

## TORTURE

### Journal on Rehabilitation of Torture Victims and Prevention of Torture

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## Preface

This issue of Torture is predominately composed of scientific articles and other contributions based on presentations at the 5th International Psychological Trauma Symposium in Istanbul, December 2007.

This symposium, launched under the slogan “Digging Up Wounds, Healing Wounds”, focused on observations, experiences and treatment outcomes from various places where psychological trauma exists, with the intention to identify the trauma, prevent injuries, and discover the conditions that create trauma and find ways to prevent them.

The symposium highlighted how while it is important to examine torture, situations indirectly following torture also have to be taken into consideration. Such situations may include refugee status, language problems, cultural alienation, unemployment and economic scarcity, among others. Therefore it may be meaningful to distinguish between torture as such and those conditions induced by torture. In this way the trauma symposium provided an opportunity to share information that supports existing knowledge related to torture.

The articles in this issue specifically focus on non-torture PTSD associated situations, and therefore conditions that often have to be considered in the evaluation of torture survivors’ situations. In this issue you’ll find articles dealing with traumatic experiences and risk factors in regions of armed conflict. Furthermore there is discussion of the psychological condition for displaced persons compared with the non-displaced in the aftermath of an ethnic conflict. There are articles that focus on disorders after exposure to traumatic events: one examines university students, and one compares cultural differences between adolescents in four Nordic nations. Another study discusses the impact of impunity in traumatized refugees. Finally there is an evaluation on problems occurring in solitary confinement.

The papers which have been selected and adapted for this issue have fulfilled the acceptance criteria and guidelines for Torture.

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# Exposure to traumatic events among adolescents in four nations

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## Abstract

*Background:* Although studies indicate that adolescents, like adults, might develop posttraumatic stress disorder after exposure to traumatic events, the research on this age group is still sparse.

*Method:* In three national representative samples and one national total sample of 1,206 8th and 9th-grade students with a mean age of 14.5 years, the prevalence of 19 potential traumatizing and distressing events were reported, along with the psychological impact of these events.

*Findings:* Ninety percent of the adolescents had been exposed to at least one event. The most common events were the death of a family member, threat of violence, bullying, near-drowning, and traffic accidents. Gender was associated with specific events. The estimated lifetime prevalence of posttraumatic stress disorder (PTSD) in the total sample was 14.6 percent, whereas another 13 percent reached a subclinical level of PTSD. Following exposure, females suffered from PTSD two and a half times more often than males. The relative risk for PTSD given a specific event is described. Being exposed to multiple traumatic events was associated with an increase in PTSD. Cultural differences were found in prevalence of PTSD, exposure to specific events and in the female male ratio in PTSD.

*Conclusion:* The findings indicate substantial mental health problems in adolescents that are associated with various types of victimization.

*Keywords:* cross-national, posttraumatic stress disorder, adolescents, gender, trauma exposure

## Introduction

In many cases adolescence is a period of rebellion and experimentation with new behaviours and roles. Though studies indicate that this group, like adults, is vulnerable to the development of posttraumatic stress disorder (PTSD),<sup>1</sup> and that PTSD might entail serious developmental consequences,<sup>2</sup> most studies, on adolescent exposure to traumatic events are limited by being convenience samples addressing exposure to a single traumatic event or a single cluster of traumatic events, for example violence or abuse.<sup>3-7</sup>

The stressor criterion for PTSD according to DSM-IV is defined as an extreme traumatic event involving actual or threatened death, serious injury, or other threat to one's physical integrity.<sup>8</sup> Joseph and colleagues<sup>9</sup> underline, however, the importance of examining less severe and more common events as a supplement to highly traumatizing and unusual events in studies of PTSD. Research investigating a broad range of traumatic or negative life events has the potential of estimating the impact of specific events

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knowing the exposure to a larger number of possible events.

Exposure can be direct and indirect, that is witnessing or learning about a traumatic event that has happened for instance to a family member or close friend, and in the DSM-IV<sup>8</sup>, the stressor criterion for PTSD was expanded to include indirect exposure, as clinical experience and research had given evidence that this kind of exposure could result in PTSD.

Studies based on adolescents, young adults and adults have shown differences in the prevalence of PTSD in various countries.<sup>9-11</sup> One explanation to this might be, that there actually are cultural differences. The variation might, however, be due to methodological differences. This is why cross-national studies applying the same methodology are strong assets.

### **This study**

The overall aim of the present paper is to study a broad range of traumatic events and negative life events among adolescents using the same measures in different countries. Four different countries with various challenges for the adolescents were selected: Lithuania as a former Soviet Republic fighting to reach living standards; Denmark, Iceland and The Faroe Islands as Nordic welfare states; Iceland and The Faroe Islands, though, as smaller countries characterised by a rough nature and recurrent natural disasters.

Domainskaite-Gota & Elklit<sup>12</sup> studied a national probability sample of 183 9th grade Lithuanian adolescents ( $M= 15.1$  years) and found that 81 percent of the males and 80 percent of the females had been exposed to at least one traumatic event. Most frequent events were threats of physical assault, near-drowning experiences and the death of someone close. Estimated lifetime prevalence

of PTSD in the total sample was 6%; 12% reached a subclinical level of PTSD.

Factors such as female gender, living with a single parent, direct and indirect exposure to traumatic events, number of events, and more recent exposure (<1 year) predicted more posttraumatic symptoms.

In a national probability study Elklit<sup>13</sup> studied 390 Danish 8th graders age 14-15 and found that 78 percent of the males and 87 percent of the females had been exposed to at least one traumatic event. The estimated lifetime prevalence of PTSD in the total sample was 9.0 percent, whereas another 14.1 percent reached a subclinical level of PTSD. Following exposure, females suffered from PTSD twice as often as males. The most common events were the death of a family member, threat of violence, or serious accidents. The most distressing subjective events were rape, suicide attempts, death in the family, serious illness, and childhood abuse. Gender, parents' education, and living with a single parent were associated with specific events. Being exposed to multiple traumatic events was associated with an increase in PTSD.

In an Icelandic national probability study of 206 9th-grade students with a mean age of 14.5 years,<sup>14</sup> seventy-four percent of the girls and 79 percent of the boys were exposed to at least one traumatic event or life event. The most common events were the death of a family member, threat of violence, and traffic accidents. The most distressing subjective events were childhood neglect, abortion, rape, and serious illness. Gender, mothers' education, and single-parenthood were associated with specific events. The estimated lifetime prevalence of PTSD in the total sample was 16 percent, whereas another 12 percent reached a subclinical level of PTSD.

