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EDITORIAL

A DREAM OF A WORLD
WITHOUT GHOSTS FROM THE PAST

Most countries in the world would agree on the desirability of a stable and sustainable social structure which gives priority to the wellbeing of the individual as well as the whole. However, in practice many countries cannot live up to such principles.

Adverse climatic conditions, financial problems, and historical facts which have caused lasting damage to the respective countries are examples of reasons why countries cannot live up to the above principles, reasons which count as legitimate excuses. But there are other reasons too, and they tend to be self-inflicted: corruption, demonstration of power by a small, influential elite, uprisings, and wars. Such factors inhibit development in the affected countries and prevent them from taking advantage of their natural wealth and from dealing with problems such as illiteracy, widespread disease, and underdevelopment. The negative situation which arises often develops into a vicious circle, leading to further despair, hopelessness, isolation - and torture. Torture is caused by the wishes of those in power to maintain status quo, combined with willingness among the representatives of law and order to carry out the actual torture. This mixture of destructive forces is enhanced by problems concerning world poverty. Widespread severe poverty endangers world peace - it is a bomb waiting to go off. This makes it the concern of the rich countries too, they have an interest in doing something about it. The existence of torture is a crucial proof that this global inequality exists. The potential improvements in living conditions and security are proportional to the eradication of torture. This is not to say that the eradication of torture would lead directly to a world without poverty and illiteracy, but it would form the right conditions for a society to be able to concentrate on these tasks. This again would mean that the eradication of torture would be an important contribution to the facilitation of a virtuous circle.

It is important to increase the popular support and the basis in international law for the fight against torture. But torture is difficult to fight. Although it is widespread - torture is practised regularly in around 100 countries in the world - it is not easy to prove its existence and the authorities deny that it takes place.

It is now 53 years ago that the UN adopted the Universal Declaration of Human Rights, and article 5 states that: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." However, it was not until the adoption of the 1966 International Covenant on Civil and Political Rights that an obligation not to torture was made part of international law. Article 7 of the Covenant states that "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation." This is a simple obligation. Nevertheless, to live up to this obligation causes problems for approximately half of the countries in the world. The obligation was further defined when the UN General Assembly adopted the Convention against Torture on 10 December 1984. The Convention is legally binding on member states, and no issue, irrespective of its merits, can serve as a justification for torture. When a country has signed Article 22 of the Convention it is also possible for individuals to complain to the associated Committee against Torture if they feel that a country has violated the Convention. So far 41 countries have ratified Article 22. Article 21 enables a member country to complain about other member countries, but this possibility has not yet been used. The UN Convention is one of the most important international legal instruments in the fight against torture, and still it has less parties than the other significant human rights conventions.

The objective of the IRCT is to work for improvements in the assistance given to torture survivors as well as to support all efforts aimed at making it clear to everybody how destructive torture is for society and for individuals. The IRCT bases its work on the intentions in the Convention against Torture and this has been shown to produce results in the fight against torture. In connection with the 52nd anniversary of the UN on 10 December 2000, a campaign was launched in order to persuade more states to sign the Convention - presently 123 have done so.

Another campaign which plays an important role in the fight against torture is the annual global campaign in connection with 26 June - United Nations International Day in Support of Victims of Torture. On 26 June 2001, individuals and organizations worldwide will join the international campaign to commemorate this UN International Day. This year, the IRCT is coordinating the fourth consecutive global campaign to support these events in every region of the world.

This year the theme of the campaign is "Together against Torture", reflecting the multi-disciplinary action needed to support victims of torture and to work for the prevention of torture worldwide. The work against torture requires the combined efforts of rehabilitation centres, human rights organizations, the legal profession, governments, the media, and individuals across the globe. This year's campaign aims to both empower torture survivors and to renew support for our shared responsibility in working for the eradication of torture.

On 26 June 2000, individuals and organizations held commemorative events in more than 80 countries worldwide. This year the IRCT hopes to both increase the number of countries participating in the campaign, and to further strengthen the impact of local events.

H.M.
The growing importance of the European human rights protection system in Strasbourg

The effects of the European Convention on Human Rights
50 years after its creation – compensation is paid, but serious violations continue in a couple of member states

Henrik Docker

It is a milestone to celebrate a 50th anniversary. In November 2000 the European human rights protection system could do so. Ministers, politicians, and lawyers from the about 40 member countries of the Council of Europe assembled in Rome to commemorate the "birth" of the European Convention on Human Rights, which was signed in Rome on 4 November 1950 by 12 countries.

The President of Italy, Carlo Azeglio Ciampi, received them in the Quirinal Palace in Rome and talked about the achievement of democracy through law. The Foreign Minister, Lamberto Dini, was there as well as the Minister of Justice, Piero Fassino. They said nothing about the concrete work of the European Court of Human Rights in Strasbourg. Nothing to spoil the festive atmosphere.

The fact is that half of all the 4500 decisions made by the Court – and until 1998 also by the Committee of Ministers of the Council of Europe – have dealt with Italy. This country has a deplorable European record in protracted trials, the so-called length of proceedings cases (1), in which Italy in almost all cases has had to pay compensation for the completion of the cases (some of them lasted up to 40 or 50 years!). Nor was it mentioned that torture is still practised in Turkey. This country has violated the European Convention for the Protection of Human Rights and Fundamental Freedoms about 75 times, and it has had to pay compensation to torture victims in 20 cases where a violation was established.1

The pertinent question is: what has Europe learnt in 50 years concerning sanctions against and prevention of human rights violations? This article will focus on the response of governments when found "guilty" of violations of the Convention. The preventive work done by the Council of Europe's Committee for the Prevention of Torture (set up by the European Convention for the Prevention of Torture and Other Inhuman and Degrading Treatment or Punishment (CPT) of 1987) has been dealt with several times in this journal.1-5 A glimpse at the statistics from the European Court of Human Rights in Strasbourg will give an indication of the effects when some countries – in contrast to the idealistic promises – have violated the "sacred" rights of their citizens.

In the course of these 50 years, only few countries apart from Turkey have been found guilty of violating the torture prohibition rule of the Convention. Whereas this was new territory for lawyers back in 1950, today we find it more than evident that an international treaty on human rights should include torture prohibition. The Second World War, not to mention the persecution of the Jews and many other peoples, provided many strong reasons for doing so. The European Convention for the Protection of Human Rights and Fundamental Freedoms in its third article introduced the first clear-cut prohibition of ill-treating, maiming and degrading human beings in international law:

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

Having no other international agreement to refer to, nor practise from other international bodies as far as "torture" and "inhuman/degrading treatment" are concerned, the former European Commission of Human Rights (an investigative body preparing the cases up to its abolition in 1998) and the European Court of Human Rights had to develop their own interpretation of the meaning of Article 3. National legislation was of little help as no member country at that time had any national law referring to torture expressis verbis.

The first thorough experience with torture in Greece

After the Greek coup d'etat in 1967, in which a junta of colonels set aside the Greek constitution, imprisoned a large number of leftwing politicians and others and subjected many to torture, the Commission and Court were confronted with numerous cases from refugees. In Court rulings, inhuman treatment was defined as "such treatment as deliberately causes severe suffering, mental or physical, which, in the particular situation, is unjustifiable", degrading treatment was when a human being was "grossly humiliated before others", whereas torture was "an aggravated form of inhuman treatment".

Greece was not put before the European Court of Human Rights, as Greece at that time had not accepted the jurisdiction of the Court. Denmark, Norway, Sweden, and Holland raised a case which, according to the Convention, was dealt with by the Committee of Ministers (i.e. the Foreign Ministers of the member countries) of the Council of Europe in Strasbourg (2).

The conflict in Northern Ireland – the misgivings between Catholics and Protestants, deriving from discrimination concerning employment, voting rights etc. – gave rise to the first case concerning Article 3. The British authorities were blamed for using the so-called five techniques (3) during interrogation of suspected terrorists, and for that reason Ireland brought a charge against Great Britain. The Court did not term this torture (in contrast to the former European
Commission of Human Rights), as the detainees were not exposed to suffering of the particular intensity and cruelty implied by the word torture. According to the Court, ill-treatment has to involve a minimum of severity if it is to fall within Article 3. The Court, however, found cases of inhuman and degrading treatment. The latter characterized as "ill-treatment designed to arouse in victims feeling of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance". The five techniques were subsequently abandoned.

France has been found violating the torture prohibition twice, viz. in the cases Tomasi and Selmouni. It would be fair to ascertain that France is no torturing nation according to any systematics. For that matter there is no state in Europe, apart from Turkey, which on a regular basis is charged with torturing people.

But these two cases were grave. The Corsican shopkeeper Felix Tomasi was arrested in 1982 suspected of being behind a series of attacks by the Corsican National Liberation Front, among these an attack on the barracks of the French Foreign Legion. Tomasi was detained for five and a half years. But it was immediately after his arrest that he suffered most: During police interrogation he was beaten for about 40 hours. He received 1 million FRF in compensation for non-pecuniary damage.

The Court considered medical reports by four different doctors establishing the many injuries on the body of the applicant and attesting the severity of the large numbers of blows he had received. The Court stated that the undeniable difficulties inherent in the fight against crime, particularly with regard to terrorism, cannot result in limits placed on the protection to be afforded in respect of the physical integrity of individuals.

In the second French case, the applicant, Ahmed Selmouni, a Netherlands and Moroccan national, was severely beaten and otherwise molested during police custody in November 1991. He was beaten with a baseball bat, assaulted in other ways, and sexually abused. He lost an eye as a result of the police action. He had been arrested suspected of drug trafficking, and he was sentenced to 15 years in prison in 1992. The Court found that the physical and mental violence committed against Selmouni had caused severe pain and suffering; indeed it was particularly serious and cruel. In addition to that, he had been subjected to a number of acts, which would have been heinous and humiliating for anyone, irrespective of their condition (the sexual abuse). He was awarded FRF 500,000 in compensation.

*In certain situations rape is equivalent to torture*

Since Turkey accepted the right of the individual to charge its government in 1988, hundreds, not to say thousands, of Turks have used that right. Turkey joined the Council of Europe – mother organization to the Convention – already in 1950. It is mainly thanks to the organization Kurdish Human Rights Project in London, a body of Turkish/Kurdish emigrants, including lawyers, that many Kurdish cases have reached Strasbourg. In several cases Turkey was condemned for preventing its own citizens from lodging their complaints. We shall look at only a few of the about 20 such Turkish cases concerning violation of Article 3 dealt with by the Court (in several cases there is additional violation of other rules of the Convention). There is a frightening similarity between these cases. As a general rule the Turkish Government has done nothing to investigate the complaints against the authorities. So the obligatory exhaustion of national remedies, as required in the Convention, is not taken into consideration.

In the case Aydin v. Turkey the Court delivered its judgment on 25 September 1997. In this horrifying case, however, the Turkish authorities instituted thorough investigations after complaints from three Kurdish citizens. The applicant, Mrs Sükran Aydin, was 17 years old when she was arrested by the police on 29 June 1993 and brought to the town Derik. During the interrogation she was put into a car tire and turned round and round, she was beaten, and sprayed with cold water from high-pressure jets. Later she was blindfolded and led to another room where, behind a locked door, a man in uniform forcibly removed her clothes and raped her. She was in severe pain and covered with blood, but nevertheless beaten for one hour and threatened not to report what had happened to her.

Together with her father and sister-in-law, who had also been arrested, she was taken away from the police headquarters about four days later. They were driven to the mountains nearby by members of the security forces and questioned about the location of PKK shelters. Subsequently they were separated. Six days later, Sükran Aydin together with her father and sister-in-law reported to the Public Prosecutor to lodge complaints of the treatment they had suffered, she specifically said that she had been tortured. All three were then sent to a medical doctor at the Derik State Hospital. The doctor, Deniz Akkus, stated that the girl's hymen was torn, and that there were widespread bruises around the insides of her thighs. She was later examined at...
the Diyarbakir Maternity Hospital and the Forensic Medicine Institute in Ankara.

The Court concluded (as previously the former European Commission of Human Rights) that Sukran Aydın's allegations were proved beyond reasonable doubt, following the co-existence of sufficiently strong, clear, and concordant inferences. The Turkish Government had been unable to adduce any evidence collected in the course of the criminal investigation into the applicant's allegation which would have served to contradict this conclusion.

The Court observed that the rape of a detainee by an official of the State must be considered to be an especially grave and abhorrent form of ill-treatment, given the ease with which the offender can exploit the vulnerability and weakened resistance of his victim. Furthermore, rape leaves deep psychological scars on the victim, which do not heal as quickly as other forms of physical and mental violence. The girl was subjected to a series of particularly terrifying and humiliating experiences. She was detained for three days during which she must have been bewildered and disoriented by being kept blindfolded and in constant physical pain and mental anguish. She was also paraded naked in humiliating circumstances, thus adding to her overall sense of vulnerability. This was the first time in the history of the Court that rape was termed torture. The girl was awarded GBP 25,000 as compensation for non-pecuniary damage.

The police has a responsibility for detainees

A recent case, Berkay v. Turkey, concerned a father and his son, Hüseyin and Devrim, who suffered maltreatment during a police raid in their home in Diyarbakir in February 1993. The father was upset as police officers had pushed the son from a balcony and — according to the father — delayed him in taking Devrim to a health centre for tomography. The facts about the events — as is often the case — are disputed by the parties, but the former European Commission of Human Rights, which conducted its own inquiry and obtained written evidence and oral statements, established that the son was arrested during the night and later brought to his home as he was asked to find a document related to an offence.

