Aspects of the examination and treatment of torture victims

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Aspects of the examination and treatment of torture victims

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The international network of rehabilitation centres for torture victims:
a survey study of treatment capacity and development priorities

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Survey on frequency of types of trauma, and prevalence of PTSD symptomatology among Kosovo Albanian refugees, in the Tirana area refugee camps, in Albania, June 1999

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Florina Myftari, MD, Ylber Rushiti, student, and Besnik Isaku, psychologist

The effects of social and legal circumstances on the psychotherapeutic treatment of torture survivors

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Transcultural psychotherapy with adolescent refugees

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Editor’s preface

The papers presented in this Supplementum include two examinations that owe their existence to the IRCT network – one as a fieldwork initiated by the IRCT, one as a statement of treatment capacity and other features of centres that the IRCT collaborates with.

Important working areas for the IRCT include assistance to the formation of networks and the collaboration between centres, networks and donors. Another important IRCT objective is to increase international understanding for the importance of the work against torture. It has been the intention to work closely with partners in the network in order to disseminate knowledge about torture through reports, analyses, and documentation. The questionnaire-based assessment study by Jens Modvig et al. is an example of the outcome of collaboration between network members and the IRCT.

In many cases, the work in the network has to proceed in spite of limited resources and a shortage of health professionals. Despite these restrictive conditions, the rehabilitation work is often carried out with admirable initiative and motivation.

The study by Klement Dymy et al. was initiated in a civil war situation. The Albanian Centre for Rehabilitation of Trauma and Torture Victims (ARCT) was set up in 1993 mainly for the rehabilitation of people prosecuted for political involvement, but it became of national importance in the treatment of torture survivors. At the end of 1998, this centre was faced with a flow of refugees because of ethnic cleansing in Kosovo. From a small office and within a few months, the ARCT carried out about 5000 medical visits and coordinated humanitarian aid.

The articles by Guus van der Veer and Ferdinand Haenel deal with two important aspects of the psychotherapeutic treatment of torture survivors: firstly, the importance of understanding the background and culture of the client, and, secondly, the significance of giving due attention to the social and legal circumstances of the individual victim.

H.M.
The international network of rehabilitation centres for torture victims

A survey study of treatment capacity and development priorities

Jens Modvig, MD, PhD, Secretary General
Christian Krone Jørgensen, MSc (econ.), Financial coordinator
Introduction
Torture is, according to the United Nation Convention against Torture,¹ the intentional infliction of severe pain or suffering for a specific purpose by a person acting in a public capacity. In spite of the fact that 132 states have ratified the convention, thereby agreeing to an absolute prohibition of torture, this human right violation is practised in more than 100 countries – widespread and systematically in an approximately 65 countries.²

Torture has severe impacts on the physical health, the mental health and the social functioning of the individual as well as the closest relatives. For this reason, close relatives of “primary” torture victims are considered “secondary” torture victims.³

Current discussions in the international community on the right to reparation of victims of gross human rights violations include the right to restitution, compensation, rehabilitation, and satisfaction and the guarantees of non-repetition.⁴ While restitution and compensation address material losses, rehabilitation and satisfaction seek to restore the health, function, dignity, and reputation of the victim as well as providing justice.

Since the early 1980s, the number of specialised rehabilitation centres for torture victims has grown from a handful to close to 200 in up to 80 countries. Although these centres appear in directories of services for torture victims,⁵ an overall description of features of these centres, including their treatment capacity, has not previously been provided.

Since 1985, the International Rehabilitation Council for Torture Victims (IRCT) has supported the initiation of such centres and provided support to existing centres.⁶ This includes focused assistance to single centres in the initiation and consolidation phases, support for the operation of networks of centres as well as international advocacy and fundraising.

The purpose of this study is to assess – through a global survey – the overall features, including the treatment capacity, of the international network of rehabilitation centres for torture victims as well as assessing centres’ priorities in the future collaboration with the IRCT.

Material and methods
A self-administered questionnaire was prepared, addressing basic features of the rehabilitation centres (services provided, features and number of clients), assessment of support received from the IRCT and indication of priorities for future support.

The questionnaire was submitted by e-mail (as well as being made available on the Internet) in October 2001 to all centres registered with the IRCT, a total of 174 centres in 76 countries. Non-respondents were reminded by phone and e-mail up to three times until June 2002, when the intake of data ended.

Data on centres’ treatment capacity comprised clients under treatment over a year and clients under treatment at a certain point of time (1st September 2001). These data allowed for a calculation of the treatment capacity of an average centre and of the total number of centres worldwide. Using the relationship “Prevalence = Incidence × Mean Duration”,⁷ and assuming balance between admittance and discharge, these figures also allow for a rough overall estimation of the number of new clients admitted during one year (clients under treatment during a year – clients under treatment at a certain point) as well as the mean treatment time (clients under treatment at a certain point/new clients over a year).

The data were processed using SAS software.⁸

Results
A total of 111 (63.8%) of the 174 centres provided data to the study. Respondents represented 65 different countries. Table 1 presents the regional distribution of centres and the response rates per region. Asia and Sub-Saharan Africa regions are over-represented while the Pacific region is under-represented in the material.

Torture modalities offered by centres
Counselling, psychotherapy, medical treatment and psychiatric treatment is provided by more than half of the centres, addressing the health dimensions of rehabilitation, cf. Table 2. Sixty-two (56%) of the centres offer services that together address physical, mental and social aspects of health.

Even if the treatment modalities addressing the victims’ health are by far the most frequently offered, more than a third of the centres offer legal counselling and more than 20% offers job training.

It is noteworthy that 36% of the centres offer emergency food and clothing. This indicates that basic survival needs remain uncovered for torture victims in many countries, and that meeting basic needs should be considered a core part of the rehabilitation provided.

Treatment capacity of centres
The data on number of clients under treatment were not complete, and around a third of the centres’ data reporting were internally inconsistent. Since no data have previously been reported in this area, the average findings are presented below.

The number of clients that received treatment during a

Table 1. Distribution of centres and response rate per region.*

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of centres represented by centres</th>
<th>Number of centres registered</th>
<th>Number of respondents</th>
<th>Response rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>30</td>
<td>73</td>
<td>47</td>
<td>64.4</td>
</tr>
<tr>
<td>North America</td>
<td>2</td>
<td>29</td>
<td>18</td>
<td>62.1</td>
</tr>
<tr>
<td>Latin America</td>
<td>14</td>
<td>21</td>
<td>12</td>
<td>57.1</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>8</td>
<td>10</td>
<td>5</td>
<td>50.0</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>12</td>
<td>17</td>
<td>13</td>
<td>76.5</td>
</tr>
<tr>
<td>Asia</td>
<td>8</td>
<td>13</td>
<td>12</td>
<td>92.3</td>
</tr>
<tr>
<td>Pacific</td>
<td>2</td>
<td>11</td>
<td>4</td>
<td>36.4</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>174</td>
<td>111</td>
<td>63.8</td>
</tr>
</tbody>
</table>

*) Regions follow IRCT conventions, i.e. Europe includes Turkey and the Caucasus, Latin America includes Mexico, Middle East and North Africa includes Sudan, and Pacific includes Australia and New Zealand.

Table 2. Treatment modalities provided by rehabilitation centres for torture victims.

<table>
<thead>
<tr>
<th>Treatment modality</th>
<th>Number of centres providing</th>
<th>Per cent of centres providing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>87</td>
<td>78.4</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>81</td>
<td>73.0</td>
</tr>
<tr>
<td>Medical treatment</td>
<td>72</td>
<td>64.9</td>
</tr>
<tr>
<td>Psychiatric treatment</td>
<td>64</td>
<td>57.7</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>49</td>
<td>44.1</td>
</tr>
<tr>
<td>Other</td>
<td>47</td>
<td>42.3</td>
</tr>
<tr>
<td>Emergency food and clothing</td>
<td>40</td>
<td>36.0</td>
</tr>
<tr>
<td>Legal counselling</td>
<td>39</td>
<td>35.1</td>
</tr>
<tr>
<td>Job training</td>
<td>24</td>
<td>21.6</td>
</tr>
</tbody>
</table>
year by the 95 centres responding was 52,788 in total, indicating that an average centre provides services to 556 clients during a year (Table 3). At a certain point of time (1st September 2001), the 84 centres responding reported a total of 30,810 clients under treatment, i.e. 366 clients per centre.

Approximately two thirds of the clients were primary torture victims, while the remaining third was equally divided between secondary torture victims and other clients. Descriptions of the type of other clients attended to by the centres are provided in Fig. 1.

Due to the incompleteness and internal inconsistency of the data on client numbers, only cautious estimates can be made as to number of new clients. If the mean numbers reported above are valid, 190 new clients on average are received per centre per year. This figure, if applicable generally, implies that 33,060 new clients are attended to each year by the 174 centres in this study. This would imply that the average treatment time of all clients (primary torture victims, secondary torture victims and other clients) would be 1.9 years or 23.1 months.

The range of average treatment times may be illustrated with a few examples, where data were complete and consistent. A centre in Asia treated 2,679 new clients a year, with 18 under treatment, i.e. a treatment time of 0.0067 years = 0.08 month = 2.4 weeks, and a centre in Latin America treated 25 new clients a year, with 143 under treatment, i.e. a treatment time of 5.7 years. A European centre close to the centre, cf. Table 4. Most frequently, centres reported having received assistance from the IRCT when establishing a treatment stent. A centre in Asia treated 2,679 new clients a year, with 18 under treatment, i.e. a treatment time of 0.0067 years = 0.08 month = 2.4 weeks, and a centre in Latin America treated 25 new clients a year, with 143 under treatment, i.e. a treatment time of 5.7 years. A European centre close to the average treated 1,184 new clients and had 2,295 under treatment, yielding an average treatment time of 1.94 years = 23.3 months.