In a Faroese total-population sample of

eighth-graders ( $N=687$ ;  $M=14.2$  years),<sup>15</sup> ninety percent of the students reported having directly experienced or having witnessed at least one event (94% of the females and 89% of the males). The most common events were: death of someone close, threats of being beaten, and humiliation or bullying. The most distressing subjective events were: The estimated lifetime prevalence of PTSD in the total sample was 20%, whereas another 14% reached a subclinical level of PTSD.

The aim of the present paper is to bring together the results from the four above mentioned studies to make specific analyses and comparisons of the data to elucidate a) to which degree there are differences between the countries in exposure rates, b) whether there are gender differences in exposure, c) to which degree socio-demographic variables are associated with exposure rates, d) whether there are gender differences in relative risk for PTSD after exposure, and e) to compare traumatization across the four countries.

## Method

### *Study design, procedure, and participants*

The data were collected from questionnaire surveys with three national representative probability samples (Denmark, Lithuania, Iceland) and one total population sample (Faroe Island); in total 1,466 students with a mean age of 14.2 years ( $SD=1.52$ ). The gender distribution was 48% males ( $n=698$ ) and 51% females ( $n=747$ ) – fourteen students did not state their gender.

Students in primary public schools constitute a very good representation of the adolescent population, as the schools in the various countries are practically obligatory. In the probability studies, the schools were selected from a list of all schools in the country by permutations. The percentage of

invited schools that participated was about 75%. The primacy of the initials of the head teachers decided which class was chosen, in case there was more than one grade class in the school. The percentage of students present participating approached 100%. Further procedural details are reported in the original research articles.<sup>12-15</sup>

## Instruments

The first part of the questionnaire contained questions about gender, age, parents' education, and living arrangements (living with one parent, two parents, or others such as grandparents or within an institution). Parents' education was chosen as a crude measure for the socioeconomic situation. More detailed demographic information was not asked because other studies<sup>16</sup> have shown that adolescents' knowledge of parents' income and occupational status is not very reliable.

In the last part of the questionnaire, the students were asked about their exposure to 19 traumatic events and negative life events (Table 1). Each question could be answered according to direct exposure or indirect exposure (i.e. witnessing an event or a person close to them experiencing an event). The list of events was selected from scientific literature and clinical experience, covering possible life-threatening experiences and distressing family conditions such as neglect, abuse, absence of a parent, and bullying.

The Harvard Trauma Questionnaire Part-IV (HTQ)<sup>17</sup> was used to estimate the occurrence of PTSD at the time of the event. When filling in the HTQ, pupils were asked to pick the event most distressing to them and to keep that in mind when answering. The HTQ contains the 17 PTSD symptoms included in the DSM-IV.<sup>8</sup> The HTQ Part-IV has been used extensively in the Nordic countries and permits an as-

**Table 1.** Trauma events and life events according to direct exposure and nation in % (N = 1466).

Event	N	1: Denmark (n=390)	2: Iceland (n=206)	3: Lithuania (n=183)	4: Faeroe Is. (n=687)	F-ratio (Tukey's b)	Gender diff. in exposure F-ratio
1. Traffic accident	264	15.9	27.1	16.9	16.9	4.64 <sup>3</sup> (2>1,3,4)	4.46 <sup>1</sup>
2. Other serious accidents	158	11.5	11.1	5.5	11.9	2.06	0.76
3. Physical assault	108	4.6	7.8	4.4	9.7	3.96 <sup>2</sup>	2.80
4. Rape	45	1.8	3.3	1.6	4.2	1.94	2.06
5. Witnessed other people injured or killed	119	9.0	5.8	3.3	9.7	3.22 <sup>1</sup> (4,1>3)	3.35
6. Came close to being injured or killed	157	10.5	8.7	6	12.6	2.61	11.80 <sup>4</sup>
7. Threatened to be beaten	433	26.9	27.6	29.7	31.9	1.00	44.81 <sup>5</sup>
8. Near-drowning	314	18.7	20.9	26.4	21.1	1.44	8.17 <sup>3</sup>
9. Attempted suicide	125	6.2	10.2	6.6	10.1	2.04	35.33 <sup>5</sup>
10. Robbery/theft	214	11.8	18.4	19.8	13.8	3.06 <sup>1</sup> (3>1)	7.68 <sup>2</sup>
11. Pregnancy/abortion	33	1.8	2.5	–	3.1	2.22	3.03
12. Serious illness	161	12.6	4.8	7.7	13.1	4.47 <sup>3</sup> (4,1>2)	0.22
13. Death of someone close	696	51.8	42.7	24.2	53.3	18.13 <sup>5</sup> (4,2,1>3)	13.96 <sup>5</sup>
14. Divorce	227	19.0	20.4	11.5	13.2	4.24 <sup>3</sup> (2>3)	0.10
15. Sexual abuse	57	1.5	3.9	4.4	5.2	2.86 <sup>1</sup>	11.57 <sup>4</sup>
16. Physical abuse	77	3.6	2.9	3.8	7.4	3.63 <sup>1</sup>	0.80
17. Severe childhood ineglect	54	3.1	2.9	1.1	5.1	2.44	0.06
18. Humiliation or persecu- tion by others (mobbing)	361	22.6	23.3	9.8	30.5	11.53 <sup>5</sup> (4,2,1>3)	1.33
19. Absence of a parent	146	7.4	5.8	4.4	14.7	12.36 <sup>5</sup> (4>1,2,3)	11.90 <sup>4</sup>

1)  $p < .05$ ; 2)  $p < .01$ ; 3)  $p < .005$ ; 4)  $p < .001$ ; 5)  $p < .0005$

assessment of whether or not a person suffers from PTSD.<sup>13,18</sup> It is also a measure of the intensity of the three core symptom groups (re-experiencing, avoidance, and hyperarousal) of PTSD. The items are scored on a four-point Likert scale (1 = not present, 4 = very often present). An item score must be  $\geq 3$  to count as a symptom for a diagnosis. A subclinical level of PTSD is gained if the respondent meets two out of three criteria and misses the last criterion by only one

symptom. The latter does not apply to the intrusion subscale, which must be reached. The subscales are scored separately. The internal consistency in this scale was found to be good: Cronbach's  $\alpha = .96$  for the PTSD questions and .78, .81, and .80 for the re-experiencing, avoidance, and hyperarousal subscales, respectively. The inter-item coefficients for the subscales were .46, .38, and .44 respectively, indicating good discriminatory power.<sup>19</sup>

## Results

### *Exposure to traumatic events and negative life events*

Ninety percent of the adolescents in the four countries reported having directly experienced or having witnessed at least one event, and the five most recorded direct events were (Table 1): death of someone close (47%), threat of being beaten (30%), humiliation or persecution by others/bullying (25%), near-drowning (21%), and traffic accidents (18%). The five least prevalent direct events were (Table 1): physical abuse (5%), sexual abuse (4%), severe childhood neglect (4%), rape (3%), and pregnancy/abortion (2%). The adolescents in the four countries had on average been exposed to 2.6 events.