When going through a pile of newspapers, the 17-year-old threw himself over the rail of the balcony. The Court stressed that people in police custody are vulnerable and that the authorities have a duty to protect them. In such situations any injury to such a person could give rise to a strong factual presumption. In the Court's view it is the responsibility of the government concerned to provide a reasonable explanation as to how the son's injuries had occurred. The Court reiterated (this being said in many previous Turkish/Kurdish cases) that the investigative imperatives and the indisputable difficulties that arise in the fight against crime, and in particular against terrorism (reference to the violent activities from part of the PKK at that time), could not justify any reduction in the protection of an individual's physical integrity.

In this case the Court found that all the versions of the incident offered by the police officers contained discrepancies between important details. Still, the criminal court had not carried out an investigation. Nor had it sought to hear evidence from the police officers or the complainant; it had relied entirely on the explanations of three police officers. Furthermore, the Court found that both applicants had been deprived of an effective remedy regarding their allegations against the police officers.

One may term the preventive effects of Article 3 a success because violation of this Article is rare in all Council of Europe members apart from Turkey. It should be recalled that the Court is cautious in its interpretation of this Article. However, it is disturbing that the use of torture is so widespread in Turkey that it may be termed a usual practise. Whereas the court (as all the other Council of Europe countries) has paid the compensation fixed by the European Court of Human Rights in all cases, there has not yet been a decrease in the number of cases accepted by the Court. Some 400 Turkish cases accepted by the Court are pending. These include complaints of torture as well as other violations such as the right to free expression.

Another example of degrading treatment was seen in a 1978 ruling against Great Britain. In this case a 15-year-old schoolboy from the Isle of Man, Anthony Tyrer, got three strokes by a birch at a police station for assault. It was called "institutionalized violence", which might cause severe psychological damage. Four years later, the Court was asked to establish whether beating children at school constitutes a violation of the Convention. The parents of two boys, the families Campbell & Cosans, wanted a guarantee that their boys would not be exposed to corporal punishment. As the school would not offer such a guarantee the boys were suspended from school. The European Court of Human Rights established that this was a violation of the Convention as the boys were denied their right to education, and the parents were denied respect for their conviction, both rights deriving from the first protocol of the Convention, Article 2.

In a third case, A v. Great Britain, the Court stated that British law did not provide adequate protection for a boy who had been beaten by his stepfather since he was nine years old. The stepfather was charged with assault occasioning bodily harm, but was found not guilty by a jury in 1994. The Court concluded that British law had to be amended as there was no protection against treatment and punishment contrary to Article 3 (the torture prohibition).

Whereas some countries, such as Great Britain, are characterized by old tradition, others, like Turkey, reflect a mentality that confesses to the use of violence. Based on the practise of the Court it can be established that two elements are necessary to assess the existence of an administrative practise: repetition of acts and official tolerance. The repetition must be substantial. The pattern of such acts may be 1) they occur in the same place, 2) they are attributable to the agents of the same police or military authority, and 3) the victims belong to the same political category.

By "official tolerance" is meant that the acts of torture are tolerated by the superiors of those immediately responsible, who fail to take action to punish the perpetrators or prevent repetition.

Since the disappearance of the Iron Curtain around 1990, no systematic use of torture in the former Communist dictatorships has been registered. The systematic use in Turkey has led the Committee of Ministers of the Council of Europe to pass several resolutions condemning this practise. The persecution of authors, journalists, and medical doctors in Turkey has confirmed a general pessimism in Europe about Turkey complying with the Convention.

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1. Decker H. Turkey is now paying for its torture practice. Torture 1999(9);1:4-6.

Notes
1. Convention for the Protection of Human Rights and Fundamental Freedoms, Article 6, 1: "...everyone is entitled to a fair and public hearing within a reasonable time..."
2. Until the abolition of the European Commission of Human Rights in 1998, the convention contained a rule (Article 32), which put any case, not referred to the Court within three months from the date of the Commission report to the Committee of Ministers, before the Committee for a final decision with a majority of two third of the members.
3. 1) Wall standing (the detainees were forced for some hours to stand with their fingers placed high above the head against the wall, causing them to stand on their toes with the weight on the body mainly on the fingers), 2) hooding (the detainees were forced to have a black or navy coloured bag over their heads all the time save during interrogation), 3) subject to noise (the detainees were forced to listen to continuous loud and hissing noise), 4) deprivation of sleep (pending long interrogations), and 5) deprivation of food and drink (during the stay at the interrogation centre and pending interrogations).

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Assessment of the psychic sequelae of torture and incarceration (II)  
— assessors’ attitudes and objective appraisal

Ferdinand Haenel, MD, Psychiatrist and Psychotherapist*

In the article “Assessment of the psychic sequelae of torture and incarceration (I)—a case study” published in TORTURE 1/2001 I have reported how reactive mental symptoms themselves can be an obstacle to an objective medico-legal evaluation. Now—with the following case—I will describe how the assessors’ attitudes towards the survivor of torture and his or her history could also be a hindrance to an objective appraisal and evaluation.

Case report

Mr C. is a Kurdish farmer from Turkey. He comes from southeast Anatolia and has been living in Germany as an asylum seeker for two years. He complained of disturbed sleep and concentration, anxiety, nightmares, general anhedonia, and a lack of vitality. He reported that he had fled to Germany in the early summer of 1995. The previous year he had twice been detained, interrogated, and tortured by the Turkish police for 20 days, and he said it was likely that he would be arrested and tortured again in the future. As the owner of an isolated farmhouse four kilometres from the nearest village, he had been suspected of providing members of the PKK with food. When he was arrested the first time the military police had burnt down his house and forced the whole family to move to the next village.

When I asked him what form of torture he had undergone, Mr C. answered that he had been beaten with clubs over his whole body, including the soles of his feet (falanga). He had been hosed down with pressurized cold water while naked, subjected to electric shocks, and kept in solitary confinement without sufficient food.

At 44 Mr C. had aged prematurely. His manner at the interview was pleasant. Initially somewhat reserved he spoke quietly but hurriedly. He modestly did his best to answer all questions as quickly as possible. However, at the same time he appeared breathless and agitated, and this became worse when he began to tell the story of his persecution. He started to mix up details and the chronological order of events, which confused the interpreter. In turn I, as the examiner, began to doubt the authenticity of his story. When I asked him to repeat the contradictory information, while at the same time assuring him that we had plenty of time for the interview, he was able to rectify the jumbled order of events in his report, reassembling them into a more plausible and comprehensible whole.

His basic mood was depressed. He showed evidence of emotional rigidity. Outwardly his drive appeared reduced, inwardly he showed clear signs of increased arousal. When, during the physical examination, I made a hand movement that he had evidently not expected, he started and involuntarily shrank back. At the physical examination I noticed a large number of small scars spread across his back for which he was unable to account. He also had a 2½-inch long, sickle-shaped scar on the left shoulder. He reported that this had been caused by a blow with the butt of a gun during his first term of imprisonment. It had been treated in a makeshift manner with a few large stitches. A second, very obvious scar that ran across the inside of his right thigh and was about two inches long and one inch wide was below the surface of the skin and showed no signs of surgical stitches. This scar he attributed to an untreated stabbing during his second period of imprisonment. He reported that from time to time the soles of his feet became painful after he had been walking for some time. The balls of his feet were soft and could be easily depressed onto the underlying bones. When he walked, he placed his feet flat on the ground, failing to place his heels down first and roll forward onto his toes. This is an indication that he was subjected to falanga, i.e. blows to the feet.

At the second and third anamnestic interviews, the dissociation of events and their chronological sequencing was repeated in the same way as at the first interview. Here again, Mr C. was able to piece them together again and add further details when I took time to put my questions patiently and calmly. Despite the fact that Mr C. shifted his perspective on the events and actions several times, in the end his report was free of contradictions.

Towards the end of the third interview, Mr C. broke down in tears. I had persuaded him to describe an aspect of an event in greater detail, to tell me at what time of day he had been arrested the second time and which members of his family had been present.

All sources of information on the political situation in eastern Anatolia (for instance Amnesty International, reports of the German Foreign Office, press reports, and coinciding reports from other persons subjected to persecution in the same region) are in agreement that in the civil war between Turkey and the PKK pressure is being exerted on the rural population by both sides. They are forced either to join the so-called village-guard system organized by the Turkish authorities or to provide the PKK with medical aid, food, and logistic support. It is not possible for the rural population to retain a neutral position between these two strongly opposed forces. The German Foreign Office has for example stated that “Attacks carried out against uninvolved parties by the security forces in the form of destruction of property,
detention, physical or psychic abuse or homicide are widespread in this region."

Together with what we know about the political situation in this region, Mr C.'s story and his mental and physical status indicated with almost absolute certainty that the information he had given in his application for asylum was correct. However, only for us, not for the Federal Office for the Recognition of Asylum. Mr C.'s application was rejected. According to the minutes of the hearing, Mr. C. had been given exactly one hour to present, with the aid of an interpreter, his reasons for applying for asylum. This was a requirement that Mr. C. was unable to comply with in his current mental condition.

At the time of my first contact with Mr C., his request for asylum had already been rejected by the highest court and his deportation was only weeks away. His lawyers submitted my medical report with the above-mentioned findings after which the Berlin Administrative Court granted a new hearing for Mr C.'s asylum procedure. The judges concurred with my medical report in that the authorities had neglected essential aspects in the previous asylum hearing of Mr C.

Discussion of the case
In this case-report hyper-arousal, disturbed concentration and memory were symptoms of the reactive, mental post-traumatic sequelae, which were an obstacle for an objective judgement in the asylum procedure. Furthermore, if we appreciate that Mr C., despite of his obviously disturbed concentration, had been given exactly one hour to present his reasons for applying for asylum, we may suppose some attitudes of the assessor towards Mr C. and his history, which have also hindered an objective judgement. Impatience of the assessor and his insufficient knowledge about post-traumatic mental symptoms might also have played a decisive role for his inappropriate decision.

In our experience, little or no attention is given by the German Federal Office for the Recognition of Asylum to the fact that survivors of torture could have disturbed concentration and reduced memory performance for crucial sequences of the traumatic events. Another important, but disregarded factor, is that asylum seekers, who have been tortured in their country of origin, associate the present hearing with past interrogations under torture.

As in psychotherapy with survivors of torture, widely divergent attitudes and countertransferences, from too great a distance with a lack of empathy to too little distance and too much empathy and over-identification, even personal empathic enmeshment with the survivor may occur in the relationship between an assessor and the person under assessment.

Thus, an assessor may show too great a distance (and too little empathy) if he or she is insufficiently informed about the psychic sequelae of trauma, about the political and historical facts or about the conditions of imprisonment in the survivor's country of origin. This may also occur if the assessors, basing themselves on their own experience of life and their image of a fundamentally harmonious world, consider the survivor's reports to be exaggerated and implausible. From the perspective of the survivor, the assessor then assumes a characteristic of the former perpetrator when he or she also seems to deny and ignore what has happened. This kind of relationship may cause the frequently observed resigned reserve of survivors in exploratory interviews, and this often leads assessors incorrectly to assume that they have no trauma-induced mental symptoms at all, or that these are only mild. This lack of recognition is a renewed injury to the survivor, and a time-consuming and expensive chain of appeals across all instances of the administrative system and courts may result.

Conversely, too little distance (and too much empathy) may develop in an assessor as a defence against his or her own feelings of guilt or shame. Assessors may also react in this way to the emotional shock and horror felt on hearing survivors' descriptions of their traumatic experiences or to an unconscious fear that the survivor will associate or even equate him or her with the perpetrator. This can lead to an exaggerated, overly involved, militant desire to help the survivor, which, if it remains unreflected, leads the assessor to submit subjective, global, and polemic arguments to colleagues and authorities. That would not be very helpful for the survivor in the long run.

Thus, psychiatric expertise and knowledge of the political and historical background of survivors' countries of origin are necessary but not sufficient requirements for the evaluation of psychic sequelae. Like psychotherapists, assessors must possess the ability to assume a position midway between the extreme countertransference poles of too great and too little distance, which can be described as "the greatest possible empathy combined with the greatest possible distance" or "controlled identification".

As I reported in my last article, assessors must also take into account the substantial resistance that post-traumatic psychic symptoms can present to exploration. Examiners must be prepared to take time and exercise patience to deal with disturbances in concentration and to sense intuitively when a person has buried memories of severe traumatic experiences. They must counter the survivors' withdrawal and isolation tendencies, their mistrust of the world, and their frequent general attitude of passive resignation with an active willingness and an active interest in their stories and fate, and in the specific meanings of the trauma in their lives as a whole.

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An associated article by Ferdinand Haenel "Assessment of the psychic sequelae of torture and incarceration (I) - a case study" was published in Torture 1/2001.
A study of the psychological state of Kosovo refugee children settled in Shkallnur village in the Durrës District

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Introduction
The Albanian Rehabilitation Center for Torture Victims (ARCT) was set up in 1993 as a centre mainly working within the area of psycho-social rehabilitation of people prosecuted for their political involvement. The centre gradually became a place of national importance concerning medical and psychological treatment of torture survivors and consequences of trauma in general. ARCT has a team of specialists including a psychiatrist, psychologist, sociologist, educator/teacher, physiotherapist, and physicians of different sub-specialities, and the centre applies a multidisciplinary approach.