Centre support from the IRCT

Forty-three per cent of the centres that responded reported having received assistance from the IRCT when establishing the centre, cf. Table 4. Most frequently, centres reported funding support or advice (33.3%) or having participated in IRCT training in treatment methods (28.8%).

Forty-six centres (41.4%) reported that they had participated in IRCT organised training. The evaluation of the usefulness of the training according to training areas is presented in Table 5. The general impression is that the IRCT training has been useful to centres. In particular, the training in care for caregivers was positively evaluated, indicating that many staff members in the centres were under high pressure due to the work with torture and torture victims, and that the need to attend to the well-being of treatment staff was high.

In terms of future training priorities, training in monitoring and evaluation of treatment is clearly the most needed issue – approx. 60% of the centres find that such training would be helpful for their work (Table 6). Secondly, care for caregivers and medical documentation of torture are training areas of high priority.

Ninety-three centres (83.8%) had received books from the IRCT. Of these, 97.6% found them very relevant or relevant to their work. Eighty-eight centres (79.2%) receive the “Torture Journal”, and 79 centres replied as to how many people read it: Summing up this figure, a total of 698 centre staff reported reading the 79 copies of the journal.

The IRCT website (www.irct.org) had been visited by 83 centres (74.8%), most frequently looking for 26 June campaign material or news from the IRCT.

The majority of centres (88 centres, or 79.3%) were interested in further collaboration with the IRCT, while six centres were not. Close to half of the centres were interested in collaboration regarding fundraising, and 45% wanted to collaborate on public relations (Table 7).

Fig. 1. Examples of other clients, not torture victims (quotes from centres).

- Victims of war among asylum seekers and refugees.
- Victims of psychotrauma due to other reasons.
- Traumatized survivors of internal displacement.
- Victims of violence politica y familiar, desplazados, encarcelados, hijos de encarcelados, hijas de indultados, trabajadoras de ONGs, familiares desaparecidos, requisitoriados, inocentes liberados, indultados, familiares de asesinados.
- Traumatised refugees and immigrants.
- Retornados del exilio, dirigentes sociales, estudiantes, sindicales, etc. que han sido victimas de la violencia politica.
- Familiares de asesinados politicos, desaparecidos forzados, desplazamiento interno por causa de violaciones a derechos humanos e infracciones al DIH, trabajadores de organizaciones sociales y no gubernamentales y defensores de derechos humanos amenazados.
- Immigrant population – victims of torture (not exclusively).
- Personas que sufrieron exilio interno en condiciones de persecucion y amenaza permanente, durante la dictadura militar.
- Victims of State violence, rape and domestic violence.
- Comunidades.
- Bomb blast victims (incl. landmines, artillery shelling & aerial bombing), war widows and children affected by war.
- Victims of violence.
- Familiares detenidos desaparecidos.
- IDPs, refugees from Chechnya, PTS – Present Torture Survivors (persons tortured in law-enforcement structures).
- Helpers.
- Survivors of war.
- Deported.
- Victims of child abuse and domestic violence.
- Victims of human rights abuse in post-war period.
- Victims of ethnic conflicts and victims of maltreatment and degrading treatment by law-enforcement authorities.
- Survivors of war trauma.
- Refugees, integration programme.
- Indirectly refugees and asylum seekers working with health.
- Refugees and asylum seekers (most of them are victims of torture).
- Prisoners, ex-prisoners and persons (youth at risk).
- Families of torture survivors.
- Victims of other severe trauma from human rights abuses which may not constitute torture (grenades attacks, domestic violence, etc.).
- Families and refugees.
- Community.
- Foreign refugees.
- Refugees in Pakistan.
- Victimes des viols, des traitements inhumains et dégradants.
- Refugees' and immigrants' children.
- We are a refugee service within a broader traumatic stress clinic.
- Main group is survivors of violence.
- Domestic violence social cases.
- Also victims of organized violence.
- In our statistics we make no difference between primary and secondary v.o.t.
- Refugees (de-facto, asylum seekers, conventional) from different countries, who live in our house for a maximum two year-period.
- Personnes déplacées ou réfugiées victimes de violences.
- Victims of severe human rights abuses and extremely traumatised refugees.
Table 3. Number of clients that received treatment in rehabilitation centres.

<table>
<thead>
<tr>
<th>Victims type</th>
<th>Number of clients treated during 2000 N=95</th>
<th>Number of clients under treatment 1.9.2001 N=84</th>
<th>Mean number of clients during 2000</th>
<th>Mean number of clients on 1.9.2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary torture victims</td>
<td>34,678 (65.7%)</td>
<td>19,733 (64.0%)</td>
<td>365</td>
<td>234</td>
</tr>
<tr>
<td>Secondary torture victims</td>
<td>8,739 (16.6%)</td>
<td>5,519 (17.9%)</td>
<td>92</td>
<td>66</td>
</tr>
<tr>
<td>Other clients</td>
<td>9,371 (17.8%)</td>
<td>5,558 (18.0%)</td>
<td>99</td>
<td>66</td>
</tr>
<tr>
<td>Total</td>
<td>52,788</td>
<td>30,810</td>
<td>556</td>
<td>366</td>
</tr>
</tbody>
</table>

Table 4. Support from the IRCT when establishing the centre (N=111).

<table>
<thead>
<tr>
<th>Support received</th>
<th>Number of centres</th>
<th>Per cent of all centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of project proposal</td>
<td>23</td>
<td>20.7</td>
</tr>
<tr>
<td>Organisational development</td>
<td>21</td>
<td>18.9</td>
</tr>
<tr>
<td>Training in treatment</td>
<td>32</td>
<td>28.8</td>
</tr>
<tr>
<td>Funding support or advice</td>
<td>37</td>
<td>33.3</td>
</tr>
<tr>
<td>Other support</td>
<td>11</td>
<td>9.9</td>
</tr>
<tr>
<td>At least one of the above</td>
<td>48</td>
<td>43.2</td>
</tr>
<tr>
<td>None of the above</td>
<td>50</td>
<td>45.0</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Table 5. Usefulness of participation in IRCT organised training.

<table>
<thead>
<tr>
<th>Training in</th>
<th>Number of centres</th>
<th>Very useful (%)</th>
<th>Useful (%)</th>
<th>Not useful (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torture methods</td>
<td>39</td>
<td>38.5</td>
<td>59.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Physical and psychological</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sequelae of torture</td>
<td>41</td>
<td>48.9</td>
<td>51.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Physical and psychological</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>examination of torture</td>
<td>29</td>
<td>55.2</td>
<td>34.5</td>
<td>10.3</td>
</tr>
<tr>
<td>victims</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview techniques</td>
<td>29</td>
<td>37.9</td>
<td>55.2</td>
<td>6.9</td>
</tr>
<tr>
<td>Counselling</td>
<td>25</td>
<td>48.0</td>
<td>44.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Medical documentation of torture</td>
<td>30</td>
<td>43.3</td>
<td>46.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Organisation of treatment services</td>
<td>23</td>
<td>43.5</td>
<td>52.2</td>
<td>4.4</td>
</tr>
<tr>
<td>Supervision</td>
<td>17</td>
<td>41.2</td>
<td>52.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Care for caregivers</td>
<td>21</td>
<td>61.9</td>
<td>38.1</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 6. Centres' needs for training.

<table>
<thead>
<tr>
<th>Area of training</th>
<th>Number of centres</th>
<th>Per cent of all centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring and evaluation of treatment impact</td>
<td>66</td>
<td>59.5</td>
</tr>
<tr>
<td>Care for caregivers</td>
<td>51</td>
<td>46.0</td>
</tr>
<tr>
<td>Medical documentation of torture</td>
<td>51</td>
<td>46.0</td>
</tr>
<tr>
<td>Physical and psychological examination of torture victims</td>
<td>47</td>
<td>42.3</td>
</tr>
<tr>
<td>Treatment of children</td>
<td>46</td>
<td>41.4</td>
</tr>
<tr>
<td>Interview techniques</td>
<td>46</td>
<td>41.4</td>
</tr>
<tr>
<td>Counselling</td>
<td>45</td>
<td>40.5</td>
</tr>
<tr>
<td>Needs assessments</td>
<td>42</td>
<td>37.8</td>
</tr>
<tr>
<td>Physical and psychological sequelae of torture</td>
<td>41</td>
<td>36.9</td>
</tr>
<tr>
<td>Supervision</td>
<td>39</td>
<td>35.1</td>
</tr>
<tr>
<td>Organisation of treatment services</td>
<td>32</td>
<td>28.8</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>31</td>
<td>27.9</td>
</tr>
<tr>
<td>Physical and psychological tortu re methods</td>
<td>30</td>
<td>27.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Table 7. Centres’ interest in further collaboration with the IRCT.

<table>
<thead>
<tr>
<th>Collaboration regarding</th>
<th>Number of centres</th>
<th>Per cent of all centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested in further collaboration</td>
<td>88</td>
<td>79.3</td>
</tr>
<tr>
<td>Fundraising</td>
<td>53</td>
<td>47.7</td>
</tr>
<tr>
<td>Public relations</td>
<td>50</td>
<td>45.0</td>
</tr>
<tr>
<td>Monitoring and evaluation of</td>
<td>43</td>
<td>38.7</td>
</tr>
<tr>
<td>torture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation of project proposal</td>
<td>36</td>
<td>32.4</td>
</tr>
<tr>
<td>Project management</td>
<td>30</td>
<td>27.0</td>
</tr>
<tr>
<td>Human resource management</td>
<td>27</td>
<td>24.3</td>
</tr>
<tr>
<td>Local networking</td>
<td>26</td>
<td>23.4</td>
</tr>
<tr>
<td>Budget and financial management</td>
<td>24</td>
<td>21.6</td>
</tr>
<tr>
<td>Report writing</td>
<td>23</td>
<td>20.7</td>
</tr>
<tr>
<td>Development of security</td>
<td>19</td>
<td>17.1</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>15.3</td>
</tr>
<tr>
<td>Not interested in further collaboration</td>
<td>6</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Discussion

The response rate of the present survey may reflect centres' feeling of affiliation with the IRCT. A review of the non-responding centres reveals a predominance of centres that historically have had only little collaboration with the IRCT and thus may have reservations in providing sensitive information to the IRCT. The overall approach and capacity of the non-responding centres does not seem to differ markedly from that of responding centres (see description at www.irct.org) and does not indicate a bias in the estimates of average treatment capacity.