A gender difference was found in exposure, as the males reported significantly more often of traffic accidents, coming close to being injured or killed, threats of being beaten, and near drowning. Females, on the other hand significantly more often reported attempted suicide, having lost someone close, sexual abuse, and having an absent parent (Table 1).

### **Cultural differences**

The results from a cross-national comparison of exposure based on ANOVA analysis and a post hoc Tukey's-b analysis is presented in Table 1. Three types of accidents or traumatic events not family related (other serious accidents, near-drowning and coming close to being injured or killed), and five family related, interpersonal or intimate traumatic events or negative life events (threatened to be beaten, rape, suicide attempt, pregnancy/abortion, and severe childhood neglect) did not vary significantly among the countries. On the other hand the analysis showed national differences in prevalence of some of the traumatic events and negative life events: The Icelandic adolescents scored relative high

on traffic accidents, divorce, and suicide attempts; and relative low on serious illness. On the other hand Denmark scored relatively low on theft/robbery, sexual abuse, and suicide attempts. The analysis furthermore showed that the Lithuanian adolescents scored relatively high on theft/robbery and having seen others injured; and relatively low on bullying, divorce, death of someone close, physical assault, rape, childhood neglect, and pregnancy/abortion. Finally, the analysis showed that the Faroese adolescents scored relatively high on sexual abuse, physical assault, rape, childhood neglect, physical abuse, humiliation, and parental absence (Table 1).

### **Sociodemographic factors**

Analysis based on data from all four countries showed that gender not was significantly associated with the number of direct events. On the contrary, female gender was associated with more indirect events ( $F(1,1444)=11.02, p<.0005$ ), as females reported 4.2 indirect events compared to males, who had a mean of 3.5. Living with a single parent was also associated with number of direct ( $F(1,1435)=60.07, p<.0005$ ), and indirect events ( $F(1,1435)=6.54, p<.05$ ), as adolescents living with a single parent reported 3.6 direct events, which is significantly more than the 2.3 direct events reported by those adolescents living with both parents. Likewise, adolescents living with a single parent reported significantly more indirect events (4.4) compared to those living with both parents (3.8). There were no significant associations between mothers' or fathers' education and exposure to trauma.

### **Prevalence and relative risk of PTSD**

The prevalence of PTSD across the four nations varied, and comparative analyses revealed that these differences were signifi-

**Table 2.** Trauma events and life events according to direct exposure and gender (N=1445). Odds ratios for PTSD, logistic regression analyses.

Event	Male		Female	
	Exp (B)	95% c I	Exp (B)	95% c I
1. Traffic accident	1.04	0.51-2.15	1.09	0.65-1.83
2. Other serious accidents	2.55 <sup>1</sup>	1.15-5.66	1.55	0.82-2.94
3. Physical assault	0.88	0.30-2.58	1.44	0.64-3.24
4. Rape	0.45	0.04-5.54	1.05	0.33-3.31
5. Witnessed other people injured or killed	0.38	0.11-1.29	1.18	0.55-2.55
6. Came close to being injured or killed	1.25	0.52-3.00	1.53	0.75-3.09
7. Threatened to be beaten	1.51	0.79-2.89	1.72 <sup>1</sup>	1.07-2.76
8. Near-drowning	1.87	0.95-3.67	0.85	0.51-1.42
9. Attempted suicide	4.61 <sup>1</sup>	1.39-15.33	2.24 <sup>3</sup>	1.27-3.93
10. Robbery/theft	1.66	0.80-3.46	0.33 <sup>3</sup>	0.16-0.71
11. Pregnancy/abortion			0.46	0.13-1.59
12. Serious illness	1.15	0.48-2.75	0.93	0.50-1.71
13. Death of someone close	0.81	0.43-1.53	1.75 <sup>2</sup>	1.16-2.65
14. Divorce	0.59	0.24-1.41	1.25	0.73-2.14
15. Sexual abuse	1.52	0.11-21.16	1.80	0.73-4.41
16. Physical abuse	2.04	0.58-7.19	1.66	0.65-4.23
17. Severe childhood neglect	1.99	0.50-7.91	0.76	0.27-2.14
18. Humiliation or persecution by others (mobbing)	0.89	0.44-1.81	2.89 <sup>5</sup>	1.90-4.39
19. Absence of a parent	3.89 <sup>3</sup>	1.56-9.67	1.64	0.94-2.89

1)  $p < .05$ ; 2)  $p < .01$ ; 3)  $p < .005$ ; 4)  $p < .001$ ; 5)  $p < .0005$

cant ( $F(1,1444) = 31.57, p < .0005$ ), as the prevalence of PTSD was significantly lower among the Lithuanian adolescents (6%) compared to adolescents in Denmark (14%) and in Iceland (16%), which again was significant lower than among Faroese adolescents (20%).

The relative risk for developing PTSD after direct exposure was analyzed by logistic regression analysis and is presented in Table 2. The analyses showed that the relative risk for developing PTSD generally was higher after direct exposure compared to indirect exposure in all four countries (data not shown). Being exposed to multiple traumatic events was, likewise, associated with an increased risk of PTSD.

The logistic regression analyses also showed a gender difference in the relative risk of PTSD after exposure to specific traumatic events and negative life events, as fe-

males had a significantly higher relative risk of PTSD after being threatened of assault, death of someone close, and bullied. Males, on the contrary, had a significantly higher relative risk of PTSD after serious accidents, suicide attempts, robbery/theft, and absence of a parent (Table 2).

The results showed that the females from all four countries significantly more often fulfilled the criteria for PTSD compared to the males ( $\chi^2 = 106.07; p < .0005$ ). When the same analyses was made for the countries separately, however, the results revealed a cultural difference, as there was no significant gender difference in PTSD prevalence among the Icelandic adolescents. Among the other three countries, the gender difference was highest among the Lithuanian adolescents (4:1), where eight females versus two males fulfilled the criteria for PTSD ( $\chi^2 = 9.07; p < .05$ ), followed by the Faroese

adolescents (3:1), where 105 females versus 32 males fulfilled the criteria for PTSD ( $\chi^2=94.37$ ;  $p<.0005$ ), and finally the Danish adolescents (2:1) where 19 females versus 11 males fulfilled the criteria for PTSD ( $\chi^2=23.28$ ;  $p<.0005$ ).