In the winter of 1998 and the spring of 1999, the ARCT was faced with the flow of people coming into Albania as refugees because of the ethnic cleansing in Kosovo. The Centre had to react immediately, especially in the very first phase when the international support to the refugees was not yet able to comprehend the whole situation.

The first group of Kosovo people was placed in a village called Shkallnur near Durrës, about 35 kilometres from Tirana. ARCT established a small office there which functioned as a field-medical polyclinic, and about 5,000 medical visits (in a population of 20,000) were accomplished in a short time. ARCT also coordinated humanitarian aid provided by organizations or individuals. After a first period of focusing on strictly medical visits and treatments, the team was organized in order to provide psycho-social support, involving Kosovo people previously working as teachers or medical staff in their homeland.

At the same time, “summer schools” and other activities were established by the Albanian government and other organizations in order to create a “normal” environment and functioning life for the children.

Over a period of a few months, a lot of field work had to be accomplished by the teams attempting to assist and support the refugees, almost all of whom had family members remaining in Kosovo. The humanitarian emergency situation and the ongoing conflict in Kosovo lasted until June 1999 when the NATO forces made it possible for them to return to their homes.

This paper presents the results of a pilot study of 150 children, randomly selected, concerning the consequences of their traumatic experiences and their level of functioning in a highly traumatized situation.

The aim of the study
The aim of the study was to:
• get to know the level of post-traumatic disorders among children.
• give evidence of the intensity of post-traumatic disorders.

On the basis of the conclusions of the study, measures should be taken for rehabilitation and prevention purposes.

A few words on psychological trauma
Psychic trauma as a term has a broad meaning. In general, it means the influence of an outer tormenting event, which can cause disorders to the protective capacities of the majority of people. These events are of the kind that threaten the person himself or his relatives in the sense of their existence, or by causing destruction of things that are essential to their lives, such as their house or other estate.

In his life, man is threatened by natural disasters such as earthquakes, hurricanes, floods, or fires, by accidents caused for example by vehicles, or by man-made atrocities. In our view the latter is the most serious.

In this context, special importance is placed on physical and moral torture. This is a kind of trauma that is often the cause of psychic disorders of a higher intensity and longer duration than those caused by natural disasters. There can be
immediate reactions, but often the symptoms emerge after some time, varying from several days to several months and in some cases even a few years.

In considering the trauma consequences and the disorders described above, we looked to the American "Diagnostic and Statistical Manual for Mental Disorders" (DSM-IV), applying the criteria for Post-Traumatic Stress Disorder (PTSD), naturally considering the elements presented there concerning disorders during childhood.

Methods
The following assessment tools were used:

1. questionnaires.
2. semi-structured interviews with children and/or parents and teachers.

From a list of 600 children, 150 were randomly selected for an interview.

In this way, one in every four children was interviewed, without preferences.

Every child had to fill out two questionnaires (for those under the age of seven, the mother or the main caretaker was involved).

The first questionnaire dealt with general information about life in Kosovo and with the kind of trauma experienced. In this 12-question paper, the information gathered covered matters such as: "living in a town or in a city?", "if the house was demolished, did this happen in his/her presence?", "leaving home during the day or at night?", "the way of travelling to the border", "if all family members were together or not", "the way of perceiving the risky situation the child experienced", etc. In this first questionnaire there were a couple of questions regarding school and the way the children perceive their future.

The second questionnaire was aimed at getting more structured and in-depth information about the elements included in the criteria of DSM-IV for PTSD. This is a 25-question paper delivered by the local UNICEF office in a seminar organized in Tirana in cooperation with the Croatian Psychological Society which has a lot of experience in working with children under similar circumstances because of the war in the Balkans.

The age of the children ranged from 5 to 15 (table 1), 44% of them came from rural areas, 26% from towns.

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>No. (in percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-7</td>
<td>12.7</td>
</tr>
<tr>
<td>8-10</td>
<td>36.7</td>
</tr>
<tr>
<td>11-15</td>
<td>50.6</td>
</tr>
</tbody>
</table>

Results
The most traumatic events were as follows:

- the murder of family members
- situations when the life of the child was directly at risk
- the ruining or burning of the family house (whether in the presence of the child or not).

Some cases
1. The girl EY, 10 years old, has fled the country together with her mother. Her father is still in Kosovo. She is completely withdrawn and has lost interest in her surroundings. She is not interested in games and other things that attracted her before. She has no friends. She says she has friends in Kosovo and does not accept other friends. She has problems with her sleep, wakes up with nightmares connected to the experience of leaving her house and to the difficulties on the way. When she was asked about her father, she started crying and gave no answer.

2. EA, boy, 12 years old. He has left home with his family and is now living with both parents. He confesses he is not happy, although he knows that one can hardly find children with both parents by their side. He feels himself to be different. He does not have the same love for his parents as he used to. His love has most likely faded away. He has problems with his sleep and gets up too early. He finds it difficult to stay in the same place for a long time. He is sometimes grabbed by a feeling of fury and he refuses to listen to war conversations. He feels bad, has a headache and a stomach upset.

3. GSH, boy, 11 years old. He is with both his parents and two younger brothers, five and six years old. His disorders started when one of his cousins was killed. Images of the past cross his mind. This makes him tired and he always has a feeling of indefinite fear. He cannot stand noise. He used to have excellent scores at school, but now, although he enjoys going to school, his scores are not satisfactory. He cannot concentrate. As he puts it: "I can't listen to the lesson for a long time".

4. AK, girl, 14 years old. She used to be a smart and outgoing girl. She lives with her parents in an Albanian family. She feels sorry for their hosts because, according to her, they live under bad conditions. They left their village and settled in a neighbouring village from which they could see their village on fire. She is aware of being safe in Albania, but she still has a feeling of fear, which she cannot understand. She cannot stand noise and is always tense. She goes to school, but has worse scores than she used to, although she tries hard to have good ones. According to her, she lacks the facilities to study.

The traumas experienced by the children were as follows:

- 11.3% of the children have experienced all three kinds of trauma
- 48.6% of them have experienced a combination of two of the traumas
- 32% of them have experienced only one of the traumas
- 8% of them have not experienced such traumas.

Out of 150 children:

- 68.6% have gone through a situation where their lives were in danger
- 6.6% of the children have been present when family members were killed and 20% of them when their houses were being burnt.

- 50% of them repeatedly go through the traumatic event
- 29.3% of them have gone through it once or occasionally
- 20.6% have not had the above mentioned experiences.
• 70% of the children report the feeling of extreme fear and terror when faced with the traumatic event.

• 81.7% of the children report concentration difficulties.

Attending school in the new environment was not at all the same as at home and they had difficulties studying:

• 71.3% are not capable of studying as in Kosovo
• 16% are capable of studying as in Kosovo
• 12.6% are of pre-school age.

Concerning horrible and unpleasant dreams:

• 38.6% of the children have them quite frequently
• 40% have them occasionally
• 21.3% do not experience them:

• 30.6% of the children frequently have sleep disorders, they cannot sleep or they wake up in horror
• 24.6% of the children sometimes have such troubles
• 44.6% have no complaints.

In many cases (22%) sleep is followed by headaches the following day.

In addition:

• 38% of the children reported that they are making efforts to avoid thoughts and conversations relevant to the trauma
• 25.3% of the children cannot remember any of the events.

• 55% of the children reported a significant reduction in their participation in activities they used to like
• 26.6% of the children constantly change their minds about such activities.

• 39% of the children feel themselves somewhat irritated and tense. Time and again they become nervous and give the impression that they cannot control themselves, although this has never happened
• 57.3% of them have responded that they have no tendency to argue with their family members, relatives or acquaintances.

A large number of children (48.6%) are annoyed by noise and unexpected voices as well as by conversations about the war. 41.3% of them have negative emotions accompanied by heart beating and sweating.

However, generally speaking the children are not pessimistic about their future:

• 48.6% of them have not lost their hopes for the future
• 36.6% of them lose their hopes at certain times
• 14.6% of them are pessimistic about the future.

• 90% are quite sure they will soon be back home
• 55% of the children believe their life will be much better in the future
• 20% believe their life will be better, but not in the short term
• The rest have no clear idea.

When presenting some of the most interesting results of the study, we should mention the fact that doing the study we were not only concerned to be able to make diagnoses. In our view, people from Kosovo living as refugees in Albania could hardly be said to be in a “post-traumatic” situation. They could easily be seen to be suffering from “ongoing trauma”, as the war in Kosovo was still taking place and their daily life was full of news and stories from the “battlefields”. According to the criteria for DSM-IV such conditions are traumatic, which our experiences confirm.

Conclusions
1. Elements of Post-Traumatic Stress Disorder were evident in the majority of the children studied. Their behaviour had changed significantly because of exposure to traumas of a kind that could easily be said to be “outside the normal range”.

2. The children suffering traumatic events such as war and displacement could easily use “dissociation” as their main defence mechanism which means that future programmes of support and assistance should consider the results of studies of this kind as a base for further follow-up and observation.

3. The assistance of medical and educational staff as well as mental health specialists is indispensable and it should be well organized to prevent aggravation of the situation, thus implementing the rehabilitation in the best possible way.

4. In difficult situations people – and especially children – need support.

How could children be helped in a complicated situation like in 1999 in Albania? Everybody can play a role, being medically trained or not. Refugee children should have the feeling that they are accepted in the new environment. In this respect it was positive that the Kosovo children were in Albania where people speak the same language and have the same customs.

However, there are no ready-made recipes when it comes to the assistance of each child. The best solution for each person should be considered carefully. Life is unique and special and has its own values, needs, and wishes.

Confidentiality should be created when meeting the child. Even among adults, it is not created by itself. During the conversation the questions should be tactful, natural, not giving him/her the impression of being interrogated.

One should patiently discover the positive inclinations of the child and activate him or her in that direction.

Their favourite games have a positive effect when well applied at the right time without imposing; otherwise a restrained child will become increasingly restrained. Various tactics and games exist and should be assimilated and applied rightly.
A nation-wide screening survey of refugee children from Kosovo

Kirsten Abdalla, Health Visitor, MPH* & Ask Elklit, Psychologist, Associate Professor**

Abstract
Within one week of arrival in Denmark, all Kosovo refugee children were screened for emotional problems with a Danish Red Cross Trauma and Symptom Form (TSF). Out of 1,371 children, the TSF was completed for 1,224 children (89%). The prevalence of separations, losses, exposure to violence, torture, extreme poverty, and hunger were described. Twenty percent of the children suffered from emotional symptoms and 24% had psychosomatic disturbances. Variables associated with the presence of emotional distress included age, duration of the flight, number of separations and losses, and exposure to violence, torture, extreme poverty, and hunger. A regression analysis showed that extreme poverty, torture, and the duration of the flight from their homes explained 16% of the variance of all emotional symptoms. The prevalence of emotional distress supports the need to deliver mental care to the victims of ethnic cleansing. The results provide guidelines for early detection of children who are at risk of developing emotional problems.

Introduction
When ethnic cleansing forces millions to flee their homes, the host countries are presented with a need to evaluate their physical, psychological, and social problems at an early stage, so that medical and psychological counselling and treatment can be initiated. In Denmark this screening is carried out by a health visitor who evaluates the health situation and together with a doctor recommends further examinations and treatment.

In order to ensure accurate and in-depth screening of the psychological and social impairments, Danish Red Cross has developed a special Trauma and Symptom Form (TSF) for children.

The aim of this paper is to describe the prevalence of emotional disorders among Kosovo children who have come to Denmark. It is also intended to identify special demographic relationships and traumatic events, which are connected with a heightened risk of developing emotional disorders. The long term aims are: 1) to exert an influence on the education of the professional groups, which carry out this type of screening as well as on the professional groups, which meet the children at the reception centres, 2) to make the professionals more aware of psychological problems, and 3) to enhance both the effectiveness and responsiveness of the different institutions which are in charge of this area.

Based on the Kosovo Refugee Bill (April 1999) Denmark received around 3,000 refugees from Kosovo. Of these, 1,371 were children between 0-18 years of age. The refugees were evacuated from refugee camps in Macedonia, where they had been living between four and ten weeks before arriving in Denmark. The refugees' backgrounds were very different: some of them had been displaced within Kosovo for up to one year already, while others had only left their homes a few weeks before. Chaos, separation, and uncertainty about the day-to-day developments as well as uncertainty about the future marked the stay in the refugee camps in Macedonia.

Procedure
Since 1984 the Danish Red Cross Asylum Department has been responsible for dealing with all asylum seekers entering Denmark. All asylum seekers including displaced persons from Kosovo were offered a medical examination. A few days after their arrival at the reception centre, a health visitor examined the children. The medical history was taken concerning earlier illnesses, the child's well-being, and the child's experiences concerning earlier illnesses, the child's well-being, and the child's experience of torture. It was also noted whether the child had witnessed violence, was a victim of violence, or had itself carried out violence. It was also noted whether the child's parents or guardian had been a victim of torture.