The 111 respondents out of the 174 centres approached are likely to be those that had received the most support from the IRCT. Thus, several centres that did not reply indicated that the questionnaire was not relevant since they did not receive support from the IRCT. However, also centres, which have had only very extensive collaboration with the IRCT, decided to reply.

Most of the specialised rehabilitation centres for torture victims are non-governmental organisations, operating outside the public health care system in their countries. This is often a necessity to demonstrate trustworthiness to survivors of torture, who often distrust governmental institutions for good reasons. It is assumed, however, that a number of torture victims are treated in general public or private health care systems worldwide. The capacity of this non-specialised treatment is unknown.

The 174 centres registered with the IRCT at the time of the data collection most likely represent the majority of the specialised centres for the rehabilitation of torture victims. However, there may be specialised treatment centres that have not registered with the IRCT – a cautious estimate may be 25 – which would add to the global specialised treatment capacity. Assuming that 200 centres each treat 300 vic-
tims of torture (primary and secondary) a year, the global number of torture victims that receives treatment each year can roughly be estimated at 100,000. Depending on the average treatment time, the yearly capacity might be less.

At this point, available data only allow for a very rough estimation of the global need for specialised treatment. According to UNHCR,9 more than 20 million refugees currently fall under the UNHCR mandate, and half a million people flee their home each year. Different studies assess that 20-30% of refugees are primary torture victims.10 Thus, the point prevalence of refugee torture victims globally may conservatively be estimated at 3-5 million. To this figure should be added the number of torture victims that did not flee the torture.

Even if the general experience from centres indicates a huge under-capacity, particularly in the developing countries, reliable estimates of the incidence and prevalence of torture victims globally and of the proportion of torture victims that need and request specialised treatment are lacking. This poses important challenges for future research on the national and the international level.

It is remarkable that approximately half of the specialised rehabilitation centres globally was initiated with the support of the IRCT. This shows that one of the most important functions of the IRCT is to provide support to new centres. It is also noteworthy that such centres – in spite of difficulties relating to security and lack of funding – remain sustainable over time.

The evaluation of IRCT training support generally reveals that training has been useful to the work of centres. The need that is expressed for future training indicates that a systematic evaluation of the impact of treatment is important. This may be seen as a process of maturation of the global movement of centres, where systematic methods and assessment of the quality of the treatment work is now on the agenda.

The interest in further collaboration with the IRCT was encouraging, even considering the possible positive bias among responding centres. The vast majority of centres were interested in expanding the collaboration. The most pertinent issue is fundraising, which is a definite challenge to the whole movement of centres. Thus, the present efforts of the IRCT to create sustainability in the international network of centres by training in fundraising skills seem to match the needs of many centres.

References
Research in emergency situations

Ole Vedel Rasmussen, MD, DMSc

During the civil war in the former Yugoslavia, the country was split. From the beginning of 1998, the Serbian police, military and paramilitary forces forced nearly one million inhabitants from Kosovo to flee and seek refuge in the neighbouring countries. A large proportion of these refugees, the so-called Kosovo-Albanians, took refuge in Albania due to their close ethnic and cultural relationship to the country.

The refugees arriving in Albania were in a desperate situation, suffering from the consequences of torture, ill treatment, missing family members, and loss of their possessions. Therefore, in the Albanian capital, Tirana, a rehabilitation centre for torture victims was set up, as a part of the IRCT network, in order to help the refugees. The rehabilitation centre also collaborated closely with the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, Denmark.

The Albanian Centre for Rehabilitation of Trauma and Torture Victims (ARCT) began to provide health care services to the many refugees in Tirana. They created a team of 17 medical doctors and a psychosocial team of five nurses and a number of students of medicine and psychology, all of Kosovo origin and most of them refugees themselves.

At the beginning of April 1999, the IRCT and RCT conducted a mission to Tirana to assess the needs and possibilities for providing psychological first aid training to the health team working in the refugee camps. The mission identified an obvious need for immediate psychological assistance to traumatised refugees and for training of health professional and psychosocial teams.

As a result of these findings, one month later the IRCT conducted a new mission to Tirana in collaboration with two psychiatrists from the MRCT, the Medical Rehabilitation Centre for Torture Victims in Athens, Greece.

A three-day workshop on psychological first aid to traumatised refugees was organised for 24 health professionals. The training included theoretical presentations, group work and interviews of refugees (one for demonstration carried out by a trainer, and one for training, carried out by a trainee) to illustrate the theoretical issues in practice. These interviews took place in the refugee camp, and they were videotaped for training purposes.

The theoretical lectures comprised psychological reactions to trauma and disaster, diagnostic approaches, and crisis intervention. Emphasis was given to appropriate interview principles ("active listening"). The lectures were supported by a 14-page manual, which was translated into Albanian.

A proposed session on documentation of trauma and mental health problems was accepted with enthusiasm, and a small research group was founded to pilot-test and implement the draft data collection form.

The motivation for this work was that the world should know about what happened. However, the form was also useful for screening refugees to identify their medical and psychosocial needs as a part of the daily contact with the refugees.

The medical team did not, however, include a pilot study in order to finalise the data collection form. The draft questionnaire was translated into Albanian, and the four medical students began implementing interviews.

The randomisation process of the study was planned to be carried out by putting the given number of tents in the refugee camp into a hat. Each interviewer should then pick up a number and continue until 50 interviews had been performed. However, when we received all the questionnaires, it was clear that some of the interviews had not been randomised. This deviation from a well-planned study was due to the students not appreciating in full the importance of a random sampling and to the lack of an adequate medical supervision of the project.

The written informed consent allowed for future contact to the interviewees in order to ask about health problems. The objective was to contact the study population at a later stage, after they had returned to Kosovo. It was anticipated that the process of repatriation would require psychosocial aid in order to reduce the associated trauma.

In July 1999, the IRCT visited Tirana in Albania and Pristina in Kosovo. The repatriation had already begun.

In September 1999, with support from the European Commission Humanitarian Aid Office (ECHO), the Kosovo Rehabilitation Centre for Torture Victims (KRCT) was established. The medical team mainly consists of the health professionals who had worked in Tirana.

Today, the centre does not have the resources to make the needed contact and follow-up interviews as intended from the beginning of the study.

Concluding remarks

Research in emergency situations is a very difficult task and is best done if there is a detailed plan before the emergency arises. Ethical problems have first priority. The present study shows that, in spite of the methodological shortages, research can be done in extreme and acute circumstances. In other words, the study shows what can be done in situations where well-planned study conditions are non-existent and the resources are reduced to what can be identified on an ad hoc basis.

However, the study also demonstrated that these problems were solved by the highly motivated interviewing team. Research of this kind can give us more knowledge on sequelae of torture and traumatisation and thereby help us to identify the best treatment approaches.
Survey on frequency of types of trauma, and prevalence of PTSD symptomatology among Kosovo Albanian refugees, in the Tirana area refugee camps, in Albania, June 1999

Klement Dymi, MD, Ole Vede Rasmussen, MD, DMSc, Jens Modvig, MD, PhD, Feride Rushiti, MD, Merita Emini, MD, Florina Myftari, MD, Ylber Rushiti, Student & Besnik Isaku, Psychologist
Introduction
In February 1998, the conflict in Kosovo reached its peak as Serbian police forces, army and paramilitary Serbian groups started a large scale operation against ethnic Albanians, shelling Albanian villages, burning homes and killing hundreds of ethnic Albanians, and forcing thousands to leave their homes in Kosovo, and move to where they could find shelter with relatives. Thousands of others were compelled to hide in the hills and forests. NATO operations began against Serbia on March 24, 1999. Many thousands of people had already been displaced within Kosovo and to other countries. It is estimated that more than 800,000 people became refugees in neighbouring countries (mainly Albania), as well as secondary countries of asylum in Europe, the United States, and elsewhere. The war ended on June 10, 1999, and Kosovo Albanian refugees began to return to Kosovo. On their return, they had to face the desperate situation of destruction of their homes and property, and the fresh memories of trauma and loss. The effects of missing family members, the traumatic experiences of violence, rape, and persecution of an entire population, have since been an important psychological impact that the refugees have also to cope with and need assistance with.

There are many studies on types of trauma and Post Traumatic Stress Disorder (PTSD) in post-conflict situations. In the case of the Kosovo war, there have been several publications\(^1\)\(^-\)\(^3\) which have focused on issues related to mortality, types of human rights abuses, PTSD levels, feelings of revenge, mental health issues, etc. PTSD levels in postwar traumatised refugee groups range, in general, from 10% to 92%, and in particular in the case of the recent ethnic cleansing Balkan wars the PTSD levels ranged from 46% to 65% among Bosnian refugees.\(^6\) The International Rehabilitation Council for Torture Victims (IRCT) in May 1999 undertook a programme of acute intervention to assist the Kosovo Albanian refugees.

A training programme for health professionals from Kosovo was implemented in Tirana in Albania. In addition a questionnaire survey was implemented, aimed to assess the magnitude of the large scale trauma and human rights abuses caused by the mass violence on Kosovo Albanians forced to leave homes and flee to neighbouring countries, and the impact on their psychological condition afterwards, assessed by interviewing refugees living in refugee camps in Albania (in May-June 1999). This effort also aimed to assess the need of aid provision, and to contribute to the prevention of the major problems related to recovery and mental health by examining the consequences of massive traumatic experiences.