### Discussion

In line with a community-based study of 427 English adolescents (11-16 years)<sup>9</sup> where 84% had experienced at least one negative life event, the adolescents from Denmark, Iceland, Lithuania, and The Faroe Islands had experienced a large number of traumatic events and negative life events. In comparison, a longitudinal study of 384 18-year old US adolescents showed that 43% had experienced at least one traumatic event.<sup>20</sup> Compared to the present study, this number is low, which might be due to the application of the DMS-III-R stressor criteria<sup>21</sup> and to the broader list entailing both traumatic events and negative life events applied in the present study. As mentioned in the introduction, Joseph and colleagues<sup>9</sup> pointed to the importance of also including negative life events when studying PTSD. Studies based on adults,<sup>22</sup> show that negative life events might also induce serious posttraumatic symptoms. This is consolidated by the present study, as it showed that negative life events also entail an enhanced risk of PTSD: absence of a parent, which does not include death of a parent, as this was included in a separate category (death of someone close), was found to be the second most distressing event for males. For females, having been bullied, a negative life event, was found to be the event with the highest odds ratio (Table 2).

Werner & Smith<sup>23</sup> found that level of education was supportive in a gender specific way, as the mothers' education had a protective effect for sons, and fathers' education had the same effect for girls. This was,

however, not supported by the data from the four present nations.

In accordance with previous studies<sup>24</sup> the relative risk for PTSD after direct exposure was generally higher compared to indirect exposure in all four countries, and the "dose-response" relationship was confirmed. Furthermore, having been exposed to multiple traumatic events was associated with an increase in PTSD. However, not all studies confirm the "dose-response" relationship. In a study of a shooting at the University of Aarhus, Elklit<sup>25</sup> found that those who were outside of the centre of the catastrophe had more acute psychological sequelae than those who had been at the centre. Similarly, Elklit,<sup>26</sup> studying the aftermath of a shipyard explosion, found that the degree of traumatization after six months was higher in the group who had had an "audience position" compared to the group directly hit by the explosion. Being in the second line of exposure, learning about killing or death and having experienced an uncertainty about ones own fate for some time can presumably sometimes result in more severe acute or long-term stress reactions than is the case of first line exposed subjects. Another explanation might also be that the reason whether the dose-response relationship is confirmed or not is to be found in trauma type or various personal variables.

According to the results presented in Table 2 exposure to some traumatic events (for example severe childhood neglect for females) did not entail an enhanced risk of PTSD. These counter intuitive findings could be explained by the phenomenon of latent class structures.<sup>27</sup> Shevlin and Elklit found a clustering of many (7-8) traumatic events and negative life events in a small percentage (2-3%) of the participants. This means that this group of participants has to pick one event for filling out the HTQ,

and that this event not necessarily is the most traumatizing, but for instance the most recent, the most socially acceptable. This individual selection might accordingly be conceived as a defence or a social bias.

### **Cultural differences**

The present study revealed cultural differences both in prevalence of PTSD and in exposure to traumatic events and negative life events; differences that not can be explained by methodological variation. The degree of collectivistic culture versus an individualistic culture may explain some of the differences seen between the four nations. There is evidence that these factors impact adolescents' judgement of life satisfaction, as adolescents in individualistic cultures report higher life satisfaction, which according to some studies serve as a buffer against the impact of stressful events.<sup>28</sup> Furthermore the rough climate and living conditions in the Faroe Islands and Iceland may play a part.

### **Gender differences**

It has been suggested<sup>13</sup> that females seem to be victimized more often in family-related events and by self-inflicted events (suicide attempts), whereas males more often seem to be victimized in activities outside of the family. This is in line with the present results. Furthermore the females in accordance with previous findings<sup>29</sup> were more traumatized compared to males. Interesting, though, was the cultural difference in the female-male ratio in PTSD. Female vulnerability can be explained through social roles (model learning), and by gender differences in sensitivity and relatedness. One might claim that Lithuania and the Faroe Islands are countries characterized by traditional gender roles, which has an influence on the high degree of traumatization among females compared to males.

### **Conclusion**

There is increasing evidence that potentially traumatic events are as much a part of adolescence as they are part of adulthood. There were relatively few gender differences in exposure to traumatic events. Gender difference, however, did exist in the relative risks of PTSD after various traumatic events and negative life events, and overall, females were found to be at least twice as vulnerable. One should therefore distinguish between risk of exposure and risk of PTSD. Vulnerability was also connected to single parenthood due to perhaps to a lack of parental supervision and stable role models, and/or to parental conflict. The endorsement of events was not randomly distributed, as for example severe forms of abuse and neglect were found to be strongly associated.

### **Limitations and strengths**

The study has a number of limitations. It is based on students' self-reports that could have produced a response bias. However, it is likely that the use of the event list may be an advantage because it promotes recognition rather than recall, which is less distressing in the report of emotionally stressful events.<sup>30</sup> Negative affectivity might function as a confounder influencing reporting, but the fact that the subjects are adolescents might produce less of a memory bias, as some events are more recent compared to similar studies of adult subjects. The anonymity of the classroom could for some have made reporting easier compared to an interview. Although the event questionnaire has not been validated, it seems to function well across European cultures.<sup>13</sup> Finally, because of the design of the study there was no way of reporting whether an event had occurred more than once, hence a distinction between the effect of a single event trauma and repetitive

traumas could not be made. The threshold for counting PTSD symptoms is high compared to other measures (for example PSS)<sup>31</sup> and Kubany and colleagues<sup>32</sup> found very good concordance between interview data and questionnaire data when asking about trauma events. The study is based on national representative populations and a total population sample with very high response rate, which strengthens the results and increases the generalisability.

### Clinical implications

As adolescence is a risk period with a considerable exposure to stressful events and 6-20% in the national populations at one point in their lives suffer from PTSD, it is important that mental health professionals learn to identify adolescents at risk and offer intervention where needed.

A standard procedure should be developed for obtaining information about stressful events from adolescents as part of the assessment and planning of interventions. Such routine procedures may result in a broader and more effective intervention program for this age group.

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# Prevalence of traumatic events and posttraumatic stress symptoms in a student sample in Poland

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## Abstract

The study investigated the prevalence of traumatic events and posttraumatic symptoms among university level students in Poland. Data was collected from 475 students:

69% women and 30% men, mean age 22.9. The measures included SLESQ, Mississippi-C Scale, IES and BDI. At least one traumatic event (according to DSM-IV) was reported by 75.6% of the studied group. Prevalence of traumatic events was higher for men than for women. Life threatening accidents, child physical abuse, traumatic bereavement, witnessing death/assault and adult physical assault/abuse were the most commonly experienced events in the whole group. There were differences in prevalence rates of specific types of traumatic events between men and women. The level of posttraumatic events between groups with different levels of exposure to trauma was analysed, as well as between the groups of persons who experienced particular types of traumatic events as compared with the groups of subjects with no exposure to this type of trauma.