The child was asked whether he/she had participated in acts of war, and whether there was physical damage as a result. Subsequently, the child was asked whether he/she had lived in extreme poverty or had suffered from hunger. A series of questions suggested by Edith Montgomery were included. Relevant symptoms are: anxiety, depression, aggression, nervousness, psychosomatic reactions, regressive traits, and problems at school. Other symptoms to look out for are: whether behaviour is introvert or extrovert, active or passive, and whether there are symptoms of post-traumatic stress disorder (PTSD) (such as traumatic memories in play, drawing, speech, uncontrolled repetitive movements/actions, evasive behaviour, extreme watchfulness, startle response due to unexpected loud noises, sleep disorders, sudden beha...
changes, fear of the dark, fear of strangers, separation fear, pessimistic expectations of the future, lack of confidence, and lack of trust in others).

Based on the information about the child's experiences and symptoms, the health visitor advised the parents and the child what they themselves could do and possibly recommended a visit to the health clinic at the asylum centre, where further evaluation could be carried out in a more relaxed atmosphere.

**Results**

The study included 1,224 of the 1,371 children who were received in Denmark. The response rate was 89.2%.

**Age distribution**

A quarter of the children were from zero to four years of age, one quarter were from five to eight years of age, one quarter from nine to twelve years of age, and the last quarter were from thirteen to eighteen years of age. The average age was 8.2 years. Data about age were missing for 8% of the children.

**Gender**

Data about gender were missing for 8% of the children. Of the stated gender, 52% were boys and 48% girls.

**Duration of flight**

Twenty-five percent had been on the run for up to one month, 25% from one to two months, 25% from two to three months, and the last 25% for more than three months. The average flight time was 3.2 months.

Table 1 shows the number of children with separation and loss of relatives and others. The numbers in this and the following three tables vary depending on which column the health visitor filled in. More than half the children had been separated from their grandparents, and one third had been separated from their father for a period of time. The time of separation from their father was 6.3 months on average; the median time was two months, which implies that half of the children were separated from their father for up to two months. The time of separation from other family members was shorter, but the median time was the same. The number of separations was distributed as follows: 36% had not been separated from anybody; 42% had only been separated from one of the mentioned persons; 17% had experienced two separations, and 4.5% three or more separations.

Thirty percent had lost close relatives, 13% had lost friends, acquaintances or neighbours ("other"), and 10% had lost their father. Very few had filled in the number of months since the loss of family members; consequently it would not make any sense to use this information.

The number of losses was distributed as follows: 68% had not lost anybody; 24% had lost one; 6% had lost someone from two of the mentioned groups (the number of people lost within each group was not registered), and 2.5% had lost people from three to six of the groups.

Table 2 shows that about 40% had witnessed violence, while 9% had been victims themselves. One percent had committed violence to others. Those who had committed violence and been victims themselves had all witnessed violence.

Table 3 shows that torture of the father and other people had been experienced by one child in seven. Eighty-two percent had not had any contact with torture, and 15.6% had experienced torture once. Three percent had experienced two or more of the mentioned groups being tortured.

Table 4 shows that only a few had taken part in acts of war and/or been injured as a result of acts of war. But a third of the children had at times suffered from hunger, and a quarter had lived in extreme poverty.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Prevalence of separation from and loss of relatives and others.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation from</td>
<td>% who have been separated</td>
</tr>
<tr>
<td>Father</td>
<td>34</td>
</tr>
<tr>
<td>Mother</td>
<td>7</td>
</tr>
<tr>
<td>Siblings</td>
<td>15</td>
</tr>
<tr>
<td>Guardian</td>
<td>10</td>
</tr>
<tr>
<td>Grandparents</td>
<td>54</td>
</tr>
<tr>
<td>Close relatives</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Children exposed to violence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>% exposed to violence</td>
<td>Number of children asked</td>
</tr>
<tr>
<td>Witness to violence</td>
<td>41</td>
</tr>
<tr>
<td>Victim of violence</td>
<td>9</td>
</tr>
<tr>
<td>Used violence</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Children exposed to torture.</th>
</tr>
</thead>
<tbody>
<tr>
<td>% exposed to torture</td>
<td>Number of children asked</td>
</tr>
<tr>
<td>The child itself</td>
<td>1</td>
</tr>
<tr>
<td>Father</td>
<td>14</td>
</tr>
<tr>
<td>Guardian</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Children exposed to different stressful life events.</th>
</tr>
</thead>
<tbody>
<tr>
<td>% exposed to stressful events</td>
<td>Number of children asked</td>
</tr>
<tr>
<td>Taken part in act of war</td>
<td>1</td>
</tr>
<tr>
<td>Physical damage</td>
<td>1</td>
</tr>
<tr>
<td>Extreme poverty</td>
<td>24</td>
</tr>
<tr>
<td>Suffered from hunger</td>
<td>32</td>
</tr>
</tbody>
</table>
Table 5 shows the occurrence of psychological symptoms of PTSD. Anxiety and nervousness were found in 10% of the children, while depression, aggression, and psychosomatic reactions were present in 4% of the children. PTSD was found in 3% of the children.

Table 6 shows a number of psychosomatic symptoms. Ten percent of the children had problems with their eating and with headaches (or toothaches). Five percent had sleeping problems and involuntary discharge of urine.

Table 7 shows the correlations between the demographic factors and the stressors.

---

**Table 5. Children with psychological symptoms.**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>10.2</td>
</tr>
<tr>
<td>Depression</td>
<td>4.1</td>
</tr>
<tr>
<td>Aggression</td>
<td>4.2</td>
</tr>
<tr>
<td>Nervousness</td>
<td>10.0</td>
</tr>
<tr>
<td>Psychosomatic symptoms</td>
<td>3.9</td>
</tr>
<tr>
<td>Regression traits</td>
<td>2.0</td>
</tr>
<tr>
<td>Problems at school</td>
<td>0.7</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>2.2</td>
</tr>
<tr>
<td>PTSD</td>
<td>2.9</td>
</tr>
<tr>
<td>One symptom</td>
<td>11.0</td>
</tr>
<tr>
<td>Two or more symptoms</td>
<td>2.2</td>
</tr>
</tbody>
</table>

**Table 6. Children with psychosomatic symptoms.**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>5.4</td>
</tr>
<tr>
<td>Eating</td>
<td>10.5</td>
</tr>
<tr>
<td>Sight</td>
<td>2.5</td>
</tr>
<tr>
<td>Hearing</td>
<td>1.4</td>
</tr>
<tr>
<td>Enuresis</td>
<td>5.2</td>
</tr>
<tr>
<td>Encopresis</td>
<td>1.0</td>
</tr>
<tr>
<td>Urine infection</td>
<td>0.6</td>
</tr>
<tr>
<td>Headaches/toothaches</td>
<td>10.5</td>
</tr>
<tr>
<td>Motor function</td>
<td>1.5</td>
</tr>
<tr>
<td>One area</td>
<td>14.7</td>
</tr>
<tr>
<td>Two or more areas</td>
<td>9.3</td>
</tr>
</tbody>
</table>

**Table 7. Correlations between demographic factors and stressors.**

<table>
<thead>
<tr>
<th>Stressor</th>
<th>Gender</th>
<th>Age</th>
<th>Duration of flight</th>
<th>Separation</th>
<th>Loss</th>
<th>Violence</th>
<th>Torture</th>
<th>Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Age</td>
<td>2.1 (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Duration of flight</td>
<td>1.8 (2)</td>
<td>4.1 (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Separation</td>
<td>3.2 (3)</td>
<td>58.2 (9)</td>
<td>54.6 (6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Loss</td>
<td>0.0 (3)</td>
<td>15.2 (9)</td>
<td>42.8 (6)</td>
<td>218.9 (9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Violence</td>
<td>7.5 (2)</td>
<td>43.5 (6)</td>
<td>15.6 (4)</td>
<td>26.4 (6)</td>
<td>47.3 (6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Torture</td>
<td>0.5 (2)</td>
<td>0.8 (6)</td>
<td>32.8 (4)</td>
<td>51.8 (6)</td>
<td>278.1 (6)</td>
<td>75.2 (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) Poverty</td>
<td>1.6 (1)</td>
<td>5.8 (3)</td>
<td>10.8 (2)</td>
<td>32.9 (3)</td>
<td>42.5 (3)</td>
<td>38.0 (2)</td>
<td>46.6 (2)</td>
<td></td>
</tr>
<tr>
<td>9) Hunger</td>
<td>2.0 (1)</td>
<td>5.0 (3)</td>
<td>32.6 (2)</td>
<td>48.9 (3)</td>
<td>50.0 (3)</td>
<td>89.1 (2)</td>
<td>37.7 (2)</td>
<td>405.2 (1)</td>
</tr>
</tbody>
</table>

*Gender* has only one correlation with one stressor, as boys more often than girls have experienced either no or a lot of violence.

**Age:** The older the children were, the more they had experienced separation, loss of close relatives, and violence.

**Flight:** The longer the duration of the flight, the more separations and losses the children had experienced. Most cases of violence and poverty occurred under a short or a very long flight. The stressors connect in a vicious circle: the more separation, the more losses, violence, torture, poverty, and hunger.

In two separate correlation-analyses (not shown here) the mutual relation between symptoms and areas of problems were studied. All the symptoms were positively and significantly correlated \((p<.0005)\), so if there was one symptom, the probability of having other symptoms will increase. It was the same with the areas of problems with the exception that two correlations were not significant (sleeping/motor function and eating/hearing).

Table 8 shows a variable analysis of the correlation between independent and dependent factors. *Gender* has no bearing on either symptoms or problems and is therefore not included in the table. Increasing age means fewer problems relating to eating and enuresis together with increasing occurrence of PTSD and headache problems. Fear and nervousness were highest in the group of the five to eight-year-olds, but were also high in the group of nine to twelve-year-olds.

The longer the displacement time, the more depression, aggression, and nervousness, and the more psychosomatic problems. Those with a short or long time of fleeing had more eating problems. The more people the child has been separated from, the higher the prevalence of PTSD, depression, regressive traits, and behavioural problems. There was also an increasing proportion of fear, nervousness, and aggression, but with the exception that the curve "breaks", i.e. falls, for those who have experienced the most separations.

The same phenomenon can be seen with loss: when the frequency of symptoms increases, more losses are experienced, but in the group with the most losses the curve "breaks", and symptom levels fall. The only exception is behavioural problems, which continue to rise.
With regard to violence we see a general increase in the frequency of symptoms, but school and eating problems along with headache tendencies fall at the highest level of violence experienced. Looking at torture we see an increasing tendency to depression, psychosomatic traits, regressive traits, school and behavioural problems, and PTSD. For aggression, fear, and nervousness together with hearing problems, the curve rises, but falls a little for those who have experienced most torture. Extreme poverty and hunger are clearly associated with an increasing frequency of all symptoms and problem areas.

The final regression analysis based on the total number of symptoms as dependent variable can explain 16% of the variation by three factors: Extreme poverty, torture experiences, and displacement time. A parallel analysis based on the problem areas could only explain 1% of the combined variation and was therefore discontinued.

Discussion
In the summer of 1999, a psychological evaluation was carried out by the Asylum Department at the Danish Red Cross in order to identify possible needs of treatment in connection with the health evaluation of the war-refugees from Kosovo. The study covered 90% of all refugee children from Kosovo. Separation, loss of close family, witnessing violence and torture, together with extreme hunger affected 25% of all the children according to the children and their parents.

The completed analysis showed that gender is not a significant factor. At first, this may be surprising. The explanation may be that when the number of violent episodes exceeds a certain level and there is a corresponding breakdown in the existing social and cultural life, there is a reduction in the significance of gender differences. After a long adjustment period, one could imagine that gender difference would reappear with regard to symptom development.

Older children experienced more violent events than younger ones, who probably withhold more, and whose cognitive abilities are not always capable of understanding the extent of all the atrocities. Increasing age is connected with increasing frequency of PTSD; however, the middle age group of children is characterized by high anxiety levels. There are at the same time relatively few associations connected to age. Montgomery reached a similar conclusion with regard to gender and age in her study of refugee children from the Middle East, who had also just arrived in Denmark.

The study also showed that the length of flight in itself is a traumatizing factor which is connected with a greater number of separations and losses. 1) A long time of flight is associated with many violent experiences and extreme poverty. 2) The same conclusion is valid for long periods in flight where waves of ethnic cleansing have involved immediate departure for many. The long duration of the flight has left its mark in the form of heightened depression, nervousness, and aggression.

Both violent assaults and symptom development become a vicious circle, as the occurrence of any symptom or any assault increases the risk of even more incidents and symptoms. Long separation time, loss, violence, torture, and extreme poverty are all particularly associated with increased occurrences of depression, aggression, nervousness, behavioural problems, and PTSD.

Psychosomatic symptoms are associated with long flight, loss, violence, and extreme poverty. Regressive symptoms are related to direct assault and extreme poverty.

Problems at school are an indication of only one type of assault, e.g. torture. Loss of hearing is the only psychosomatic problem that is related to torture. Whereas relatively few of the children have been subjected to torture, hearing loss in some cases might be a psychological defence against the assailants' shouting and the victims' screams.

In earlier studies of refugee children the meaning of separation, loss, violence, and torture was analysed to show the association with specific symptoms. New in this particular study is that hunger and extreme poverty can also have very negative consequences. When basic survival is strongly threatened, this apparently influences the severity of the
psychological problems the children have to the same extent as direct assaults.