Methods
The study was designed as a cross sectional study, and was carried out by interviewing a sample of the Kosovo refugees in Albania, filling in questionnaires containing 130 specific questions, and categorized in 5 sections: 1) the part for the family, 2) the part for the individual, 3) the objective examination, 4) PTSD assessment, and 5) data on children under 15 years. The interviews and the filling in of the questionnaires were conducted by Kosovo-Albanian students of medicine and psychology. Informed consent of all the participants in the survey was obtained. Those who did not want to participate were equally offered the medical services provided by the medical team. In certain cases, the very difficult situation in the field has affected the procedure of implementing the random sampling selection of participants. Randomisation was done by writing the tent numbers on pieces of paper, pooling them together, and then picking out those that would be selected. For various reasons, however, a number of other tents were included. The survey was conducted in Albania in the refugee camps in Tirana and other well guarded locations, and there were no security problems or obstacles to the realization of the survey. The questions included in the questionnaire aimed at assessing the trauma suffered before the arrival to Albania, and the present health complaints at the time of the interview. Respondents were asked about: missing family members, trauma history before and during escape, physical and mental health problems at the time of the interview, the needs for medical care, the medical care/treatment eventually received after arrival to Albania, and an assessment of the mental state, including evaluation of PTSD. PTSD symptomatology was evaluated using the Harvard trauma questionnaire symptoms checklist, and was considered positive over a threshold that was set at 2.5 points per question or a total of 37.5 points. During analysis, the questionnaire data were entered using EpiData 1.13 and were analyzed using the Statistical Analysis System (SAS).

Material
The survey included refugees that had come from Kosovo and were located in 182 tents and 26 other temporary facilities in refugee camps in the Tirana area, in Albania. The data was collected from 72 Kosovo-Albanian refugee families (with a total of 480 members) by interviewing 158 individuals, over 14 years old (one or more from each of the 72 families). Out of those selected for inclusion into the survey, 20 persons refused to participate. The reasons for refusing to participate were not recorded, but in a few cases the interviewers have recorded comments that the person refusing to be interviewed “was too upset emotionally to talk about his/her traumatic experiences”. The questionnaires were designed so that a distinction between individuals and families was made, in view of the pattern of events, as known at that time, where a part of the traumatic experiences was perceived and lived through by the family as a whole, and another part was related only to individuals. The data collected on children under 15 years was incomplete and was excluded from the analysis.

Results
Exposure to traumatic violence
ON THE FAMILY LEVEL
An outline of exposures to traumatic violence, on the family, and the individual level, is presented in Table 1. Most families had been compelled to leave their homes. 27 (38%) families left their homes because their villages were being gnedaded and fired at. 16 (22%) families left their homes because of Serb police or military and paramilitary groups threatened to kill them if they didn’t leave within minutes. 12 (17%) families left their homes because Serb police or military and paramilitary groups evicted them bodily from their houses. 14 (19%) families left their homes because of the fear and insecurity of their lives. Three (4%) families left their homes because their villages were surrounded by tanks and Serb military, and they were afraid of being shot. 41 (57%) families had their property destroyed and in most cases were robbed of all their valuables, their money and jewelry. 36 (50%) families saw the burning of their own houses; 14 (19%) families had witnessed the sackings of their own house. 28 (39%) families were assaulted (fired at, beaten, robbed) by Serb soldiers, even during leaving their homes and while on the road, walking in the column of refugees. 38 (53%) families had already experienced organized vio-
TORTURE Supplementum No. 2, 2003

Table 1. Frequency of types of trauma reported by respondents of KRS.

<table>
<thead>
<tr>
<th>Families (n=72)</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families that had members/relatives missing</td>
<td>61</td>
<td>84.7</td>
</tr>
<tr>
<td>Number of missing persons</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>Number of murdered persons</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Organised violence before the bombings began</td>
<td>38</td>
<td>52.8</td>
</tr>
<tr>
<td>Organised violence after the bombings</td>
<td>50</td>
<td>69.4</td>
</tr>
<tr>
<td>Insults</td>
<td>40</td>
<td>55.5</td>
</tr>
<tr>
<td>Physical assaults</td>
<td>29</td>
<td>40.3</td>
</tr>
<tr>
<td>Murders of family members</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Threats</td>
<td>34</td>
<td>47.2</td>
</tr>
<tr>
<td>Violation of property (including burning of the house, material damage/loss, etc.)</td>
<td>41</td>
<td>56.9</td>
</tr>
<tr>
<td>Families that were forcibly expelled from their homes</td>
<td>55</td>
<td>76.4</td>
</tr>
<tr>
<td>Families that left their homes because of fear for their lives</td>
<td>17</td>
<td>23.6</td>
</tr>
<tr>
<td>Families assaulted when leaving their house</td>
<td>28</td>
<td>38.9</td>
</tr>
<tr>
<td>Families witnessing murders</td>
<td>13</td>
<td>18.1</td>
</tr>
<tr>
<td>Families that had been (and/or witnessed) sacked/looted</td>
<td>44</td>
<td>61.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family members individually (of age 15 and over) (n=158)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous traumatic experiences (before the bombings): Insults</td>
</tr>
<tr>
<td>After the beginning of bombings: Eye witness of organised violence</td>
</tr>
<tr>
<td>Physical assaults</td>
</tr>
<tr>
<td>Mental pressure</td>
</tr>
<tr>
<td>Individual traumatic experiences during the interval: Expulsion from homes until reaching safe refuge</td>
</tr>
<tr>
<td>Individuals reporting missing members of close family</td>
</tr>
</tbody>
</table>

lence before leaving their homes the last time (before the bombings began).

38 (53%) families reported missing members, and four (6%) families reported having members murdered by Serbs. On average, families had been travelling for five days, or out on the roads, after being forced to leave their homes, and until arriving to the refugee camp. 40 (56%) families had experienced insults, and 29 (40%) families had experienced assaults. 34 (47%) families had experienced various threats from state officials (police, soldiers) and paramilitary groups. 32 (44%) families were threatened to be killed. 68 (94%) families reported who their aggressors were. 23 (32%) families reported that their aggressors were the Serb police, the Serb army and the Serb paramilitary groups, acting together. 15 (21%) families reported that their aggressors were the Serb police and the Serb paramilitary groups, acting together. The remaining families reported that their aggressors were different combinations of the above mentioned.

ON THE INDIVIDUAL LEVEL

26 (16%) respondents reported that they had had previous traumatic experiences (before the beginning of bombings). These experiences included: their village being attacked by grenades, the burning of the houses, having had to run away several times from their village because of grenade shelling attacks, murders of family members, being beaten by the police or witnessing beatings of family members, arrests, maltreatment and being robbed of personal documents by the police, searching of the house by police, being compelled to leave their house, separated from the families and moved to other parts of Kosovo, being compelled to stay inside the house from fear of being shot by snipers, and being forced to live in a state of continuous fear. 22 (14%) respondents reported they had been directly threatened they would be killed. 19 (12%) respondents reported the Serb police had searched their houses for arms, insulting and threatening them during the search. Seven (4%) respondents reported they had been beaten.

• Missing family members

12 (23%) of the married female respondents reported that their husbands were missing, and six (14%) of the married male respondents reported missing wives. Missing of the father or mother was reported by 41 (26%) respondents; the missing of children, and sons and daughters by 25 respondents (37% of the 44 respondents who were parents); the missing of brothers and sisters by 68 (43%) respondents. Also 90 (37%) respondents reported missing other relatives (uncles, cousins etc.).

• Witnessing organized violence

39 (25%) respondents reported direct exposure to armed military attacks – they saw the houses of their village put to flames, attacks by grenades, shellings by tanks, the shootings of snipers. Ten (6%) saw attacks of soldiers on targets burned or killed, saw family members being killed in front of their eyes, saw the killing of neighbours, or other persons, being taken and executed, then burned, or people killed by shellings, or shot. 11 (7%) respondents reported they saw people being killed or shot. Seven (4%) saw family member(s) being beaten, threatened to be killed, robbed of documents, etc. 29 (18%) respondents had witnessed the beating of neighbours or other people with gun butts, by the police. 34 (22%) respondents reported they saw soldiers pull out of the walking column whomever they pleased and beat them. One (0.6%) respondent reported she saw the police take apart three females to rape them. Ten (6%) respondents reported witnessing the burning of their own house. 14 (9%) respondents reported sacking.

• Mental pressure

20 (13%) respondents had been told that they would be killed. One (0.6%) respondent had been told that they would dress him in Kosovo Liberation Army (KLA) uniform and then kill him. Three (2%) respondents were threatened they would be killed if they wouldn't give information to the soldiers. Six (4%) respondents were threatened with killing of their family members. One (0.6%) respondent reported she had been threatened to be forced to cut the throats of her own children with a sword. Ten (6%) respondents reported they dared not go out of the house (even to buy cigarettes) because the soldiers would fire at them. Three (2%) respondents were humiliated by political chauvinistic remarks.

Ten (6%) respondents reported they had been living in terror, every minute afraid of a knock on the door. One (0.6%) respondent reported his family had been forced by soldiers to leave their house, but then when out were ordered to return inside, then later in the same day were ordered to leave again. One (0.6%) respondent reported that when her husband and other men were taken away, a Serb woman had threatened that the soldiers would also take the women. Six (4%) respondents reported they had been made to listen to terrible and saddening voices/sounds from synchronized recording devices.