*Keywords:* prevalence of traumatic events, post-traumatic symptoms, SLESQ, university students

## Introduction

Originally, research on traumatic experiences and PTSD focused on survivors of combat and war trauma (e.g. Vietnam war veterans and Holocaust survivors) and specific traumas such as natural disasters, rape or criminal assaults. Research on the prevalence of traumatic events in the general population started about 15 years ago.<sup>1</sup> These studies provide data on the prevalence of PTSD and distributions among different groups, suggest risk factors for PTSD, and identify the types of traumas most likely to lead to PTSD.<sup>2</sup>

Estimates of the prevalence of exposure to trauma vary by the definition of the traumatic stressor and the methods used to measure exposure to traumatic events. Studies on the prevalence of trauma in the general population suggest that it is rather common for people to experience different traumatic events during their lives.<sup>3,4</sup>

Research on university level students can be seen as reflective of the studies on the general population, as they are not done on any specific clinical groups or a group of persons with increased risk of PTSD (e.g. survivors of disaster or combat veterans). The data offers information on the possible threats for mental and physical health in that group, and suggests how to arrange for prophylactic and therapeutic interventions.

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The first studies on the prevalence of traumatic events among college students were done in the USA. Vrana and Lauterbach,<sup>5</sup> using the Traumatic Events Questionnaire, found that 84% of college students related that they had been exposed to at least one traumatic event during their life. More than one third of the respondents in that study experienced four or more traumatic events. Bernat, Ronfeld, Calhoun and Arias<sup>6</sup> studied 937 students (303 men and 634 women; mean age: 19.7) from a university in the southern USA, measuring the prevalence of traumatic events using the TAA Questionnaire.<sup>7</sup> In addition to the items dealing with such traumatic events as combat, physical and sexual assault, life threatening illness and being a witness to somebody being seriously injured or killed, the authors added questions about physical abuse in childhood and about an event the respondent would not like to describe. 67% (N=626) of the students sampled reported experiencing at least one high-magnitude traumatic event in their lifetime. 35.5% of the respondents related experiencing a natural disaster. Other highly prevalent traumatic events among that group of students were: serious accident (31.9%), being witness to serious injury or death (22%), and experiencing sexual coercion during adolescence (21.5%).

Goodman, Corcoran, Turner, Yuan and Green<sup>8</sup> studied a group of college students using their own Stressful Life Events Screening Questionnaire (SLESQ). 72% (N=140) of the respondents reported at least one traumatic event. The mean number of events was 1.83 (SD=1.96). There was no significant difference in the total number of events reported by women vs. men. Child and adult physical abuse/assault, sudden bereavement, and life-threatening accidents were the most

commonly experienced events. Women were significantly more likely than men to have been molested and to have experienced attempted sexual assault. Men were significantly more likely than women to have experienced adult physical assault, and other serious injury or life threat. Green et al.<sup>9</sup> also used SLESQ to study second-year female university students (N=2.507). Besides measuring the prevalence of traumatic events the authors compared outcomes of single vs. multiple trauma exposure. The psychological consequences of trauma were measured with Trauma Symptom Inventory, TSI.<sup>10</sup> 65% of the studied sample reported at least one event and 38% reported two or more event types. According to Green et al. the results of their study show that it is important while estimating the impact of a particular type of traumatic event to measure other exposures in the studied group.<sup>9</sup>

Purves and Erwin<sup>11</sup> conducted research on 700 students during their first years of university in Great Britain (222 men and 465 women, mean age: 23, SD=6.26). To measure the prevalence of traumatic events the authors asked one question based on the definition of trauma in DSM-III-R. 39% of the students responded that they had experienced a traumatic event. The authors estimated also the level of "posttraumatic stress" (PTSD), with the high lifetime prevalence = 23.3%.

Amir and Sol's<sup>12</sup> study was completed using Israeli students. Besides prevalence of traumatic events the authors analysed the outcomes of single vs. multiple traumas and also the impact of physical injury. Among the 983 students (412 men, 571 women) in this group, 20% (98 men and 100 women) were army officers, which according to the authors is typical among the student population in Israel, as all Israeli citizens must complete mandatory military service. To

measure prevalence of traumatic events an Israeli version of the Traumatic Event Questionnaire<sup>6,13</sup> was used. The authors qualified as traumatic those events which follow the DSM-IV definition – but respondents were asked to relate only the events they experienced personally. Out of ten questions, six were related to the exposure to traumatic events associated with combat. The “psychological impact” of traumatic events was measured with IES, PTSD Scale and SCL-90. 67% of respondents in that study related experiencing at least one traumatic event, 31% experienced two events and 37% more than two events. Among those who experienced at least one traumatic event, 6% (N=38) received a “full” PTSD diagnosis, which represented 4% of the whole study group. The study also found significant differences in the level of psychological distress between the persons who did not relate any exposure to trauma and those who experienced at least one traumatic event. The persons who experienced physical injury scored significantly higher in SCL-90 compared to those without such injuries.

Haden, Scarpa, Jones & Ollendick<sup>14</sup> studied 150 undergraduate students (50 male, 100 female; the mean age = 19.33; SD=1.31). Participants reported experiencing a range of traumas including accidents (e.g., car accidents, 30%), natural disasters (24%), violent crimes (16%), unwanted adult sexual experiences (14%), childhood abuse (10%), and abusive relationships (6%). The number of years since participants experienced the reported trauma ranged from a few months to 18 years, with an average time of 5 years and 6 months (SD=4 years, 5 months).

#### *Aims of the study*

The aims of the present study were two-fold: (1) to get preliminary data on the

psychometric characteristics of the Polish adaptation of Stressful Life Events Screening Questionnaire (SLESQ) by Goodman et al.<sup>8</sup>; and 2) to estimate the lifetime prevalence of traumatic events and the level of post-traumatic symptoms among the sample of university students.

#### **Method**

##### *Procedure and participants*

There were 475 participants; 325 women (69.4%) and 143 men (31.1%). The mean age of the study group was 22.92 (SD=3.89), with the majority of participants between the ages of 20 and 24 (84%). Participants were recruited from seven university-level schools and faculties located in Warsaw. The data were collected either before or after the lectures/seminars. Subjects agreed to participate voluntarily, and the study was anonymous. Substantial physical distance between the subjects was provided. Persons conducting the study have had previous experience in implementing clinical psychology studies.