Many of the described symptoms are known from asylum centres and the administration in the local municipalities, who meet the refugees at a later stage. For this reason it would be obvious, in a future study, to follow a group of refugees for some years after arrival, to observe what changes appear in their symptomatology in relation to their physical problems and the social integration process. To what extent do the problems disappear, to what extent do they stabilize, and to what extent do they change over time?

It is also worth mentioning that we have seen that the amount of symptoms does not continue to rise for the children who have experienced most stressors. It may imply that there are threshold values to the amount of strain or that resilience occurs in some children.

Three stressors: torture, duration of the flight, and extreme poverty could explain 16% of all symptoms. Future studies, which include more factors, will probably be able to explain an even greater part of the variance.

Comparisons with other published studies are difficult because of differing aims and methods. This study is unique because it deals with a total population of refugees from a limited area, because a large part of the population escaped during a short time, because the time spent in the refugee camp was short, and because a large group came to Denmark together and were treated equally.

The primary limitation of the study is that the health visitor in a relatively short time has to judge the children via an interpreter, based on the information from their parents or from the children themselves, if they are old enough. The children’s disinclination to talk to complete strangers about the horrors they have experienced may limit the value of the results. There is also a risk of problems of understanding because of the large cultural differences. Another Danish study of the same group of Kosovo children shows a higher amount of traumatization (PTSD). The cause of this difference could be that Stehr uses a self-rating questionnaire, which the children fill in themselves (Impact of Events Scale).

This particular study is primarily based on the observations of the health visitor and the information from the parents. Therefore the parents may not know how affected their children are. More information about the emotional signs could be obtained by interviewing the children themselves. In any case, it would be worth continuing to study exposed populations with different methods to find out how effective these methods are.

The advantage of using a standardized form is that it improves the reliability of the data. If properly conducted it is an effective method and can give more valid information about atrocities and their effects than the unstructured interview. Interviews may also be difficult to carry out because of the time involved. The results of the present analysis will be included in the making of a new version of the Trauma and Symptom Form.

References

Further literature

Selected list of publications
received in the IRCT International Documentation Centre


Organized election violence in Zimbabwe 2001

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Abstract
With the recent history of Zimbabwe as background and in the light of other reports of organized violence, we examined nine persons who had participated in lawful campaigning during a by-election in Bikita, Zimbabwe in January 2001.

All nine persons reported that they had been beaten, some that they had been ill treated in other ways by the Zimbabwean police. In all nine cases there was agreement between the history of ill treatment, the ensuing symptoms and the result of the clinical examination, i.e., all nine testimonies were found to be valid on medical grounds.
Six of the interviewed men reported that they identified MP Dr Chenjerai Hunzvi, leader of the War Veterans, among the aggressors. Many persons who supported a legal election campaign were apprehended, beaten, and harassed in the same manner by these three groups: the police, ZANU-PF, and the War Veterans. This must be seen as an indication of a pattern of organized violence, involving the security forces, the political party in power, and its supporters.

The fact that an MP participated systematically and overtly, further stresses the political responsibility and indicates an unfortunate confusion about and abuse of legislative and executive power. The findings fit to the description of the present human rights crisis in Zimbabwe given by other organizations.

We note that there seems to be a clear relationship between the level of governmentally instigated violence and the strength of the political opposition, which points to the possibility of a high level of violence up to the parliamentary election next year.

Both the Zimbabwean government and governments of donor countries should consider the human rights crisis in Zimbabwe and take appropriate actions.

Introduction
The Zimbabwean general election took place last year in a context of widespread abuse and intimidation of civilians, and this pattern of violence was repeated in December 2000, when a by-election was necessitated by the death of a Member of Parliament.

The Bikita by-election took place on 12-13 January 2001. We had the opportunity to examine a number of persons who told that they had been assaulted and ill-treated because of their participation in legal election campaigning activities. The aim of the examinations was to appraise on medical grounds the validity of testimonies of exposure to organized violence shortly after the said exposure.

In this article we outline the recent history of Zimbabwe in order to see whether the level of organized violence could be related to obvious political factors and thereby say something about the risk of the country experiencing organized violence in the years to come.

Zimbabwe: a history of political intolerance
Zimbabwe is a nation with a long history of human rights violations and impunity for the perpetrators, dating back to colonial Rhodesia in the late 1800s. The use of violence and repressive legislation to suppress alternative political voices was thus put in place during colonialism, particularly during the 1970s; this pattern has recurred during the last 20 years of post-independence rule, particularly, but not exclusively, during election years.

As the atrocities of colonialism and the war of liberation have been well documented by the Catholic Commission for Justice and Peace (CCJP)1-3 and by other human rights activists4-5, historians, and general social commentators6-9 in the years since independence in April 1980, this article will rather draw attention to the less well-known excesses of the post-independence government of ZANU-PF, under the leadership of Robert Mugabe.

"Gukurahundi" (1) – Matabeleland in the 1980s
The post-independence period was an unstable one, as the new ZANU-PF government struggled to integrate three armies into one – ZANLA, ZIPRA, and the Rhodesian Armed Forces. Prime Minister Robert Mugabe became particularly concerned about the threat to his exclusive hold on political power. The threat came from the Zimbabwe African People’s Union (ZAPU), the dominant party in the western part of the country and the only other significant political party at that time. Within months of coming to power, Mugabe commissioned North Koreans to train a special army unit that was to be answerable only to himself, and was to be used to quell “dissidents”.

This “Gukurahundi” unit, the Fifth Brigade, became the most notorious brigade in Zimbabwe’s history.10-11 They unleashed a campaign of murder, torture, and arson against unarmed civilians. A fact which is still denied by many.
An estimated 10-20,000 civilians were massacred, including women and children, mostly in 1983-84, and tens of thousands were beaten, forced to witness army atrocities, or had their entire homes destroyed. They were told that they
were "dissidents", because they were Ndebele-speaking and ZAPU-supporting. Zimbabwe as a nation has not yet faced the full devastating truth of this period.

This period of violence ended with the signing of the Unity Accord in December 1987 - and in April 1988, a general amnesty granted impunity to all perpetrators. In return for a cessation of violence, ZAPU agreed to be absorbed by ZANU-PF. This effectively resulted in a one-party state. Every general election since 1980 has been marred by violence, and all violence carried out by the ruling party has been granted impunity.

Election 2000 - the political background
Until the late 1990s there continued to be no real political opposition to ZANU-PF.

By 1998, against a backdrop of falling living standards and corruption, civil society in Zimbabwe became alarmed. Fourteen constitutional amendments pushed through parliament in a few years had resulted in almost unlimited powers for the President.

The Movement for Democratic Change (MDC) was formed in late 1999, and it soon became a nation-wide movement. It is the first real alternative national party since the dissolution of ZAPU in 1988.

A National Constitutional Assembly, which appealed to all Zimbabweans to come together to design a new, popular constitution, was formed. However, the government took over the initiative and started its own 400-member Constitutional Commission, which soon presented a draft constitution that granted further powers to the President. The new constitution was put before the electorate in February 2000. The people turned it down by a 54% majority. This was the first time in 20 years that ZANU-PF had received a defeat at the polls. Two weeks later a concerted campaign of violence against all those perceived not to support the ruling party began. While presented as an issue of land and race, the real intention of this violence, which began with invasions of White-owned commercial farms, soon became obvious: to destroy the support for the MDC. This was highly reminiscent of the 1980s efforts to disguise the terror campaign against ZAPU as a fight against "dissidents". In the last 20 years, anyone who has not supported ZANU-PF has been treated as a "dissident" and an "enemy of the State".

During 2000, more than 30 opposition supporters were killed, thousands were beaten, and properties were destroyed. The people of Zimbabwe went to the polls on 24-25 June 2000, and in spite of high levels of intimidation, the MDC won 57 of the 120 seats. The election was declared to be not free and not fair by several international bodies, including the National Democratic Institute and the European Union, on the grounds that the pre-election period had so high levels of intimidation that many voters were unable to vote according to their own preferences. Clemency Order No 1 of 2000 was announced in October 2000, granting impunity to all perpetrators except for murderers and rapists.

Post-election violence
Violence has continued after the election, although at a lower rate. The State has become more blatant in its use of force against civilians, and the army has frequently been used in urban areas; the war veterans continue to use violence, most notably to terrorize suspected MDC supporters in a by-election in Marondera West, following the death of the sitting MP.

Attacks on the judiciary, including the forced resignation of the Chief Justice, attacks on the media and MDC officials, and threats against civil society have been continuous during 2001. The attacks on the judiciary are particularly serious, as impartial rulings of the court are all that has halted the growing lawlessness and total anarchy.

Bikita by-election: January 2001
In the month preceding the by-election on 12-13 January 2001, ZANU-PF used the same tactics as throughout 2000. Hundreds of War Veterans, under the leadership of Dr Chenjerai Hunzvi, set up camp to intimidate residents of the area. Hunzvi, who is a Member of Parliament, has been clearly identified as a perpetrator by many victims, including six of the interviewees in this report. His violence has been condoned by the government, and he is clearly being kept above the law by the President and the police.

Before the end of 2000, verbal reports from key informants and the media indicated that several scores of civilians in Bikita had sought medical treatment after beatings by War Veterans. In December 2000, a ZANU-PF supporter was stabbed to death in Bikita by MDC supporters. One or possibly two other deaths took place during this by-election, allegedly at the hands of the War Veterans.14-15

The death of the ZANU-PF supporter intensified attacks on the legitimate opposition. This included night raids on the MDC candidate's house, the detention of all those found there, and harassment of people throughout the district. The election went ahead on 12-13 January, but voting roll fraud meant that thousands of young people found that they had been disenfranchised, and thousands of ZANU-PF supporters were taken by bus into the constituency carrying certificates authorizing them to vote in Bikita. Predictably, the election was won by ZANU-PF. After the election, reports of harassment and violence against those believed to have voted for MDC in Bikita continued to be published. School teachers and other civil servants were among the most targeted groups.

Interviews and findings
All examinations were carried out according to a method previously described.16 The history about torture (a) is compared to the examinee's description of ensuing symptoms (b) and the results of the clinical examination (c). In each individual case it is appraised whether there is consistency between these three elements (a, b, c), thereby on medical grounds assessing the validity of the statements of exposure to violence. All examinees had, together with many others, participated in a by-election campaign in the beginning of January 2001 in Bikita, Zimbabwe.

All agreed to be interviewed and examined with a view to publish evidence of violence committed during the pre-election period in January 2001. In this report, all examined persons are anonymous to protect them from reprisals. All examinations were carried out on 17 January.

Case 1
A 23-year-old man from Harare gave the following account: Presently he is unemployed and lives with his parents. For a long time, he has been campaigning for the MDC. Previously he had been in good health, never suffering from any chronic disease or condition. Only one previous minor accident: he was hit by a bottle; the lesion left a small scar behind his left ear.
**Present history**

On 7 January 2001, he was campaigning in the countryside, Bikita West, in Bikita Minerals. He travelled with three other MDC members. Their car stopped because of technical problems. The driver left them, and they were found by War Veterans and ZANU-members arriving in two cars. None of those were in uniform. There were around 15 people present, and the examinee with his friends were accused of betraying the country and were threatened with execution. The perpetrators concentrated on the examinee so that the two friends managed to escape. He was kicked and beaten all over the body, particularly on the head, shoulders, right side of the chest, and legs. The aggressors used rifle butts and iron rods. At one point he was thrown onto the rocky ground. His forehead and face hit the ground, and also his knees were injured.

He managed to throw sand in the eyes of the nearest perpetrator; thereby he got a moment to escape to the mountains. He hid for the best part of 24 hours. The cars of the perpetrators were easily identifiable; one of them had the initials of ZANU-PF, and some of the perpetrators were high-level War Veterans, among them the MP Dr Chenjerai Hunzvi, leader of the War Veterans. The car used by the examinee was easily identifiable by the perpetrators as it was an MDC car owned by the president of the MDC.

The examinee has been approached several times by the Central Intelligence Organization, after the incident practically on a daily basis. He has been threatened, and once he was attacked by a car-driver deliberately trying to drive into him. Luckily, he managed to escape.

**Subjective complaints**

At the time of the examination he still had headaches. He wakes up at night due to pain in the neck and shoulders. He still has pain in his knees and on the left first toe. He feels that he easily becomes short of breath, not due to pain. He is anxious and he easily gets a feeling of rapid heart beating. Swallowing food has been difficult for him after the incident. At the time of the examination he still had a constant low-grade pain in the middle of the abdomen, not related to hunger or food intake. His worst ailment is chronic headache, and a slight pain in the left side of the jaw. Swallowing is a little difficult. He still has pain in the legs when he walks, ascribed to the physical effort of walking approximately 80 km out of the game reserve. He has had nightmares, finding himself screaming in the middle of the night, dreaming that he is in the game reserve among wild animals. He becomes anxious when he sees white police cars in the streets, sees himself in the hands of police officers, gets anxious, and has a feeling of rapid intense heart beatings.