• Various traumatic experiences

Various individual traumatic experiences during the interval between the moment they were forced to leave their homes and until they crossed the border to Albania included a wide range – from personally escaping death by providence, even
after being shot and burned – to seeing fellow refugees dying from exhaustion on the road or going insane, etc. One respondent (0.6%) referred to rapes. Three (2%) respondents reported they had been in fear of being raped, all the way, because of being escorted by Serb soldiers. 39 (25%) respondents reported witnessing acts of violence that constitute torture. Three (2%) respondents had seen soldiers beating an old woman to death. Two (1%) respondents had seen Serb soldiers scratching the forehead of Kosovo refugees with a knife: “UCK” (KLA). One (0.6%) respondent reported that a man was beaten in front of many people, to frighten them. One (0.6%) respondent saw her son beaten by the police. One (0.6%) respondent saw village men shot in front of him, and others beaten to the ground and stepped over by cavalry. 12 (8%) respondents had seen neighbours or others being beaten with gun butts by the police. 11 (7%) respondents had seen an old woman being beaten. One (0.6%) respondent had seen soldiers beating an old woman to death. Two (1.0%) respondents had seen soldiers beating a young man with a gun butt. One (0.6%) respondent saw villagers shot in front of him, and others beaten to the ground and stepped over by cavalry. 12 (8%) respondents had seen neighbours or others being beaten with gun butts by the police. 11 (7%) respondents had seen an old woman to death. Two (1.0%) respondents had seen soldiers beating an old woman to death. One (0.6%) respondent had seen a child being beaten. One (0.6%) respondent had seen soldiers beating an old woman to death. Two (1.0%) respondents had seen soldiers beating a young man with a gun butt. One (0.6%) respondent saw villagers shot in front of him, and others beaten to the ground and stepped over by cavalry. 11 (7%) respondents had seen an old woman to death. One (0.6%) respondent had seen a child being beaten. One (0.6%) respondent had seen soldiers beating an old woman to death. Two (1.0%) respondents had seen soldiers beating a young man with a gun butt.

Table 2. Respondents who had been tortured – by type and description of torture, and gender (n = 158).

<table>
<thead>
<tr>
<th>Type of torture</th>
<th>Description of torture</th>
<th>Number of respondents who had been tortured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>males</td>
</tr>
<tr>
<td>Physical torture</td>
<td>Beating on the head and body with fists,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>truncheons, gun-butts, sticks</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Suffocation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Beaten in prison</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>14</td>
</tr>
<tr>
<td>Mental torture</td>
<td>Personally threatened to be killed</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Personally threatened to be killed and then</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>burned</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Made to listen to recorded terrible voices/</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>noises and lights</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Threatened to be forced to kill her own</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>19</td>
</tr>
<tr>
<td>Both physical and mental</td>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

Discussion
Randomisation was not done under ideal conditions and may have affected the validity of the findings in this study. The selection of refugee families to be included in the survey was done by writing all the tent numbers of the refugee camp (as a rule one tent was occupied by one family) on pieces of paper and pooling them together, and then randomly picking out those that would be selected. For various reasons, however, a number of other tents were included.

A possible source of bias could be the fact that the interviewers were themselves Kosovo Albanians and this may have influenced the choice of words when filling in the answers given by the respondents, the latter used synonyms or several
Table 3. Respondents who were in need of physical treatment/cures (n=158).

<table>
<thead>
<tr>
<th>In need of physical treatment/cures</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiopulmonary</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Neurologic</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Muscle-skeletal</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Need examination by a specialist</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>3.8</td>
</tr>
<tr>
<td>Need check-up by a physician</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>7.6</td>
</tr>
<tr>
<td>Need to cure various conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or to continue/maintain the therapy started previously</td>
<td>5</td>
<td>5</td>
<td>10</td>
<td>6.3</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>24</td>
<td>38</td>
<td>24.0</td>
</tr>
</tbody>
</table>

Table 4. Respondents with positive PTSD scores – by age-group and gender (n=158).

<table>
<thead>
<tr>
<th>Age-group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>2</td>
<td>20.0</td>
<td>13</td>
<td>59.1</td>
</tr>
<tr>
<td>21-30</td>
<td>6</td>
<td>40.0</td>
<td>17</td>
<td>73.9</td>
</tr>
<tr>
<td>31-40</td>
<td>4</td>
<td>57.1</td>
<td>9</td>
<td>56.2</td>
</tr>
<tr>
<td>41-50</td>
<td>1</td>
<td>6.7</td>
<td>11</td>
<td>64.7</td>
</tr>
<tr>
<td>51-60</td>
<td>4</td>
<td>36.4</td>
<td>8</td>
<td>72.7</td>
</tr>
<tr>
<td>61-70</td>
<td>2</td>
<td>33.3</td>
<td>1</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>29.7</td>
<td>59</td>
<td>62.8</td>
</tr>
</tbody>
</table>

Table 5. Respondents who had been tortured, and with PTSD symptomatology (n=158).

Respondents who had been tortured 24 (15.19%)

Respondents who had been tortured and with PTSD positive score 15 (9.5%)

Table 6. Description of the mental state of respondents (n=158).

<table>
<thead>
<tr>
<th>Signs used to describe the mental state of respondents</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worried/upset</td>
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Additional remarks or clarifications to answer the open-ended questions; or the fact that interviews were made in the tents where no privacy was possible and respondents might have been influenced by answers given by other family members interviewed in the same tent.

The respondents had been subject to various types of violence. The majority had been exposed to police and military attacks, and almost all had been forcefully compelled to leave their homes, in many cases under threats of murder at gunpoint, or brutally ordered by Serb state-representing officials, to abandon their houses within minutes. Many refugees had been exposed to the loss of relatives, a number of them had witnessed murders of family members, relatives or of other persons; many had been beaten, threatened and insulted. Some had suffered direct injury and loss of a limb during shelling attacks by the Serb military, and many had their health impaired. One of the major forms of exposure to organized violence was the witnessing of the burning of their house and destruction of all their material property, as well as sackings and robbery of their money, personal jewelry and their cars. This was done systematically, in a massive way and affected almost all the respondents. The data obtained from this survey are similar with those of other studies on the matter.1,2

The reported missing of close relatives, except for those living in the same household and who were supposed to be together at the time of the interview, may rather be considered as an indication of interrupted contacts – depending on how the term of “missing” is defined.

The almost complete silence of the respondents on the rapes or other sexual abuse (only one respondent referred to rapes) may be explained by the cultural taboo of not to disclose what is perceived as shameful disgraces, especially when the disclosure may not happen in total privacy. Similar data are found in other studies.1

The health problems indicated by the interviewed refugees comprised both previously existing, as well as, present health problems. It should be noted that when answering the questionnaire items which required the interviewer to make an assessment of the mental state of the respondent 96 of the respondents had been noted by the interviewers to have one or more of the reference signs. The interviewers might have encountered some difficulty in the assessment of the respondent’s mental status by using the set of signs mentioned above, as some of the figures seem to be rather high, (like for instance, there were 16 (10%) “yes” answers to “hallucinations”, most of which (12) were diagnosed by one of the interviewers) which may reflect the insufficient professional knowledge of the interviewers on the subject. The difficulties related to this part are reflected also by the fact that the whole section on the objective examination was left blank in 15 of the questionnaires.
In view of the long standing conflict in Kosovo even before the last crisis and war, and the continuous pressure reflected in many ways on children’s health, there is a great need to assess the trauma and psychosocial recovery problems for the Kosovo refugee children, which is more difficult and requires qualified resources with proper knowledge in child psychology etc. This survey has lacked such means but this element could be introduced and strengthened in eventual further interventions which might follow up aiming to prevent mental stress and damage.

In cases of such large scale humanitarian crises, attention should be paid to the prevalence of torture and extreme trauma, and to the rehabilitation needs of victims. Having the opportunity to process the mental consequences of traumatic experiences, and to perceive their history in a balanced way, may help survivors to realize social reconstruction. Previous studies on patients with PTSD have found a doubling of the average time needed to achieve significant remission of symptoms if treatment is not provided early in the emergency phase of a post-conflict situation. The data obtained by this survey show that half (49.4%) of the respondents above 14 years of age had PTSD symptomatology, and one in every four (24.7%) had suffered at least one form of torture. The forms of torture used, as well as the physical evidence observed during the physical examination of the respective respondents, were similar to those described in other studies. Among those tortured, a high proportion (82.1%) reported mental torture. This figure is similar to those found by other authors. While most of the tortured respondents were males, most of the respondents with PTSD symptomatology were females (more than half of all the female respondents between 15 and 40 years old).

The finding that female respondents of the age group 15-30 years had the highest positive PTSD scores, might be related to the additional fear of rape they had had to go through.

The fact that no association between PTSD symptomatology and torture was found (p > 0.1), might be explained by a tendency of the male respondents (who constituted the majority of those who had undergone torture), not to talk about their emotional problems.

The word “symptomatology” has been added to the term PTSD in recognition of the fact that its diagnosis, under the circumstances, has not been made in accordance with all the criteria of the DSM-IV, 1994. One of the criteria, point E, being that: “the duration of the disturbance (symptoms in criteria B, C and D) is more than one month”.

Conclusions

The information obtained by the survey strongly reveals extensive and deep consequences suffered by the refugees and contributes to confirm the pressing need for initiating as soon as possible further assessment of the present and future public health needs in Kosovo, and planning and implementing treatment/rehabilitation programmes.