##### *Measures*

Stressful Life Events Screening Questionnaire, SLESQ<sup>8</sup>

SLESQ is 13-item self-report screening measure designed to assess lifetime exposure to a variety of traumatic events. Participants are asked whether they have experienced each of 11 events and two “catch-all” experiences. If they answer affirmatively they are asked to provide additional information including the following: age (of self and perpetrator), a brief description of the event, extent of injuries, relationship to perpetrator, frequency of occurrence, etc. This descriptive information can be used by researchers to see if the description of the traumatic event fits the A1 definition of PTSD. Goodman et al.<sup>8</sup> reported good test-retest reli-

ability, with median kappa of 0.73, adequate convergent validity (with lengthier interview) with median kappa of 0.64, and good discrimination between Criterion A and non-Criterion A events.

In a preliminary study of a group of 100 students in Warsaw (test-retest interval: 2 to 4 weeks) median kappa was 0.74 (the range for particular items was from 0.68 to 1.00).

#### Mississippi-C PTSD Scale<sup>15,16</sup>

A civilian version of Mississippi Scale for Combat-Related PTSD<sup>15</sup> was developed to measure PTSD symptomatology. The 35-item scale is derived from DSM-III PTSD diagnostic criteria and requires subjects to rate items on a 5-point Likert scale. Lis-Turlejska and Łuszczynska-Cieślak<sup>17</sup> describe four studies using a Polish version of the Mississippi PTSD-C Scale. The results show satisfactory reliability and validity of the Polish version of the Scale. Cronbach's alpha for the present study = 0.91.

#### Impact of Event Scale (IES)<sup>18</sup>

IES is the self-report 15-item measure of subjective stress related to specific events. Participants were instructed to think about an especially difficult event from the previous questionnaire (SLESQ). Based on that event, they were instructed to rate the frequency with which they had experienced each of the 15 symptom statements during the past seven days. Cronbach's alpha for the present study = 0.92.

#### Beck's Depression Inventory (BDI)<sup>19</sup>

BDI consists of 21 items describing various symptoms of depression. Each item is rated on the scale of 0-3 with a rating of 3 reflecting the greatest intensity of feeling. The subject is instructed to base his or her ratings on the way he or she has been feeling over

the past week. A Polish translation of BDI was used in several studies on representative national samples.<sup>20</sup> Cronbach's alpha for the present study = 0.87.

## Results

### *Prevalence of traumatic events*

Similar to the research done in other countries, the results show that traumatic events had been experienced by the majority of the students in the study group. Among the respondents, 345 subjects (75.6%) experienced at least one potentially traumatic event according to the Criterion A1 of the PTSD diagnosis.<sup>21</sup> 26.5% experienced one such event, 20.9% – two, 11.75% – three, and 8.55% – four events. 77 subjects (16.5%) experienced four or more traumatic events. Men experienced a greater mean number of events than women ( $M=2.21$ ;  $SD=1.67$  vs.  $M=1.68$ ;  $SD=1.69$ ,  $t(466)=3.12$ ,  $p<0.001$ ).

Life threatening accidents, child physical abuse, traumatic bereavement, witnessing death/assault and adult physical assault/abuse were the most commonly experienced events in the whole group. There were significant differences between genders in the prevalence of particular types of traumatic events. The highest prevalence rates among women were related to experiences of traumatic bereavement, child physical abuse, life threatening accidents and witnessing death or assault. Women also were significantly more likely than men to have been molested, to have experienced being sexually abused and to have experienced attempted rape. Men had the highest prevalence rates for experiencing robbery/mugging, life threatening accidents, child physical abuse, witnessing death/assault, adult physical assault/abuse and being threatened with a weapon. Prevalence rates of the traumatic events are presented in Table 1.

**Table 1.** Prevalence of potentially traumatic events by gender.

Traumatic event	Total, N=468, %	Women, N=325, %	Men, N=143, %	$\chi^2$ df=1
Life-threatening illness	12.4	12.6	11.9	0.05
Life-threatening accident	23.5	21.2	28.7	3.06
Robbery/mugging	18.8	9.3	40.6	63.56***
Traumatic bereavement	21.8	23.1	19.0	0.96
Sexual assault (penetration)	5.8	7.7	1.4	7.16**
Attempted sexual assault	3.9	4.9	1.4	3.35*
Molestation	8.8	12.0	1.4	13.96***
Child physical assault/abuse	23.1	22.5	24.5	0.65
Adult physical assault/abuse	12.2	8.6	20.3	12.5**
Threatened with weapon	9.6	5.2	19.6	23.41***
Witnessed death/assault	20.8	19.4	23.9	1.24
Other life threat (e.g. combat)	4.3	3.4	6.4	2.15
Other horrifying event	18.7	17.3	21.9	1.31

\*)  $p < 0.05$ ; \*\*)  $p < 0.01$ ; \*\*\*)  $p < 0.001$ .

*Comparing the data on the prevalence of traumatic events among Polish and American study groups using the SLESQ to measure exposure to traumatic events*

As Table 2 shows there are some differences between the data from Goodman et al.<sup>8</sup> and Green et al.<sup>9</sup> and the prevalence rates obtained in the present study, which used the same instrument (SLESQ) to measure exposure to traumatic events.

Comparing the results of the present study with the data from Goodman et al.<sup>8</sup> our research shows that among the Polish students there are much higher rates of experiencing robbery/mugging (19% vs. 6%), witnessing someone being killed/assaulted (21% vs. 12%) and life threatening accidents (24% vs. 16%). The rates of traumatic events associated with sexual abuse: sexual assault (penetration) and molestation are lower among the Polish students than among the American ones (6% vs. 11% and 9% vs. 14%). The differences between the sexual abuse rates for the Polish and American students are more salient when comparing the rates among only the women.<sup>9</sup> Attempted rape was reported more than twice as less often by the Polish women students

compared to the Americans. The rates for sexual assault and molestation are higher in the American groups. Also the rates of adult physical abuse in women (the wording of this item stresses the abuse is perpetrated by a partner and/or family member) are much higher among the American women students (9% vs. 18%).

The present data show that Polish students, compared with their American counterparts, have experienced more traumatic stress events, especially connected with criminal assaults and life threatening accidents. However, the rates of sexual assault, attempted rape, molestation and adult physical abuse are lower for Polish students. It is not clear whether the data presented here reflect the real picture of the prevalence of these types of traumatic events or if there are cultural differences in perception and readiness to disclose these kinds of events.

*Exposure to traumatic events and level of post-traumatic symptoms*

The IES and Mississippi-C Scale were used to assess posttraumatic symptoms, and BDI was used to assess the symptoms of depression. The results are shown in Table 3.