**Clinical findings**

Physically, he appears well. His gait is normal. There is no abnormality in his breathing or heart-rate. Movements of shoulders and legs are normal. On the forehead, there is a 1 x 3 cm irregular wound with slight swelling in the surroundings. There is no crust, it is almost dry. The edges are irregular. Under the right eye, there is a 2 x 4 cm excoriation, consisting of smaller lesions arranged in lines. There are no crusts. Under the right side of the nose, there is a 10 x 10 mm crust. On the jaw under the mouth, there is a 2 x 1 cm excoriation consisting of smaller lines with exactly the same orientation as the lines above. On the right knee, there is a 3 x 2 cm excoriation with crusts. On the right calf, there are 3 excoriations; the first 10 x 2 mm, the second 20 x 1 mm, the third 8 x 6 mm, all covered by crusts. On the left side over the knee, there are three excoriations; 2 x 3 cm, 3 x 4 mm, 8 x 8 mm, all covered by crusts. On the medial aspect of the left calf, there is a 9 x 2 cm excoriation. At the lowest point there is a thick crust and swelling in the surroundings, at the upper end there is a thinner crust. On palpation there is slight soreness, but no swelling or deformity of the shoulders, neck, or on the right first toe.

**Opinion**

There is agreement between the history of beatings all over the body, a fall to a rocky ground following pushing, and the multiple clinical findings. All the clinical findings are judged to be approximately one to two weeks old. The non-specific psychological symptoms are also in agreement with his history of assault, harassment, and threats.

**Case 4**

A 32-year-old man from Harare gave the following account:

Previously he has been in good health, but in June 2000 he was assaulted by the police. As participant in a funeral for an MDC member, he and many other people were attacked by approximately 50 police officers in uniforms. He was beaten all over the body with hands and fists, especially on the head. After this incident, he has had slight chronic pain in the left side of the jaw. He was detained for nine days.

**Present history**

He participated in the MDC election campaign in Nyika, Bikita. While putting up posters, he was arrested by local police officers in uniforms and taken to the police station in Bikita. He was arrested together with three other persons. In the detention centre a total of around 50 persons were detained. From 5-9 January 2001, he was in the police station and interrogated three times. During the first two interrogation sessions, he was systematically beaten and kicked all over his body. The police officers used truncheons. He was stripped completely naked and beaten all over. On various occasions police officers stood on his abdomen. While lying completely naked on his back with his head on the floor, he felt a sharp pain in his genitals, but he could not see what the police officers did to him.

On 9 January, he and 12 other detainees were taken to a game reserve. He was informed that he would be taken to an MDC rally. They were driven in police Land Rovers guarded by six police officers in uniform and seven or eight plain-clothed men, some of whom were recognized by some of the detainees as agents from the Central Intelligence Organization (CIO). All the police officers and CIO agents were armed.

The 13 detainees were let out from the cars in various places in the game reserve, 40-80 kilometres from the entry to the reserve. The detainees then had to walk back to the entry. It took the interviewee four days to get back to Harare.

**Subjective complaints**

At the time of the examination, he still had a constant low-grade pain in the middle of the abdomen, not related to hunger or food intake. His worst ailment is chronic headache, and a slight pain in the left side of the jaw. Swallowing is a little difficult. He still has pain in the legs when he walks, ascribed to the physical effort of walking approximately 80 km out of the game reserve.

He has had nightmares, finding himself screaming in the middle of the night, dreaming that he is in the game reserve among wild animals. He becomes anxious when he sees white police cars in the streets, sees himself in the hands of police officers, gets anxious, and has a feeling of rapid intense heart beatings.

**Clinical findings (all body examined)**

A few cm below the knee on the anterior aspect of the right
calif: a 2 × 1/2 cm excoriation with a crust. Approx. 10 cm below the above, two small lesions with crusts, approximately 1/4 cm. On the left calf, just below level of knee, a 1 1/2 × 1 cm excoriation without crust. Five cm below the above: a 1/4 × 1/2 cm lesion with a crust and a 2 × 1/4 cm lesion with a longitudinal orientation covered with crust. Two small 2 × 2 mm lesions with crusts and, furthermore, just above the ankle, a 2 × 1/2 cm lesion with crust. Gait was normal, normal performance and mobility of arms and legs.

Opinion
There is agreement between his history of exposure to systematic non-sophisticated violence and harassment, his ensuing symptoms, somatic as well as psychological, and the multiple non-specific lesions on his legs. The lesions are judged to be approximately one to two weeks old.

Discussion
All nine men told that they had been beaten and threatened. One told that he had been exposed to chemicals, three that they were forced to strip naked during interrogations, two told that they were beaten in a more sophisticated manner (under the soles of the feet) and one that he had been burnt with cigarettes.

Three reported that they had been in a group that was attacked with petrol bombs.

Seven had visible physical lesions in accordance with the accounts of ill-treatment. Furthermore, one had other physical signs of exposure to violence, and one had marked psychological symptoms, as observed during the clinical assessment.

In all nine cases, there was agreement between the history of ill-treatment, the ensuing symptoms, and the results of the clinical examination, i.e. all nine testimonies were found to be credible on medical grounds.

The histories are remarkably similar to each other. In all nine cases, the basis for the ill-treatment, harassment, and threats was that they had participated in an election campaign in Bikita for a legal political party 4-7 January 2001. In none of the cases was the arrest followed by a formal charge for criminal acts. All told that they were rounded up by ZANU-PF's (eight cases), War Veterans (six cases), and/or the police (six cases).

Three managed to escape shortly after apprehension, the remaining six were held in police custody for some days and thereafter transferred to a remote place in a game reserve where they were left, a life endangering procedure.

Six of the interviewed men reported that they identified MP Dr Hunzvi among the aggressors.

The fact that many people who supported a legal election campaign were arrested and beaten in the same manner by three groups (the police, ZANU-PF, and the War Veterans) must be seen as an indication of a pattern of organized violence, involving the security forces, the political party in power, and its supporters. The fact that an MP participated systematically further stresses the political responsibility and indicates an unfortunate confusion and abuse of legislative and executive power. Our findings are in agreement with the human rights violations in Zimbabwe that have been described by others, including the US Department of State and Amnesty International17-21 and our own previous findings from 2000.22

We note that the most violent periods in Zimbabwe's recent political history have been characterized by the existence of a strong opposition to the ruling political party throughout the whole period since independence in 1980. The actual violent repression should be seen in the perspective of next year's general election where the ruling party ZANU-PF must foresee great difficulties in maintaining its power. The political logic of ZANU-PF would be to increase the use of organized violence to suppress political opponents during the next year.

Recommendations
1. The Parliament of Zimbabwe is currently debating whether to sign and ratify the UN Convention against Torture and Other Forms of Cruel, Inhuman and Degrading Treatment and Punishment. The Parliament of Zimbabwe should approve this motion as a matter of urgency, and the Government should act upon it.
2. The Government of Zimbabwe should appoint an independent judicial commission to investigate the human rights violations that took place in 2000 and that are continuing into 2001. In particular, the direct involvement of sitting Members of Parliament in inciting and enacting violence against their fellow Zimbabweans should be investigated and dealt with through due legal process.
3. The Government of Zimbabwe should develop and implement a policy of reparation for victims of organized violence, including restitution, compensation, and rehabilitation.
4. The rule of law and the Constitution of Zimbabwe should be respected by all Zimbabweans, regardless of political affiliation, and there should be a tolerance of all points of view: all citizens' rights to freedom of association, expression, and movement should be respected.
5. The Government of Zimbabwe should repeal all laws and regulations, which form the basis of impunity of perpetrators of torture and organized violence.

Until the Zimbabwean Government complies with the above recommendations, donor countries should:

1. Direct all development aid to Zimbabwe to projects carried out by NGOs, aiming to strengthen democracy and human rights and to alleviate consequences of human rights abuses.
2. Withhold economic support to all development projects administered by the Zimbabwean Government in order to avoid that donor funding is used directly or indirectly to repress legal activities of democratic parties and movements in opposition to the Zimbabwean Government.

The international community should be aware of the risk of an increase in the use of violence by the ruling party to control the political life in Zimbabwe. Particular attention should be paid to the period around the elections, and massive support should be offered to monitor the democratic process.

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Note
(1) Gukurahundi is a Shona word meaning “the rain that washes away the rubbish from the last harvest before the spring rain.” The allusion to the people in Matabeleland is clear.

Actual update
Since the finishing of this manuscript, the political situation in Zimbabwe has further deteriorated and appears highly volatile. Private companies have been attacked by war veterans, and Cheniersir Hunzvi has said that “... next target ... will be to deal once and for all with foreign embassies and non-governmental organisations who are funding the MDC.” This statement has been commented internationally, and the Danish Minister for Development Cooperation has established that further threats against NGOs and embassies will cause reduction in the development aid from Denmark to Zimbabwe. It appears that Mr. Hunzvi subsequently has withdrawn the threats against foreign embassies, but they has not formally been retracted by the Zimbabwean Ministry of Foreign Affairs.

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Torture victims after psychotherapy
- a two-year follow-up

Angelika Birck, Psychologist*

Abstract
In a longitudinal analysis of 30 patients at the Treatment Centre for Torture Victims in Berlin, Germany, symptoms were described at the beginning of psychotherapy as well as two years after the end of treatment. Standardized instruments and interviews with former patients and their therapists were used for assessment. Results show that at the follow-up assessment, former patients were highly symptomatic, although intrusive symptoms had decreased. Many subjects experienced stressing events during the post-therapeutic period leading to reactivation of symptoms. Results indicate that torture victims are highly vulnerable to further stressors. In this population post-traumatic symptoms may diminish, but they do not disappear. Instead symptoms may have a phasic course.

Keywords: torture, follow-up, PTSD, reactivation, refugees.

Introduction
Various disorders have been described in torture survivors, especially post-traumatic stress disorders (PTSD), anxiety, pain, dissociation, somatoform and cognitive disorders, and social withdrawal.1-2 Most studies assess symptoms before psychotherapy has taken place, only few follow-up studies exist, and randomized control trial studies are non-existent.

Out of 50 Bosnian concentration camp survivors who received psychotherapy in the Netherlands, 83% were PTSD-positive at a three-year follow-up.3 In a Danish sample of 20 torture survivors, 17 subjects reported positive effects of psychotherapy in a follow-up interview, although most of them still suffered from post-traumatic symptoms.4 Weisaeth studied 14 members of a ship's crew who had been tortured and kept in captivity. Seven subjects developed PTSD and remained PTSD-positive six months after release despite psychotherapeutic treatment.5

Most patients of the Center for the Treatment of Torture Victims Berlin (Behandlungszentrum für Folteropfer Berlin (BZFO)) have suffered persecution with repeated torture. About 95% of the patients are asylum seekers. When they come to the centre, most disorders have already become chronic. In chronic and complex post-traumatic disorders spontaneous recovery is not very likely.6

The BZFO offers medical care, psychotherapeutic treatment with a mainly psychodynamic approach, and social support. We wanted to know more about the longitudinal course of post-traumatic symptoms in treated torture survivors and we were interested in former patients' individual evaluation of treatment effects and satisfaction with the psychotherapy. Our main hypothesis was that post-traumatic symptoms, anxiety, and depression were still present, but had improved at follow-up. We assumed that subjects with granted asylum would present less severe symptoms at follow-up.

Methods
Study design
Symptoms were assessed with standardized measures on three occasions (at the beginning and at the end of psychotherapy, and at follow-up). The follow-up assessment also included qualitative interviews with former patients and their therapists. As mean duration of treatment in the BZFO is about one and a half to two years, a similar two-year follow-up period was chosen. In a case-by-case approach the following criteria were used to evaluate the individual success of psychotherapy: (1) symptom improvement, (2) personal evaluation of the effect of psychotherapy with special regard to individual aims, (3) evaluation of the clinical relevance of symptom changes by the former therapist, (4) evaluation by an uninvolved clinical expert, and (5) the social situation and satisfaction in general, post-treatment changes. The individual results were integrated in a cross-case analysis.7

This study remains uncontrolled because no highly comparable group of untreated tortured asylum seekers could be obtained. We tried to compensate this lack by using a case-by-case approach to understand symptom changes or persistence.

Measures
The German version of the Impact of Event Scale – Revised (IES-R) was translated into Arabic, Croatian, and Turkish; a regression model allows differentiation between clinical PTSD-cases and others.8-9 The Hopkins Symptom Checklist 25 (HSCL-25) has been widely used as a measure of improvement. Mollica et al. recommend a cut-off score of >1.75 (mean item score) to differentiate between clinical cases and others.10 The Harvard Trauma Questionnaire (HTQ) was developed for the assessment of refugees. Mollica et al. use a cut-off score of >2.5 (mean symptom score) to classify PTSD-cases.12 HSCL and HTQ were used in the Turkish and Arabic versions from the IRTC in Copenhagen.

At follow-up, the author conducted semi-structured interviews with former patients as well as with their therapists. Former patients were questioned about their general wellbeing and state of health, about symptoms at the beginning of treatment, at its termination, and at follow-up; individual goals, symptom improvement and worsening, individual evaluation of changes, satisfaction with psychotherapy, current social situation, current status of residence, and other problems. The interviews with therapists concentrated on symptoms at the beginning of treatment, prognosis and therapy

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Germany
aims, course of treatment, main interventions, course of symptoms, and status of health at the termination of treatment.