References

2. Cardozo BL et al. Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. JAMA 2000:284:569-77.
The effects of social and legal circumstances on the psychotherapeutic treatment of torture survivors (1)

Ferdinand Haenel, MD, Psychiatrist and Psychotherapist
Introduction
The Treatment Centre for Torture Victims Berlin (BZFO) was founded in 1992. The BZFO provides outpatient medical and psychotherapeutic treatment and psychosocial aid for people who have been persecuted and tortured in their countries of origin and suffer from the physical and mental sequelae of torture and civil war. The Centre is organized as an outpatient centre in which the different disciplines—general practitioners and psychiatrists, psychotherapists, social workers and physiotherapists—work together. The services provided include psychosocial support, medical and psychiatric/psychological diagnosis and therapy, and psychological or medico-legal assessment reports. These reports are mainly for submission to the Administrative Courts in support of clients' appeals against the rejection of their asylum applications, or for appeals under the “SED – Unrechtsbereinigungsgesetz” (2) lodged at social courts by persons having suffered political persecution in the former German Democratic Republic (GDR).1,2

The patients come from different countries and cultures. One main patients group are the Kurds, most of whom came from Turkey, and the Bosnians followed by refugees from the countries in the Near and Middle East. Politically persecuted persons from the former GDR constitute another large group. As a rule our patients have experienced traumatization, in some cases even multiple traumatic events, over a prolonged period, that is, the effect has become cumulative. The range of pathological mental sequelae of torture experienced by our patients is thus by no means limited to the diagnostic categories of Post-Traumatic Stress Disorder (F43.1) and Enduring Personality Change after Catastrophic Experience (F62.0) listed in the ICD-10. We also observe severe depression, somatization and dissociative disorders and also, in a few isolated cases, paranoid (hallucinatory) schizophrenia following torture and experiences of civil war. While the administration of neuroleptic drugs is necessary for the treatment of the latter disorders and some patients with pronounced depressive symptoms require antidepressant medication, the therapeutic services offered by the Centre focus mainly on individual and group psychotherapy, usually with the aid of interpreters.3 The range of psychotherapeutic methods employed at the Centre includes breathing therapy, Gestalt therapy, psychodrama, systemic family therapy and psychodynamic psychotherapy, and also Concentrative Movement Therapy (CMT) and art and creative therapy, music therapy, child and adolescent psychotherapy.4

The theory of psychotherapeutic treatment of victims of torture
Viewed from the standpoint of object relations theory, psycho-reactive post-traumatic symptoms can be seen as resulting from the instillation of a traumatic introjection5 which, since it is incompatible with previous subject and object representations, acts like a psychic foreign body6 in ego consciousness. The traumatic introjection consists of situations, involved persons and, above all, the experience of powerlessness, being at the mercy of a tormentor, massive assaults on self-esteem and humiliations, and is cathexed with a large amount of psychic energy, so that all previously internalized object and subject representations pale in comparison and are invalidated.

Part of psychotherapy with victims of torture consists in re-discovering old resources or developing new resources to bolster the patient's ego strength, thus supporting him or her in the struggle against the dominance of the traumatic introjection. It also includes providing patients with an opportunity to express in the therapeutic setting in words, feelings, body posture, movement, sensations and also with creative media what they have experienced and suffered and not yet been able to communicate to others. If the therapist is able to understand and empathize sufficiently, he or she then reflects this back with reduced intensity and to an extent that the client is able to tolerate. This is the core or basic process and is repeated many times over the course of the therapy. At the end of the therapy, the old, dominating traumatic introjection is replaced by a modified introjection of which the psychodynamic, symptom-generating grip and restricting effect on the survivor's daily life is attenuated. This new introjection can be integrated into the internal representations of world and self in the patient's ego consciousness and thus becomes controllable.7 The wish that many patients express at their intake interviews that their memories of the trauma and the associated symptoms could be simply erased like files on a computer, can, of course, not be fulfilled. The realistic goal of psychotherapy with a torture survivor is to reduce the dominance of the traumatic introjection and its associated symptom-generating psychodynamics during the course of therapy to a point where patients are able to control their memories of their traumas in their daily lives, and are once more able to experience joy in living and turn their attention to planning their futures.

The practice of psychotherapeutic treatment of victims of torture
Physical and psychological traumatization arising from political, ethnic or religious persecution is usually not attributable to a single, discrete event such as, for example, a road accident or criminal attack, but as a rule results from several events or episodes in the survivor's history which were spread over several years. These can have sequels that cast a shadow over the survivor's entire later life.

Survivors of persecution and war atrocities not only suffer from reactive, post-traumatic phenomena of varying degrees of severity, but are also exposed to the effects of the changes in their internal environments resulting from uprooting and migration. They may also have been separated from their families and lost the social roles, property and possessions they had in their countries of origin. They are therefore in the position of having to adapt to the norms, values and language of a different culture in their host countries. An enormous adjustment is thus required of them, in addition to having to cope with post-traumatic symptoms. Events that occur in this context can be experienced as further traumatic situations with a cumulative effect, similar to the "sequential traumatization" that Hans Keilson observed in the Jewish children who survived the German National Socialist occupation and persecution in Holland during the Second World War.8

The rule of abstinence, which requires that substitute needs that arise during the therapeutic process should not be gratified by the therapist, is one of the important cornerstones of psychotherapy. It is intended to enable patients to become conscious of their real needs and wishes, to accept them and satisfy them independently, maturely and responsibly in accordance with their actual means. However, refugees who consult the BZFO usually come with a host of social and legal problems, at least some of which need to be solved before we can even begin to think of attempting trauma-focused psychotherapy. They include:

a. having no residence permit
b. restricted freedom of movement
c. reduced rate of the monthly social security payments
d. restricted access to medical treatment  

c. Social security benefits  

Social security benefits for asylum seekers are governed by the “Asylbewerberleistungsgesetz” (4). Since this law was amended in 1997, the monthly social security payments for asylum seekers are reduced for the first three years after they arrive in this country. Most of the benefit is paid in the form of goods vouchers. In 1997 in Berlin these vouchers could originally only be exchanged at two supermarkets specially set up for the purpose, which meant that refugees were forced to travel long distances and wait in queues in front of the two shops for long periods of time, after which they were often confronted with empty shelves when they were finally able to enter the shop.

CASE REPORT 2  

Mr. A., an asylum seeker from Romania who had already been waiting for six years, together with his wife and their two-year-old son, for his court case to be heard by the Berlin Administrative Court, had been arrested and tortured by members of the security police in Romania in connection with the December demonstrations in Timisoara. As a result of a craniocerebral trauma he sustained during torture he now suffers from severe depression with a low drive, post-concussional syndrome, post-traumatic stress syndrome, and incomplete, right-sided motor hemiparesis. Despite repeated requests by our Centre with reference to his disorders and the resulting substantial restrictions he suffered in his daily life, the “zentrale Leistungsstelle für Asylbewerber im Landes­einwohneramt Berlin” (5) is not willing to make an exception to this rule for Mr. A. and his family.

CASE REPORT 3  

Mr. K., a 45-year-old Kurd from south-east Anatolia, was suffering from atrophy of the liver with chronic hepatitis, which he had, like many others in the same situation, probably contracted while he was imprisoned for several years in Turkish prisons. After his last stay in hospital his doctors had estimated that he had only a few more months to live. Despite this poor prognosis, the Berlin local authority continued to refuse to increase his benefits to allow him to pay for a special diet. However, six weeks later the same office did consent to pay his widow, who was in the advanced stages of pregnancy, and her five children their monthly social security benefit in cash rather than in vouchers.

d. Restricted medical care  

Since the Law on Benefits for Asylum Seekers was amended in 1997 many asylum seekers no longer receive so-called “U vouchers” for payment in accordance with the German Federal Law on Social Welfare, but “A vouchers” for medical treatment, on which the following restrictions are printed: “Benefits paid on the basis of Section 4, Para. 1 of the Law on Benefits for Asylum Seekers are issued solely for the treatment of acute illnesses and pain conditions. In accordance with Section 6 of this law other benefits can be paid particularly when they are essential for safeguarding health in the individual case.”

CASE REPORT 4  

Two brothers from Nusaybin in south-east Anatolia presented at our Centre. Both of them had below-knee prostheses as a result of injuries sustained during a grenade attack on their family home during the riots on the Kurdish New Year celebrations in 1992. They presented newspaper reports and a documentary book published by a Turkish human rights organization in which they and their family were mentioned...
by name several times in support of their claims. They were living in a refugee hostel in an isolated wood in the German "Land" of Brandenburg outside of Berlin. They had to walk several kilometers through this wood to go shopping and to local authorities. Owing to the many old and new pressure points, calluses and blisters on the stumps of their legs this was a highly painful undertaking. However, their application to the local social welfare office for new prostheses was not accepted until our social work department had intervened repeatedly and insistently.

e. Accommodation in hostels

The obligatory accommodation in hostels for asylum seekers during the first three years of their stay in the Federal Republic of Germany can constitute a substantial additional burden for people with reactive trauma sequels, as the associated cramped living quarters and increased level of noise aggravate their generally raised level of arousal, increased irritability and susceptibility to startle and anxiety.

CASE REPORT 5

A Kurdish patient living in Brandenburg who had come for treatment at the request of the local health office and was obviously, together with her family, suffering from the exceptionally bad and unhygienic living conditions in a hostel for asylum seekers, was refused permission to move into an apartment of her own with her family. This was justified by the remark that she was receiving treatment from myself, was unable to travel to and from her appointments without someone to accompany her — which had actually only been the case in the first four weeks of her treatment — and was thus not in a position to live in an apartment on her own without supervision or to take care of her daily needs without aid.

This is a particularly good example of how strongly external influences can affect the therapeutic context. In this case, the intervention of our social work department was necessary, although it must be added that the local authority could not be persuaded to change its opinion until the Commission for Foreigners of the region had also intervened.

f. Prohibition of work and training

Asylum seekers in Germany are not permitted to take up gainful employment or undergo training. This rule is also not restricted to asylum seekers, but may also apply to refugees with other forms of residence permit such as a "Duldung" (temporary suspension of deportation) or "Aufenthaltsbefugnis" (permission to stay for exceptional reasons).

CASE REPORT 6

Mr. Z., a Palestinian who comes from Damascus, where he spent several years in prison, had been receiving outpatient psychiatric treatment for his reactive paranoid psychosis and post-traumatic stress syndrome for one year when the competent Administrative Court decided to award him permanent leave to remain in the Federal Republic of Germany under the provisions of § 53.6 of the Aliens Act on account of his impaired health. However, a work permit which was issued in connection with his "Aufenthaltsbefugnis" was restricted to a rural district where he had no prospects of finding employment, in either the near or distant future. The permit was not valid for Berlin, where Mr. Z. had received an offer of regular employment in the construction branch with the help of fellow Palestinians. The Berlin Labour Office continued to refuse to issue Mr. Z. a work permit, despite the submission of several reports from our social work depart-

ment confirming his mental disorder and his need for a task to structure his time. It was not until an appeal lodged at the Social Court was held by the court to be justified that the Labour Office could be persuaded to change its mind. In the meantime Mr. Z. had been forced to spend day after day without structure to his life, leaving him prey to pronounced depressed moods and thoughts, feeling that he was "a useless parasite in Germany" who was still not capable of earning his own living, let alone able to actively plan his life and put his plans into action, so that he could at least send a small monthly contribution back to his parents in a Palestinian camp in Damascus.