**Table 2.** Prevalence of traumatic events among Polish and American students.

Traumatic event	Lis-Turlejska (SLESQ) N=468 %	Goodman i in. 1998 (SLESQ) N=202 %	Green et al., 2000 (SLESQ) N=2507(women only) %
Life-threatening illness	12	13	8
Life-threatening accident	24	16	13
Robbery/mugging	19	6	3
Traumatic bereavement	22	19	15
Sexual assault (penetration)	6	11	14
Attempted sexual assault	4	8	12
Molestation	9	14	19
Child physical assault/abuse	23	22	17
Adult physical assault/abuse	12	18	18
Threatened with weapon	10	6	–
Witnessed death/assault	21	12	18
Other life threat (e.g. combat)	4	11	–
Other horrifying event	19	13	20
Any trauma (excluding „other“)	72.4	66	65

**Table 3.** Descriptive statistics for Mississippi-C, IES and BDI.

Measure	M	SD	Min	Max
Mississippi-C	73.97	17.27	43	147
IES – total	16.20	18.32	0	71
Intrusions	6.08	8.40	0	35
Avoidance	8.68	10.01	0	36
BDI	7.97	7.75	0	53

The study group was divided according to the number of traumatic events experienced. The first group (N=114) consisted of the subjects who did not report any traumatic event; group two (N=114) consisted of subjects who experienced one traumatic event; group three (N=98) experienced 2 events and group four, 3 or more events. The level of symptoms as measured with IES in these four groups was compared with one-way analysis of variance ANOVA (and additionally the Gabriel's and Games-Howell's tests). There were significant differences between the groups ( $F_{[3,42]}=9.542$ ;  $p<0.01$ ). There were no significant differences between the group without exposure to any traumatic event and the group with only one

traumatic event ( $p=0.25$ ). There was also no significant difference between the group of subjects who experienced two events and those who experienced three or more traumatic events ( $p=0.97$ ). However, the group of the students with no traumatic event had a lower level of symptoms compared to the subjects who experienced two such events ( $p<0.01$ ) and the group of subjects who experienced three or more traumas ( $p<0.01$ ).

There were statistically significant differences between groups in the level of posttraumatic symptoms measured using Mississippi-C ( $F_{[3,40]}=3.437$ ;  $p<0.05$ ). There was also difference between the group with no traumatic event and the group with three or more such events ( $p=0.03$ ), such as a difference between the group of subjects who experienced one traumatic event and the group of persons who experienced three or more traumas ( $p=0.06$ ). There was no significant difference between the subjects who were not exposed to trauma and those with one traumatic event ( $p=1.00$ ) or two such events ( $p=0.68$ ). Also there was no dif-

ference between the groups of subjects who experienced one vs. those who experienced two traumatic events ( $p=0.84$ ). The level of symptoms in this group does not differ from the group with three or more traumas.

The level of posttraumatic symptoms between the groups of persons who experienced a particular type of traumatic event with the groups of subjects with no exposure to this type of trauma was compared. The significance of the differences was analyzed with the t Student's test for the independent groups, with the Cox-Cochrane correction if the variances were heterogenic.

This analysis was done for the BDI, IES and Mississippi-C scores. The results showed that the persons who experienced rape or child physical abuse have a significantly higher level of depression compared to those who did not have such traumatic experiences.

For the IES scores almost all types of traumatic events are significantly correlated with the level of posttraumatic symptoms (exceptions are: robbery/mugging; adult physical assault/abuse; being threatened with a weapon). For the Mississippi-C scores the results of the analysis show that the subjects who experienced serious accidents, physical assault/abuse in childhood, being threatened with a weapon or witnessing someone being killed or injured exhibit a higher level of posttraumatic symptoms.<sup>22</sup>

### Discussion and conclusion

One of the aims of this study was to obtain data for the Polish adaptation of Stressful Life Events Screening Questionnaire (SLESQ) as the measure of exposure to traumatic events. The obtained data on the psychometric characteristics of this instrument (reliability and validity) are promising. The kappa values for the whole questionnaire as well as for the items addressing specific types of traumatic events are satisfactory.

There are statistically significant differences between the prevalence of specific traumatic events between men and women. Men are more frequently victims of assaults and physical violence. Women are more likely to experience molestation and sexual assault. The differences in prevalence of specific traumatic experiences between the present results and the results obtained through study of American students (with the same measure) are worth attention: higher prevalence of events among Polish students involving physical violence (physical assaults, child physical abuse); lower prevalence of events involving sexual abuse (sexual abuse, molestation). Further research is needed however to clarify whether the data presented here reflect the real picture of the prevalence of these types of traumatic events or if they are due to cultural differences in perception and readiness to disclose these kinds of events.

The results indicate the interdependence between the overall number of experienced traumatic events and the intensity of posttraumatic symptoms (statistically significant correlations with IES and Mississippi-C scores) and the exposure to specific types of traumatic events and intensity of posttraumatic symptoms.

While analysing and interpreting the data on the prevalence of traumatic events among the university level students it is worth considering that the highest rates of exposure to traumatic events were obtained among subjects aged between 16 and 20.<sup>2</sup> Obviously, however, the data on the prevalence of traumatic events among the students from the university level schools in Warsaw needs attention, especially those who have been exposed to multiple traumas. Previous research<sup>9</sup> confirms that multiple exposures are associated with a significantly higher risk of posttraumatic symptoms.

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# Comparing psychological responses of internally displaced and non-displaced Turkish Cypriots

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## Abstract

During the 1963-1964 ethnic conflict and 1974 war in Cyprus, many Turkish Cypriots were displaced by Greek Cypriot forces. The psychological condition of Turkish Cypriots after these conflicts has not been studied to the present day. At the time of the Annan Plan Referendum on April 24th 2004, when people on both sides were to decide whether to reunite or not, and when old traumatic events were being discussed in vivid detail, the psychological responses of the internally displaced and non-displaced Turkish Cypriots were investigated.

The sample of this study derived from a sample of a larger household survey study conducted on 408 adult people taken randomly from three different districts. People who settled down in Cyprus after 1974 or who had never experienced a war in Cyprus were not included in the study. 129 Turkish Cypriots who experienced either the 1963-64 conflict or the 1974 war were included in the present study. 86 of these had been displaced. The first part of the questionnaire that was administered to the subjects included demographic characteristics, war-related traumatic experiences, the level of seriousness, and traumatic incidents resulting from other circumstances. In the second part of the questionnaire, the Traumatic Stress

Symptom Checklist (TSSC) and Brief Symptom Inventory (BSI) were used to investigate the symptoms of the post-traumatic process.

The outcomes indicate that the internally displaced persons (IDPs) were subjected to traumatic incidents at a higher degree due to killing, displacement, captivity, or killing of family members and relatives. The rate of posttraumatic stress disorder (PTSD) of IDPs is 20%, and is significantly higher than for non-displaced persons. The comparison of BSI subscales show that IDPs had a higher level of depression scores than the non-displaced persons. The somatization subscale scores are higher in non-displaced persons.

The study reveals a higher frequency of war-related traumatic events in IDPs than in non-displaced people, greater suffering from post-traumatic stress and more negative beliefs about future reunion.