Data collection and analysis
Data were collected from February to August 1999. Subjects were interviewed in their preferred language, 15 subjects were interviewed in their mother tongue with the help of interpreters from the BZFO, 13 persons chose the German language, two former patients chose English for the interview. Literate former patients completed the questionnaires, for five illiterate subjects the HSCL was used as an interview. SPSS for Windows 6.1 was used for all statistical calculations. Normal distribution of scores was proved by Kolmogorov-Smirnov-tests. Symptom scores at t1 and t3 were compared by t-tests for paired samples. Differences between subgroups were compared by two-tailed t-tests for independent samples, by Mann-Whitney-Tests or by calculating chi-square coefficients (Pearson). For correlations, Bravais and Pearson coefficients were calculated.

Description of the sample
The sample consisted of 57 former patients of the BZFO who had ended psychotherapy between late 1996 and early 1998. ICD-10 diagnoses as well as standardized symptom assessment (IES-R, HSCL or HTQ) had been made at the beginning and sometimes also at the termination of treatment. All subjects were informed about the aim and nature of the study, voluntariness and confidentiality. Twenty-three persons of the original sample could not be reached at follow-up, most of them had been repatriated, four subjects did not wish to take part in the study. The study-sample therefore consisted of 30 subjects (drop-out rate of 47%). Study-sample and drop-out sample did not differ in traumatic events, symptoms or security of residence at the beginning of therapy. The biggest part of the drop-out sample came from Bosnia-Herzegovina (34%) followed by Kurds from Turkey. In the study-sample only one woman was Bosnian, most subjects were Kurds from Turkey.

Demographics
The sample consisted of 12 women and 18 men with a mean age of 34.4 years (SD 8.9, range 19-51 years) at follow-up. Eighteen subjects were Kurds from Turkey; the others came from different countries in the Far and Middle East and from Africa. Five subjects were illiterate. At follow-up, 12 subjects had been granted asylum, 17 subjects were still seeking asylum, and one person was to be repatriated.

Traumatization
All subjects had been tortured (all except one during detainment). Imprisonment lasted from two days up to eight years (Median: 45 days, M 8.89 months, SD 19.36 months). Most subjects had been imprisoned several times (M 2.3 periods of detention). At follow-up, the most recent torture had taken place about seven years before.

Psychotherapy
Mean duration of psychotherapy was 23.5 months (SD 9.7, min. 7, max. 40 months) with one session a week. Twenty-five subjects were in psychodynamic psychotherapy, two were in systemic therapy, two in Gestalt therapy, one in cognitive behavioural treatment. Main themes of psychotherapy were torture, imprisonment, exile and social situation. Twenty-six subjects ended treatment in mutual agreement, three subjects broke off. Mean follow-up period was 24.9 months (SD 10.5, min. 9, max. 46 months).

Results
Symptoms and symptom changes
BEGINNING OF PSYCHOTHERAPY
According to ICD-10 criteria, main disorders were post-traumatic stress disorder in 27 subjects and enduring personality change after catastrophic experience in three subjects. Additional disorders were somatoform disorders (25 patients, F45.4 or F45.1) and depression disorders (eight subjects). One person had an eating disorder, one had an obsessive-compulsive washing disorder, and one had a speaking disorder. Twenty-one subjects had been assessed with the HSCL, 19 subjects had total scores, anxiety and depression scores above cut-off. Seventeen persons had an HTQ assessment, 11 subjects were above cut-off. Only seven subjects had filled out the IES-R, six patients were PTSD-positive.

END OF PSYCHOTHERAPY
Descriptions of symptoms or detailed diagnosis were lacking in most cases. Only five subjects filled out the HSCL at the end of psychotherapy, four subjects were above cut-off for anxiety, depression and total test scores. Only one IES-R and one HTQ were filled out, both were PTSD positive.

FOLLOW-UP
In 12 persons symptoms were acutely reactualized, each subject described a triggering stressful event. Many of the other 18 subjects reported that their insecure exile situation lead to maintenance or aggravation of symptoms, but did not report triggering events. Twenty-two subjects were assessed with the IES-R, seven subjects were PTSD-positive. Twenty-eight former patients filled out the HSCL, 24 subjects were positive for the total scores. Of 23 subjects who were assessed with the HTQ, 11 subjects were PTSD-positive.

SYMPTOM CHANGES
Because of missing data at the end of treatment, only symptoms at the beginning of therapy and at follow-up could be compared. HSCL depression scores showed improvement tendencies at follow-up, though the results failed to reach statistical significance. HSCL anxiety symptoms and HTQ symptoms showed no changes. Intrusive symptoms in the IES-R have clearly decreased from the beginning of therapy to follow-up assessment, arousal and avoidance symptoms remained unchanged.

Eleven of 18 Kurdish subjects in the sample reported symptom aggravation as a reaction to the kidnapping and imprisonment of the leader of the PKK, Abdullah Öcalan, which took place on February 15, 1999, and the following political demonstrations. One subject from Bosnia-Herzegovina suffered from aggravation of symptoms after having seen media reports from Serbian massacres in Kosovo. On the whole, 19 former patients were mainly affected by the stressful political events because of their ethnic membership, 12 of them (63%) reacted with sometimes dramatic reactivation of post-traumatic symptoms. Subjects with reactivation of symptoms at follow-up (N=8) showed somewhat higher IES-R intrusion scores than comparisons (N=14; intrusion means 23.0 vs. 17.7, t 1.53, p .14, non-significant) and asked more frequently for further treatment (Pearson chi-square coefficient 10.20, p .001). Subjects with reactivation had experienced more periods of detainment and torture than...
their comparisons (2.9 vs. 1.9 periods of detainment, t 2.24, p .03). The security of the residence situation did not seem to influence the occurrence of reactivation of symptoms at follow-up. However, subjects with granted asylum (N=6) reported lower IES-R intrusion scores at follow-up than persons with an insecure status of residence (N=16; intrusion means 15.6 vs. 21.8, t 1.49, p .15, non-significant).

Analysis of interview data

Goals at the beginning of treatment, attainment of goals

When asked about which goals had been of primary importance at the beginning of therapy, 18 former patients reported symptom improvement; 11 persons looked for support in the insecure social and residence situation. According to their own evaluation, 11 former patients had attained their primary goals, 15 subjects had partly attained them, and four subjects could not reach them. Therapists reported symptom change as being the most important individual goal for former patients, followed by social and legal aims. Therapists evaluated that they could reach these goals in nine cases, partly reach them in 15 cases and were not able to reach them in four cases (two cases: missing data due to termination of employment).

The evaluations of therapists and patients were in agreement in 18 cases, in four cases therapists scored higher attainment than patients, in six cases patients reported higher attainment than therapists (comparison was based on three-fold degrees of goal attainment).

Satisfaction with psychotherapy

Twenty former patients declared themselves very content with treatment, seven called themselves somewhat content, and three were completely discontent (two of them reported getting help in seeking asylum as primary therapy goal). The expressed satisfaction with therapy was not correlated with getting help in seeking asylum as primary therapy goal. The security of residence at follow-up (three-fold security rating, two-fold security of residence, Mann-Whitney Tests: U 107, W 185, p .959).

Interfering variables in treatment

Former patients were asked to describe what had bothered them during therapy and what should be improved. Two persons were bothered by the limited results of social services (e.g. no influence on legal proceedings), two subjects felt burdened by a premature termination of treatment by the therapist, one person reported each of the following concerns: frequent change of therapists, recurrent aggravation of symptoms, therapist disappointed the client by destroying his/her hope, not enough political involvement of the BZFO, too many patients at the centre, and being presented to a supervisor-therapist. Three subjects reported problems with interpreters. Questioned about their current state of health (in persons with reactualized symptoms: prior to the stressing event), 12 persons stated that they were symptom-free except in times of additional stress, 14 persons said that symptoms had decreased, three subjects reported unchange symptoms, one person reported symptom aggravation. At follow-up assessment, 12 subjects asked again for social support or for regular treatment sessions. When asked what was most helpful, 15 former patients mentioned the trustworthiness and the possibility to talk to somebody about torture and refugee problems. Six persons valued results obtained by the social workers as most helpful, two persons mentioned medical care, seven persons had no answer.

Termination of treatment

According to therapists, 26 cases had been terminated in mutual agreement, four patients had broken off treatment. According to former patients, 21 therapies had been terminated in mutual agreement, four patients had broken off treatment (one because of loss of confidence, one because of lacking improvement of symptoms, one because of mistrust regarding a new interpreter, and one because of pregnancy), five subjects said that the therapist had terminated treatment too early.

Table 1. Descriptives and comparison of symptom scores at the beginning of treatment and at follow-up.

<table>
<thead>
<tr>
<th>Item</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>% above cut-off</th>
<th>N of pairs</th>
<th>df</th>
<th>t-value</th>
<th>p</th>
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<td>69.36</td>
<td>15.79</td>
<td>90</td>
<td>20</td>
<td>19</td>
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<td>17.29</td>
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<td>20</td>
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<td>6.78</td>
<td>89</td>
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<td>11.39</td>
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<td>17</td>
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<td>0.58</td>
<td>69</td>
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<td>9</td>
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<td>Before treatment</td>
<td>7</td>
<td>77.85</td>
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<td>6</td>
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<td>21.06</td>
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<td>Intrusion</td>
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<td>Before treatment</td>
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<td>26.71</td>
<td>9.48</td>
<td>-</td>
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<td>19.68</td>
<td>7.95</td>
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<td>Avoidance</td>
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<tr>
<td>Before treatment</td>
<td>7</td>
<td>28.57</td>
<td>5.26</td>
<td>-</td>
<td>7</td>
<td>6</td>
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<td>17.59</td>
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<td>Arousal</td>
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<td>20.09</td>
<td>8.16</td>
<td>-</td>
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**Improvement of the social situation**

The security of the status of residence had clearly improved from the beginning of therapy to follow-up assessment. Whereas at the beginning of therapy only three subjects had been granted asylum, at follow-up 12 subjects had unlimited right to residence. Also housing and employment conditions had improved slightly.

**Discussion**

In a sample of refugee torture survivors, more than half of the subjects still suffered from PTSD after psychotherapeutic treatment, most of them also reported clinically relevant depressive symptoms. Similar degrees of chronicity of symptoms in torture survivors are reported by other authors. Many subjects reported a connection between their persisting anxiety symptoms and the long-term insecurity of residence and living conditions. Despite high chronicity of symptoms, intrusion had improved significantly, whereas anxiety and arousal symptoms persisted. These results agree with observations of the longitudinal course of post-traumatic stress disorders.

One of the most striking results was the high percentage of aggravations of symptoms after recent stressors. Similarly, Solomon, Garb, Bleich & Grupper reported reactivation of PTSD symptoms in combat veterans. The high frequency of reactivation of symptoms after prior improvements cannot be explained by common concepts of recovery or chronicity. Instead, results indicate that in torture survivors post-traumatic symptoms do not disappear, but at best go into remission. A definition of chronicity where symptoms remain stable seems to be inappropriate. This supports a phasic concept of post-traumatic symptoms. Post-traumatic disorders may have permanent sequelae even when symptoms remit.

In refugees, the stressing social environment may play a crucial role in the maintenance of symptoms. In the study, a worsening political situation and the consequences thereof for the refugee and his family members were a major cause of reactivation of symptoms.

Because of a response rate of only 47% of the original sample, the interpretation of our results is limited. Small response rates are a basic problem of long-term follow-ups, even more so in a target population of highly mobile refugees. Because of the limited sample size, the study may have had insufficient power to detect any but the largest effects. As the study was not designed prior to the follow-up period, some data were missing. Therefore, we could not compare symptoms at the end of treatment with follow-up assessment; instead we had to rely on retrospective information by former patients. The questionnaires in themselves may have been another methodological problem as the high end points of the scales may not have been sensitive enough to differentiate between a wide range of severe symptomatology. However, interview data showed clearly that clinical significance of improvement sometimes existed also in absence of statistical significance. This observation supports a single-case approach for the evaluation of treatment outcomes.

**References**


**Acknowledgement**

The study has been funded by Professor Dr Jan Philipp Reemtsma, Institute of Social Studies, Hamburg, Germany.
Difficulties in identifying torture survivors

Dear Editor,

Jacobs\(^2\) refers to our work\(^1\) in the interesting paper "Psychopolitical challenges in the forensic documentation of torture". We are happy to continue this discussion publicly, as his paper addresses issues that we are dealing with in our own professional work, and we hope that we can learn from one another's practices. We were also involved in the development of the Istanbul Protocol, and we strongly support the principles it espouses.

In our paper, we were writing about a specific aspect of our practice, in response to earlier articles about documenting torture where the physician has only a limited opportunity to spend time with the patient. Sadly in an organization with limited resources and ever increasing demands, we cannot give many of our patients as much time as they deserve. However, there are psychotherapists, psychologists, and counselors within the Medical Foundation to whom we refer patients, and they do also provide reports for the use of a client's lawyers within the asylum seeking process. One of us (GH) sees patients both as a general physician and as a psychotherapist.