Conclusions

It is evident from these case stories that it is not possible to adhere to the rule of abstinence in psychotherapy with survivors of torture and to ban urgent social and legal problems from the therapeutic space as is usual in psychotherapy with patients with other kinds of presenting problems. If we do, the patient may interpret this as lack of understanding, compassion and empathy. This, in turn, may lead patients to drop out of therapy as a result of their tendency to be mistrustful, withdraw and become resigned.8

An efficient social work department is thus indispensable for all treatment centres for survivors of torture. However, on the other hand care must also be taken to limit social support interventions to those that are strictly necessary. If this rule is not adhered to or if these interventions start to play a major role in the patient-therapist relationship, the therapeutic process comes to a standstill. In such cases the patient will have little motivation to contribute much to reducing his or her symptoms owing to the resulting secondary gain. On the therapist's part, frequent social support interventions may arise from unconscious feelings of guilt or inadequacy and be an indication of a resulting enmeshment with the patient, in which the psychotherapeutic endeavour degenerates into a joint struggle against the agencies of the state in a world that is experienced as generally "bad" and hostile. Issues that can be stressful or frustrating to the patient can thus be conveniently avoided by both parties.

However, the dynamics of reactive post-traumatic symptoms are influenced not only by social and legal conditions, but also by political events.

These include not only political events in the host country, e.g. changes in the legislation or racist motivated attacks, but also those in the clients' countries of origin, for example, the destruction of Kurdish villages, the burning of the harvest by Turkish soldiers in eastern Anatolia, the invasion of the Turkish army into northern Iraq, the abduction of Ocalan from Nairobi, Serbian attacks against Bosnian returnees, the NATO action in Kosovo, the memorial ceremonies held to mark the anniversary of the taking of Srebrenica or Egon Krenz's release from Plötzensee prison on parole. Our patients have reacted to such events with sometimes even marked increases in their post-traumatic symptoms, which in some cases were even dramatic.9

Thus, the environmentally induced reactive disorders of survivors of war and torture can be triggered by external events for the rest of their lives. This problem must be addressed by all psychotherapeutic approaches. Physicians and psychotherapists need to deal with the difficult social and legal situations their patients face in their host countries by carefully dosing social support interventions for their dealings with state authorities that are helpful to the therapeutic process. They must react to changes in the dynamics of patients' symptomatologies induced by external political events.
with support, not in a political sense, but as humane support for the integrity and inviolability of their patients' dignity, as of that of all other people.

Let us take care not to assume a similar attitude towards torture survivors to that of a well-known Berlin training psychoanalyst in the last weeks of the Second-World War, who is said to have replied to his analysand's complaint that she had been bombed out the night before with the remark, "Your dream first, please".

Notes
2. Act on the Abrogation of Injustice Committed by the Socialist Unity Party (SED).
4. Law on Benefits for Asylum Seekers.
5. Central Benefits Office for Asylum Seekers at the Berlin Regional Registration Office.

References
Transcultural psychotherapy
with adolescent refugees

Guus van der Veer, Psychologist
When therapists in Western countries work with victims of torture and other refugees, they often meet people from a different cultural background than their own. Therefore, they have to become transcultural therapists. In this article, the focus is on transcultural psychotherapy with adolescents.

A practical example: three transcultural elements
Marc, an African adolescent, was 16 when he was referred to a therapist by his (guardian) social worker. Marc suffered from occasional outbursts of violent rage, in which, admittedly, he didn’t hurt a fly, but he did manage to terrify those around him. Added to that, he slept badly. The reason was, he said, that he was visited at night by ghosts. According to Marc, these ghosts were those of children whom he had murdered when he was a soldier. Marc felt guilty about what he had done after his mother and sister had been killed and he himself had been forced to become a child soldier. His mother had impressed on him that you weren’t allowed to kill other people. And if you did, their ghosts would come and haunt you. In the first session Marc said, “I don’t like myself anymore”.

It didn’t take much to see that Marc needed a bit of parental support and encouragement, contact with someone who would give him time and try to understand him. His stories were occasionally gory when they concerned the past, but no more shocking than what we’re sometimes confronted with on the TV news. The anecdote which aroused the therapist most strongly was about a recent event.

Marc had had no education at all in his homeland. He was glad to be able to attend school in the Netherlands. Soon the summer holidays would be starting. Marc really dreaded them. What would he do with himself for the two months that school was closed? He didn’t have enough money to go on holiday. He liked sport, and he often stood watching the boys playing football in the park. Sometimes he joined in, but that wasn’t much of a success as he didn’t have any football boots. It so happened that he had saved some money which he wanted to spend to buy some. He couldn’t face doing that on his own, so he’d asked one of the supervisors of the hostel where he lived to go with him. The supervisor had said that he would discuss it in the weekly supervisors’ meeting. A week later Marc was given the verdict: the supervisors were extremely busy, but in four weeks from now one of them would have time to go with Marc. By that time Marc’s holiday would be nearly over.

The therapist’s first thought was: right, after five o’clock I’ll go to the high street with Marc myself. Marc’s story made him angry and sad. The supervisor’s way of doing things, however well meant, was experienced by Marc as cold and impersonal, and aroused, a mixture of rage and sadness in Marc. The rage and sadness Marc did not allow to enter his consciousness, it was transferred to the therapist.

Marc’s story illustrates what a not inconsiderable number of helping professionals considers to be professional conduct. The most important transcultural element in Marc’s therapy was that it forced the therapist to take a fresh critical look at his own professional code. If Marc had been Dutch, the therapist would probably have encouraged him to repeat his request to his supervisor in an assertive way. In Marc’s case that seemed too cold and distant. This led to a second transcultural element in the treatment: the therapist intervened in order to build a bridge between Marc and his Dutch mentors. He telephoned the institution in question, and explained why he found the course of events less than satisfactory. That had the desired effect: one week later Marc had his football boots.

Another transcultural element in the treatment of Marc was that his complaints initially sounded a trifle bizarre. For they were about ghosts.

In the first session Marc made a sad and anxious impression, but he didn’t seem to be psychotic. The therapist decided to regard his talk of ghosts and spirits as his way of talking about nightmares and flashbacks. He treated his complaints as if they were about nightmares and flashbacks. Sometimes he slipped up and used the word nightmare or dream, and then Marc would say: no, it wasn’t a dream, it really was a ghost, a spirit. And then the therapist would say: yes, I made a mistake, I meant ghost.

Marc’s somewhat bizarre complaints about ghosts were not automatically seen by the therapist as delusions. The therapist tried to find out the significance of these complaints within Marc’s cultural background, and based his treatment on this presumed significance.

A developmental psychological view of adolescent refugees
Initially the therapist talked to Marc a lot about his symptoms. But the subjects of discussion became broader and broader: practical problems which the therapist generally couldn’t solve, existential questions, loneliness. Once Marc was given a fine of 50 guilders because the rear lamp of his bicycle wasn’t working. This meant that he had hardly any money for food for the rest of the week. On that occasion the therapist gave him 25 guilders.

Many psychotherapists at first sight will consider that unprofessional. But one could also say that it was professional intervention to support the conditions for psychological development, because it is one of the preconditions of normal development, see Fig. 1, that an individual receives a gift or a stroke of luck now and then.

In the case of Marc at least it did not lead to the development of an unhealthily dependent relationship.

The actual living situation of adolescent refugees is unfavourable in many cases because a number of the preconditions for normal psychological development are insufficiently met. The psychotherapist can try to supply some of the lacking preconditions. But there’s more to it than that. For many adolescent refugees, being approaced and traumatised have given an important twist to their development. This uprooting and traumatisation has to do with painful events in the past, but that’s not the end of it. These events in the past form only the beginning of lifelong processes: processes which produce their own particular developmental tasks at every stage of life. These developmental tasks for adolescents can be summarised as shown in Fig. 2.

In the treatment of adolescent refugees actual developmental tasks are at least as important as their cultural baggage, the horrors which they have experienced in the past, or the problems which confront them as unwelcome foreigners.

Psychotherapy with adolescent refugees: a few important ingredients
Besides three transcultural elements, the story about Marc’s therapy also illustrates other important ingredients of psychotherapy with adolescent refugees which are separated from their cultural origin. It concerns ingredients which are connected with the particular previous history of these
youngsters and with their marginal position in the country of exile. The therapist gave Marc the opportunity of entering into a relationship with him. The therapist conducted this relationship in at least five ways.

1. He saw the relationship in the first place as an opportunity for Marc to undergo corrective emotional experiences. He offered Marc the opportunity to experience being treated as a person, not as a disposable child soldier, nor as a troublesome dossier. The therapist tried to make it a personal, meaningful relationship for Marc.

2. The therapist deliberately used the relationship as a means of fulfilling an important, in Marc's case absent precondition for favourable psychological development. I refer here to precondition number 5 of Fig. 1: security, support and understanding from at least one adult.

3. The therapist used the relationship in order to gain more insight into Marc's way of living and thinking. On the basis of that insight he was able to offer Marc a wider range of options as regards coping with post-traumatic complaints. This gave Marc support with development task number 10 (Fig. 2). Other problems of everyday life in the Netherlands also became visible in this way, enabling the therapist to support Marc with most of the other developmental tasks.

