, broader social and political structures may be overlooked. In the current study, all of the children of war were confronted with many traumatic events as a result of their shared experiences as refugees. Although care must be taken not to "essentialize" the "refugee experience," children and adolescents who have fled their homes and countries because of war share many health experiences that may transcend differences based solely on cultural heritage or ethnicity.

There is growing evidence that violence jeopardizes health and well-being (Garbarino et al., 1992; Jaffe et al., 1990), yet this important relationship receives little attention. The problem is intensified among children who are witnesses to violence, because, unlike children who are abused directly, they do not bear visible scars and are thus easily overlooked. It is noteworthy that the Ontario Child Health Study, one of the largest provincial surveys of child health, included no questions

on violence in children's lives. In view of current statistics on woman abuse, such an omission represents a serious limitation.

Nurses must be prepared to develop a collective consciousness about the influence of violence on health and children's understandings of health when violence has been a part of their everyday reality, and to implement short- and long-term strategies to help these children. Humphreys (1993, 1997) has compiled a comprehensive list of interventions aimed at primary, secondary, and tertiary prevention for children of battered women, many of which are also relevant for children of war. Very briefly, at the primary level interventions are aimed at eliminating all forms of violence, either at the structural level through interaction with policy-makers or at the grassroots level through education and work with individuals, families, and communities. Through such initiatives, the ways in which society condones and supports violence can be examined, to help children understand and challenge war and woman abuse. At the secondary level, initiatives are intended to prevent recurrence of violence and to identify those in need of help. At the tertiary level, the goal is rehabilitation and establishment of long-term services. Humphreys (1997) provides a more detailed discussion of these points. Several investigators describe the advantages of group programs, particularly for children of battered women (Peled, Jaffe, & Edleson, 1995; Sudermann, Jaffe, & Hastings, 1995). The programs offer these children an opportunity to: talk about their experiences; gain insights into the causes of violence and learn that they are not responsible for what has occurred in their homes and their countries; learn basic safety skills; and derive a sense of solidarity as they begin to see they are not alone. As well, a group can provide a context for identifying and evaluating strategies for dealing with the emotional turmoil caused by witnessing violence. Through such validation of their thoughts and feelings, children gain self-esteem and, ultimately, become empowered. Although there exist fewer descriptions of programs for children of war, indications are that group programs for this population may be equally effective (de Andrade, 1992).

Regardless of the specific interventions selected, some principles should apply to all: (1) willingness to listen to children in a sincere and non-judgemental manner, (2) respect for the child and recognition of his or her strengths, (3) willingness to try non-traditional approaches with children from diverse cultural backgrounds, (4) awareness of the political dimensions of violence, with a view to enabling the child to develop age-appropriate understandings of political and social contexts, and (5) development of strategies to help children find health in an unhealthy world.

Conclusion

The health experiences of children who grow up amid violence are, in fundamental ways, incongruous with Western notions of childhood. Although this stage of life is a social and cultural construction, the prevailing image of childhood is rooted in the humanist tradition characteristic of Western industrialized society. Within this schema, childhood is a time of innocence and vulnerability, a time when children are not meant to experience or witness violence. Clearly, however, many do.

Because of the many ways in which violence is supported and encouraged in our society, the health problems of these children should not be viewed as private problems. Meleis (1990) urges nurses to reconceptualize health as a community issue and as a social and societal obligation rather than a personal objective. The inherent limitation of the dominant view of health as an individual concern is that it leads us to encourage our clients to adjust and adapt to the worlds around them, regardless of how fundamentally unhealthy those worlds may be. Failure to acknowledge and critique the ways in which violence precludes the attainment of health inadvertently results in a tacit acceptance of such behaviour. As nurses, we must be vigilant in our efforts to make this world a more peaceful one, and to challenge a status quo that allows violence to flourish. Strategies should go beyond short-term interventions with those affected, to include lobbying for policies, laws, and procedures that ensure that children who witness violence receive the protection they deserve and so badly need.

While the results of this study show that children who live amid violence encounter a range of health challenges, we should not presume that long-term harm is an inevitable outcome. Through their struggles to find meaning from their experiences, the children demonstrated remarkable courage and strength. While wounded and hurt, they revealed a capacity for healing. I would like to close this paper with the words of a girl who came to Canada from her home in Bosnia in 1993.

Human greatness is the ability to forgive. The world would be very strange if people only gained desire for revenge. I read what happened in World War II. It was the same: occupation, killing, destroying. War stopped and people have started to live a normal life. They could live it because they were capable of forgiving. I cannot forget people's faces and eyes looking toward the heavens. I cannot forget children's tears, people's hands waving goodbye, and my father's words, "See you soon," on the day when my mom, my brother, and I, between bombs and gunshots, left Sarajevo. After that I pray to God every night never again will there be a war anywhere on earth, please. Now is the time for happiness, understanding, and forgiveness.

– Sejla, age 12

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