In report writing, our principal duty is to offer an objective expert opinion to the courts. If we were perceived as being patients' advocates, we could achieve much less for our total patient population. As Jacobs says, legal standards are different in different countries, and the judges in the United Kingdom tend to give less weight to psychiatric and psychological evidence than do those in the United States. We are participating in an ongoing process of educating those involved in determining applications by asylum seekers. We have managed to get reports by Medical Foundation physicians about physical signs accepted by the authorities as expert evidence, and we are fighting to get psychological reports accepted on the same basis. We do not consider psychological evidence as being "second best", although some of whom we write reports often do. However, it takes a long time for our colleagues and us to build up a full picture of the psychological state of our patients. Where can we report on objective physical signs, we tend to do so, and refer the patient for counselling by a colleague who may not wish to write forensic reports.

The challenge, as Jacobs says, is in documenting those patients who are victims of torture, but have no objective physical signs. It is true that many torturers know this, and work hard to frustrate any efforts to expose them. More importantly for our work, victims of torture are having asylum applications refused in the UK because there are no significant physical findings, and evidence of psychological distress alone is not accepted.

Torture survivors' psychological stress is compounded by policies designed to deter asylum seekers. Consequently we cannot tell to what extent psychological symptoms are the result of torture, and to what extent they are the result of growing up under a repressive regime, witnessing random human rights violations, then being disbelieved by the British authorities, and being branded by parts of the media as public enemies. This is our dilemma. Many of our patients have experienced a number of traumatic events, not all of which count as persecution under the 1951 Convention Relating to the Status of Refugees. Although victims of torture probably do have different patterns of distress from those who have suffered other forms of trauma and loss, this has not yet been fully established.

From a therapeutic point of view, all these experiences can and should be explored, as they all contribute to the psychological distress, but medico-legally we cannot separate out different causes from the symptom clusters. We would be very interested to know how Jacobs and other readers of your journal address these issues.

We are all working together to create a world in which there is no more torture, and we must teach politicians, lawyers, and everyone else the dangers of torture and its psychological impact. Physical scars heal, and although they might act as a reminder of past events, they are not equivalent to persistent psychological damage.

We must not only help asylum seekers in our own countries, but also press for the prosecution of perpetrators throughout the world. This requires medical skills of physical examination, psychological assessment, and one that we have not discussed: history taking.

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United Kingdom

References

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LETTERS TO THE EDITOR

A call for action to the IRCT network

Since 1991 a working group under the UN Commission on Human Rights has had annual two-week-long meetings in order to attempt to draft an Optional Protocol to the UN Convention against Torture. The Protocol should enable the introduction of unannounced inspection visits to places of detention in every state that has ratified the Optional Protocol.

The Council of Europe's Convention for the Prevention of Torture includes such inspections, which have been carried out for more than ten years, and all European states have ratified this Convention and accepted anti-torture inspections. Based on this experience it should not be difficult to finalize the Optional Protocol now.

The inspection system intends not only to react against ongoing torture, but also to focus more on prevention, as has been stated by the former and present UN Special Rapporteur on Torture.

According to reports from the working group, a few states continue to raise objections to some of the principles which are central to an effective Optional Protocol. The objections are raised by delegates from Algeria, China, Cuba, Egypt, Saudi Arabia, the Sudan, and Syria. With two exceptions all

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States which ratified or acceded to the UN Convention against Torture and other Inhuman or Degrading Treatment or Punishment as at January 2001 (123)

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</table>
LETTERS TO THE EDITOR

of these countries have ratified the UN Convention against Torture, in spite of which they are all know as countries which accept torture. As the Protocol is optional, states would not be obliged to ratify it.

At the most recent session, 12-23 February 2001, it was recommended that the next meeting, 1-12 October this year, should be the final meeting of the working group, regardless of the result of this meeting. The decision is up to the UN Commission on Human Rights at their meeting in Geneva from 19 March to 27 April 2001. There are fundamental principles which must be included in the text of the Protocol if it is to be an effective tool for the prevention of torture, viz. a standing invitation to visit the territory of any state party to the Protocol, as well as a guarantee for representatives of the UN Committee against Torture to have unlimited access to all places of detention and to all detainees as well as a right to interview defaees in private.

No reservations to the Protocol should be permitted, as it would otherwise be better to be without the Protocol at this stage in time.

I therefore suggest that the IRCT network around the world approach the relevant decision-makers and international organizations with the aim to support a finalization of an effective Optional Protocol for the eradication of torture. Hopefully, the lobbying and advocating can be done without jeopardizing your organization’s safety and freedom of activity.

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Comment to the Letter to the Editor

The IRCT supports the early establishment of an Optional Protocol to the CAT and believes that the establishment of an international mechanism for regular and unfettered visits to prisons and other places of detention would make a significant addition to international efforts towards the prevention of torture.

At the most recent meeting of the Working Group in February, two new text proposals were put forward, one by Mexico, on behalf of the Latin American group of countries, and a counterproposal by Sweden on behalf of the EU member states.

Both new texts attempt to incorporate both national and international elements as part of an overall model for establishing a system of preventative visits. The Mexican text places the primary responsibility for carrying out visits on the national mechanism. The role of the international mechanism is limited, in large part, to monitoring the work being carried out at the national level. The Swedish counterproposal, on the other hand, seeks to emphasize the primary importance of the international mechanism.

The IRCT, which was represented at the meeting as an NGO observer, stands together with a group of other NGOs who, while supporting references to the importance of national mechanisms in the text of the Optional Protocol, believes it is vital that the powers of the international mechanism are maintained. This was the intention of the original Costa Rican text proposal, and the IRCT considers it important in order for the Protocol to be an effective instrument, one that adds real value to existing standards at international and regional levels.

The two new text proposals will be negotiated in more detail at the next meeting of the Working Group, to be held in October this year.

Paul Dalton
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Media and Institutional Relations
IRCT

Romania
Republic of Moldova
Russian Federation
Saudi Arabia
Senegal
Seychelles
Slovakia
Slovenia
Somalia
South Africa
Spain
Sri Lanka
Sweden
Switzerland
Tajikistan
The Former Yugoslav Republic of Macedonia
Togo
Tunisia
Turkey
Turkmenistan
Uganda
Ukraine

United Kingdom of Great Britain and Northern Ireland
Uruguay
Uzbekistan
Venezuela
Yemen
Yugoslavia (Serbia and Montenegro)
Zambia

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The sound of silence


In his book, Serge Patrice Thibodeau puts forward many views on what torture is in different parts of the world. This proves – to people who might have been doubting it – that torture is a worldwide problem.

But the book is not only a review of the different torture methods, a catalogue of the unlimited human imagination when it comes to ways of making other human beings suffer, when it comes to ways of humiliating them. The book also asks an important question, a question that every human being probably asks himself when he thinks of this barbaric practice: “Why?” – Why do people practice torture?

- To make someone talk? It is not only that.
- To punish him? Perhaps, but does that give the right to make other people suffer?
- To frighten social groups or political militants? If that is so, this will not be sufficient!
- To intimidate, to dehumanize? Most probably.

To make it simple, torture is all of that at the same time. Torture is a weapon against democracy. Most of the time torture is used to prevent a person, a group, a nation from talking. Torture makes silent.

Serge Patrice Thibodeau is also studying a very important aspect, well known to practitioners who take care of torture victims: humiliation. This is an element of torture that the victim has to face day after day. The humiliation is created by the torturer and remains present in the victim’s mind, it makes the victim silent.

The book starts with the Egyptians and the Syrians, and it goes on to describe the present where at least 125 countries are using torture. “Why” – this is no doubt much more important than “how”. Why is it possible for a man like me to torture another human being? A terrible question.

The book also shows that the victims of torture are not only political prisoners, journalists, it is also children and youngsters, it is elderly people, women, refugees, and gays.

Torture is also discussed from a linguistic point of view. It is interesting to realize that a specific method of torture is named differently depending on the country where it is used; it has its own “culture”. It is also clearly shown that life is never the same after torture. This quasi-poetic text emphasizes – through its “softness” – the inhumanity of torture.

The last part of the book is a useful “guide” for those who want to fight against torture, those who refuse impunity. This part proves that torture can be fought, that there is no need to use torture, that the police can use other methods.

The book is far from simple, it is not just another book about torture. It is a fight against inhumanity, it is a militant’s fight, it is a poetic way to keep up the hope, to fight for hope, to hope that one day the world will get rid of this disgrace.

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**Selected list of publications**

received in the IRCT International Documentation Centre


EMDR - cognitive behavioral method for posttraumatic stress disorder in torture victims / Ilic, Zoran; Lecic-Tosevska, Dusica; Bokonjic, Srdjan; Drakulic, Bogdan; Jovic, Vladimir. - In: Psychiatry today; vol. 31, no. 2-3. - 19990000. - p. 245-258.

Posttraumatic stress disorder in an urban area of Albania - the yellow areas in the Gaza strip / Bokonjic, Srdjan; Drakulic, Bogdan; Jovic, Vladimir. - In: Psychiatry today; vol. 31, no. 2-3. - 19990000. - p. 245-258.


Posttraumatic stress disorder in an urban area of Albania - the yellow areas in the Gaza strip / Bokonjic, Srdjan; Drakulic, Bogdan; Jovic, Vladimir. - In: Psychiatry today; vol. 31, no. 2-3. - 19990000. - p. 245-258.


BOOK REVIEWS

Srebrenica – the story of the survivors


The failure to protect the 30,000 inhabitants of the world's first United Nations Safe Area Srebrenica, in Bosnia-Herzegovina has been discussed on many occasions and in several reports. We have heard little from the survivors of the massacre themselves. In the book After the fall members of the Oric family speak about their haunting experiences, their despair, but also about their determination to give their children a better future. Their story gives, together with the many photographs in this book, a human face to the destiny of thousands of Bosnian refugees.

The first part of the book is a brief chronology of the events that led to the killing of thousands of Muslim men and boys. It is based on reports, United Nations documents, journalistic accounts, and witness testimonies. Short descriptions, sometimes no more than two or three lines, are given of the different incidents. Satellite pictures and video imagery illustrate almost every page of this chronology.

In the second part of the book members of the Oric family tell their story of the fall of Srebrenica. The Oric family is the extended family of six brothers and sisters, their husbands, wives and their children. Their father, Sujo, was killed in Srebrenica. Brother Haso is missing and feared death. The family now lives in St. Louis, in the United States of America. Each member of the family describes in their own hood, feeling unprepared for street crime . A traditional nitiy. This is the least interesting part of the book and I would rather have seen it at the end.

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Manual of legal remedies against torturers


The UK-based REDRESS Trust, established in 1992, promotes repARATION for torture survivors and their families and encourages standards, which provide remedies for torture. The aim of the organization is to ensure that the needs and rights of torture victims are respected, and the organization has been made aware that individuals, who have been involved in the practice of torture, in numerous cases have been found to be residents or visitors to Great Britain. The Pinochet visit was an illustrative example of that. The Pinochet case is among the relevant cases analysed in the book. The knowledge about these cases gave inspiration for the organization to advocate for better legal remedies in the UK for torture committed abroad. This would be an important contribution to the fight against impunity.

The manual is the result of that work. The authors emphasize that it is a fast developing field, and this is used as an excuse for not covering all the points of law that might have been relevant. But with the publication of the manual the work has nevertheless been initiated – and that in itself is positive. The manual is directed primarily at UK-based legal practitioners and human rights activists, but it will certainly also be of interest to those seeking to use the law to combat impunity for torture in other countries.

In 1999 REDRESS published The torture survivors' handbook: information about support for torture survivors in the UK, providing information about the possibilities of obtaining reparation. This Manual is a follow-up and valuable complement to the handbook.

Henrik Marcussen

NEWS FROM CAT AND CPT

CAT – 26th session

At the 26th session of the UN Committee against Torture, which is to be held on 30 April 2001 – 18 May 2001, states parties' reports to be considered by the Committee are: Georgia (second), Greece (third), Czech Republic (second), Slovak Republic (initial), Bolivia (initial), Brazil (initial), Costa Rica (Initial), and Kazakhstan (initial).
**FORTHCOMING CONFERENCES AND SEMINARS**

Montreal, Canada  
1-6 July 2001

26th International Congress on Law & Mental Health: Mental Health Crisis and Social Change

**Pre-Conference: “Fundamental Options in Health Care”**

During the Plenary Day on 3 July 2001, leading scholars will actively engage in dialogue on family crisis, law, mental health and society. In the parallel sessions on 4, 5, and 6 July a wide range of multidisciplinary topics in the field of Law and Mental Health will be dealt with.

**Further information:**

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The Editorial Board of *TORTURE* is pleased to receive conference announcements, calls for papers, and other related information of interest to the readers of the journal.

The Editorial Board also receives short reports about conferences already held. These may be published in the section “Conference reports”.

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The IRCT is a private non-profit foundation, that was created in 1985 by *The Rehabilitation and Research Centre for Torture Victims (RCT)*, Copenhagen.

The objectives of the foundation is on an international basis to promote the provision of specialized treatment and rehabilitation services for victims of torture and to contribute to the prevention of torture globally.

To further these goals the IRCT seeks on an international basis

- to develop and maintain an advocacy programme that accumulates, processes, and disseminates information about torture as well as the consequences and the rehabilitation of torture
- to operate a documentation centre about torture and related topics
- to establish international funding for rehabilitation services and programmes for the prevention of torture
- to promote education and training of relevant professions in the medical as well as social, legal, and ethical aspects of torture
- to encourage the establishment and maintenance of rehabilitation services
- to establish and expand institutional relations in the international effort to abolish the practice of torture, and
- to support all other activities that may contribute to the prevention of torture.