4. The therapist's consulting room became the "holding environment", the safe place where Marc could stop and think about his fears, his aggressive impulses and his feelings of guilt. His internal conflicts concerning war crimes which he had committed under compulsion were clarified, making them easier to deal with. And a whole complex of impediments to Marc's psychological development was thereby dismantled.

5. The long-term and predictably limited availability of the therapist gave Marc the opportunity to become attached to another person, after a traumatic separation from his mother. And subsequently the opportunity to direct his energies towards others and to detach himself once more.

Transcultural methodology

Transcultural psychotherapy is psychotherapy in which client and therapist are from different cultures. But that difference in cultural background does not lead to a particular methodology. A survey among transcultural psychotherapists in the Netherlands shows that they don't see transcultural psychotherapy as a particular set of techniques which demands particular skills to be acquired by special training. There are no data which indicate that one particular form of therapy is more suitable than another for a particular ethnic or cultural group. On five points there are perhaps differences in emphasis.

1. Transcultural psychotherapists try as far as possible to connect with the world as perceived by the patients in question. This may result in their being less prepared to stick to fixed protocols.

2. There are certain prior conditions attached to transcultural psychotherapy: the therapist sometimes needs more time to establish contact with the client and to get an insight into particular backgrounds. An interpreter is sometimes needed, which also takes extra time.

3. The therapeutic relationship appears to have a directive nature more often than with Western clients.

4. On the continuum between closeness and professional distance, the therapist sometimes chooses a different position than might be the case with a Western client.

5. As regards the aim of the therapy, the emphasis is less on increasing the client's autonomy, and more on the improvement of relationships within the community.

Fig. 1. Conditions for the optimal development of adolescent refugees.

General developmental tasks which demand new skills of adolescent refugees

1. Looking after oneself more
2. Becoming more independent in social intercourse
3. Becoming more independent in giving shape and direction to one's own life

General developmental tasks which are more complicated for adolescent refugees

4. Independently making friends with one's own age group
5. Integration of increasing sexual impulses which result from becoming physically adult
6. Coping with one's own aggressive impulses and aggression in one's environment
7. Giving renewed form to the relationship with the parents
8. Mapping out a plan for the future

Extra developmental tasks

9. Breaking through social isolation
10. Coping with post-traumatic problems
11. Relationship with family left behind
12. Finding one's niche in a strange, sometimes experienced as hostile, society
13. Coping with norms and values from two different cultures
14. Coping with exile in the long term

Fig. 2. Developmental tasks.
Transcultural knowledge

If transcultural psychotherapy is not a methodology, it might be defined as the application of knowledge of exotic cultures during psychotherapy. But that is also debatable.

Jim, who was 19 years old, came from the same country as Marc. He had been referred by his supervisor on a work opportunity project. He slept very badly at night, which made it impossible for him to concentrate at school during the day. According to Jim, his sleeping badly was caused by ghosts: he saw the ghosts at night when he lay in bed trying to get to sleep. The ghosts spoke, but he could not hear what they were saying.

The therapist asked Jim what the ghosts looked like. Marc had told about that in great detail, it had been a relief to him, and that's why the therapist asked Jim the same thing. But that had the wrong effect: anyone who knew anything about ghosts would never ask such a thing, said Jim. The therapist said to Jim that he was right: as a Dutch person he knew nothing of African ghosts. Had Jim ever put his problem to a traditional African healer? Jim had done that on various occasions, but without success. He had been told that it had to do with spirits which had helped his father to obtain diamonds. In exchange his father was supposed to sacrifice a cow every year. His father had been dead now for seven years and his debt to the spirits had been transferred to Jim. If Jim sacrificed seven cows, the problem would be solved. Various things would have to be done according to a particular ritual, a ritual which could only be learned in Africa from a qualified medium.

On the basis of what Jim told the therapist arrived at the hypothesis that Jim interpreted his sleeping problems in a way that fitted with his specific cultural background, but that he could not completely rule out the existence of a psychotic disorder. The way in which he spoke of his problems could be interpreted as a metaphor for his feelings of alienation, loneliness, powerlessness and sorrow. In short, a depressive episode with a possible corresponding delusion, based on identity problems. The description of his suffering in terms of ghosts could, from an other point of view, be regarded not as a delusion, but as what would be regarded within his culture as an adequate form of coping with almost unendurable feelings. These thoughts became the basis of the treatment plan.

Jim agreed with the following interpretation of his problem: when he sees ghosts he becomes afraid. The fear makes his head hot and his body stiff. The therapist would help him to get more control over his body, by means of medicine and advice, so that he would have a chance of hearing what the ghosts wanted to tell him. If that worked, the therapist would then try to help him to interpret what they said.

The anti-depressive drugs and the complaint-oriented and supporting structuring interventions did not have the desired effect. That led to a new formulation of the aim of the therapy. In the twelfth session, therefore, Jim agreed with the therapist that they would continue to talk with the aim of gaining access to the wisdom which his father had passed on to him, but which he could not yet put into words, and to make use of it in his everyday life. The therapist tried to focus more on the identity problems which he suspected. After this there was more discussion during therapy of his life history and his feelings of powerlessness.

This also was a not a big success. In the seventeenth session Jim said that he was still troubled by ghosts. Since they were more troublesome at night, he slept during the day. He had a night job, and was now saving money to travel to Africa. So the outlook was promising in some respects. After this, Jim no longer reacted to invitations.

Would Jim's psychotherapy have been more successful if the therapist had known more about the different types of ghosts and their significance in West African culture? Perhaps an anthropologist could have told the therapist that you should never ask an African to describe the ghosts who haunt him. Perhaps the treatment of Jim would then have taken another turn. But Marc's treatment succeeded precisely because, unhampered by this anthropological information, the therapist asked him directly what the ghosts who besieged him looked like. Exotic knowledge might well be useful, but it can also hamper you or give you the wrong impression. The transcultural psychotherapist has to realise that he's dealing every time with unique individuals, who now and then behave not quite according to the anthropological handbooks. Their behaviour and ideas can be ascribed to their cultural background only to a limited degree. For example, Marc and Jim, though born with a distance of 50 kilometres, were very different people, and that had consequences for the course of their therapy.

Of course, it can be useful to know certain things. For example, in their own country Tamils often do not have the custom of shaking hands when meeting. That means that the odd Tamil adolescent may give a weak handshake, and a weak handshake has a negative significance for Westerners. So you can't teach the youngster in question how to shake hands in a way that will make a good impression. Iranian boys hold onto your hand rather longer than is customary in western countries. For one of my clients this resulted in his classmates calling him a queer.

This sort of practical thing one learns in practice, and from leisure contacts with foreign neighbours and friends: not from books by anthropologists. Even after years of transcultural work, awkward situations or misunderstandings may still occur between the therapist and a client. That does not always lead to a break in contact: the therapist still had 16 sessions with Jim after his mistaken question about ghosts.

Many refugees realise perfectly well that the therapist grew up in another culture and therefore reacts occasionally in a way which seems blunt in their culture. In general they react in a tolerant and helpful way. They are generally not narrow-minded and rigid, but prepared to rise above the limitations which accompany their culture's prevailing concept of man and his place in the world: They are transcultural clients.

The transcultural psychotherapist

The characteristic mark of transcultural psychotherapists is their special frame of mind. They are continually reflecting in a special way. The transcultural psychotherapist always has in mind that his own experience and that of his client may differ sharply. Acting on that assumption, he tries to make contact and to communicate. The transcultural psychotherapist and his client seek an interpretation of the complaints which is acceptable to both of them, in spite of their widely differing experience of life. In this way both parties try together to surmount the limitations which each has incurred through his cultural background. Further, the transcultural psychotherapist keeps a sharp look-out for any automatic assumptions in his own dealings; in that sense he has a constant thirst for knowledge.

The transcultural psychotherapist is in principle prepared to depart from apparently obvious ways of dealing and proceeding, when that is useful or necessary. He is deliberately experimenting with extending traditional professional boundaries. He is prepared to answer for that at all times. He
is open to the values, norms and attributions of the client. Moreover, the therapist realises on the one hand that the client has a non-western cultural background which he shares with others, and which determines his view of his own problems: but on the other hand he realises that the same client may experience his non-western cultural background in a highly individual way.

From this position it is natural to ask the client questions now and then, so that the therapist gains more insight into how this individual client looks at life in the country of exile from his own cultural background. From this position the therapist will above all be cautious in making a diagnosis: behaviour which he may regard as strange or bizarre might be adequate coping within the cultural background of the client. From this position the therapist will sometimes adapt his behaviour, in order to meet the client half-way.

From this position the therapist can also draw the client's attention to prevailing Western values, norms and rules which he would do well to take into consideration. An appeal is thus made to the client's flexibility. He has already displayed this flexibility by entering into discussion with the therapist. Transcultural clients such as Marc and Jim did not see the therapist in the first place as not-an-African, but as someone who was trying to understand them, to comfort and help them, someone who made them feel welcome.

The other side of the picture is that the transcultural client apparently receives insufficient support from his own cultural background. One possible cause is that the client is isolated from those who share his culture. The second possible cause is that, although he is surrounded by members of his culture, he has no part in the supporting processes usual in his culture, because these cannot take place. That can happen for example when particular rituals cannot be carried out in the country of exile.

Transcultural psychotherapy
is scientific research in practice

A psychotherapist is someone who applies science. A transcultural psychotherapist is therefore not just messing around by casually throwing overboard all sorts of evidence based professional norms and customs. If anything is thrown overboard, it is after due consideration; what has been done can be justified afterwards. Transcultural psychotherapy is therefore, intentionally or reluctantly, a form of scientific research in clinical practice. Every treatment is an N=1 study, every session is a hermeneutic voyage of discovery, every intervention is an experiment and thus also intended to test a hypothesis and so gain information.

Perhaps for that reason a transcultural psychotherapist could do with a bit of skill training after all. Not specific psychotherapeutic skills, but the methodological skills which are necessary for scientific research in everyday practice. For these skills are little taught in the academic education of today.

References
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.