*Keywords:* internal displacement, PTSD, Cyprus conflict

## Introduction

The definition of internally displaced persons is given by the Representative of the Secretary General on Internally Displaced Persons as followed: "Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situation of generalized violence, violation of human rights or natural or man-

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made disasters; and who have not crossed an internationally recognized state border.”<sup>1</sup>

Although many studies have focused on refugees’ traumatic experiences and the effects of these experiences on their mental condition as well as on their process of adaptation to their new environments, internally displaced people (IDP) have received much less attention. The United States High Commission for Refugees stated that by the end of 2004, approximately 35.5 million of the world’s population had been forced to leave their homes due to organized violence. Nearly 23.6 million people became IDPs and 11.9 million left their countries to become refugees.<sup>2</sup>

Cyprus, an island in the Mediterranean Sea, has long suffered from foreign domination and ethnic conflict. The ethnic conflict between the Turkish Cypriot and the Greek Cypriot communities has been continuing for more than 40 years. The displacement of Cypriots can be traced to two important political incidents.

The first of these incidents was the inter-communal violence of 1964. Approximately 20,000 Turkish Cypriots were forced to move to Turkish Cypriot enclaves. Twenty-four Turkish villages and Turkish houses in seventy-two mixed villages were abandoned. Most of these movements seem to have been caused by fear, but in some cases the people involved were forced to leave.<sup>3</sup>

The second wave of displacement came in July-August 1974. When the military junta of Greece removed the legal president, Turkey intervened in Cyprus in July 1974. It is reported that 180,000 to 200,000 Greek Cypriots fled to the south and approximately 50,000 to 60,000 Turkish Cypriots, many of whom had been displaced before,<sup>3</sup> escaped to the north.

In over 30 years, 210,000 ethnic Greek and Turkish Cypriots have been internally displaced, the longest-standing internal

displacement situation in Europe. The internally displaced people (IDPs) are no longer in need of humanitarian aid in Cyprus unlike in the vast majority of protracted displacements in the world. On both sides of the island, the IDPs are helped to integrate into the community by the respective authorities. In the South, IDPs have received much support from the Greek Cypriot government through special programmes that include social and tax benefits. In the North, the Turkish Cypriot government has allocated properties abandoned by the Greek Cypriot owners to the displaced people.<sup>4</sup>

The Annan Plan was a United Nations proposal aimed at settling the Cyprus dispute and uniting the divided island as the United Cyprus Republic.<sup>5</sup> In the 2004 referendum on the Annan Plan, 75 percent of Greek Cypriots voted “no” because of their perception that the Annan Plan was biased and excessively pro-Turkish. On the other hand, 65 percent of Turkish Cypriots were willing to accept it as they believed it would end their prolonged international isolation and exclusion from the European economy.

The aim of this study is to investigate the psychological responses of the internally displaced and non-displaced Turkish Cypriots in the period when the two communities were voting for and against reunification and when the old traumatic events of the past were high on the agenda. We aim to investigate 1) the prevalence of posttraumatic stress and other psychological symptoms within the IDPs compared with the control group, 2) the attitudes of IDPs for the future and reunification compared with the control group.

### Method

*Sample:* The sample of this study is derived from a sample of a larger household survey study conducted on 408 people taken randomly from three different districts.<sup>6</sup> A strat-

ified sampling quota was used for the purpose of comparison and to keep the samples from each district as similar as possible. Age (35 and older), gender (male/female), nationality (Turkish Cypriot) and geographical region (Alayköy/Gönyeli/Lapta) were used as strata. Alayköy was a predominantly Greek village where most of the houses belonged to Greek Cypriots before 1974. After the 1974 Turkish military intervention, Turkish Cypriots who were forced to leave their own houses in the South were given these houses by the Turkish Cypriot government. Lapta village had the same history. Gönyeli was a Turkish Cypriot village in the past and the population was not displaced. 129 people who are originally Turkish Cypriots and who had experienced at least one war in Cyprus participated in the present study. 158 people were left out of the study because they had settled down in Cyprus after 1974 and 121 people were eliminated because they had never experienced a war in Cyprus.

*Procedure:* In this cross-sectional survey, face to face interviews were conducted by volunteer fourth year students studying at the Psychology Department of Near East University in Northern Cyprus. Before conducting the interviews, each student was trained about the content of the questions and how they should apply. The data were collected over a period of two weeks.

Interviewers proceeded in a specific order when selecting households in order to eliminate interviewer bias. First they started from the centre of the villages and went north, east, south and west and covered squares. That is to say, they started at the house with the lowest number on the right-hand side of a street and went to every third house. At the first turning, they would turn right and would continue contacting households on the right-hand side until they covered the whole square. Then they would

proceed to the next square and followed the same procedure.

*Instruments:* The interview comprised four parts administered in the following sequence:

The first part of the questionnaire was about socio-demographic factors and pertinent background information. The questions were designed to obtain data on sex, age, marital status, level of education, employment details, monthly income, location of the house, the legal status of the house (whether or not their house belonged to a Greek Cypriot), whether or not the district will be given back to the Greek Cypriots according to Annan Plan provisions and also the opinions of the participants about their anticipated sense of security and socio-economic status in the case of Greek Cypriots settling in North Cyprus.

The second part of the questionnaire included questions designed by the researcher to determine any previous trauma history as regards to childhood abuse, natural disaster, fire or explosion, traffic accidents, physical or sexual assault, presence in a war or internal conflict area, torture or similar maltreatment, events like murder or suicide, sudden death of a loved one, sudden separation from a loved one, family violence, sudden loss of a job or severe financial difficulties, workplace accident, or any other stressful events. War-related experiences were also investigated according to the type and severity of traumatic events. Questions were yes/no type and enquired about experiences related to hearing, witnessing and experiencing displacement, injury, imprisonment or death of friends, relatives, family members and self.

The third part of the questionnaire included the Traumatic Stress Symptom Checklist (TSSC) to determine post-traumatic symptoms. The checklist was composed of 17 items related to DSM-IV

Variable	IDP	Non-displaced	p
Age	54.61±11.35	52.14±12.11	t=-1.142 p=0.256
Gender			
Female	43 (50%)	21 (48.8%)	$\chi^2=0.016$ p=0.901
Male	43 (50%)	22 (51.2%)	
Marital Status			
Single	4 (4.7%)	1 (2.3%)	$\chi^2= 2.964$ p=0.397
Married	70 (82.4%)	40 (93%)	
Widowed	8 (9.4%)	1 (2.3%)	
Divorced	3 (3.5%)	1 (2.3%)	
Education Level			
Literate	1 (2.3%)	2 (2.4%)	$\chi^2=2.245$ p=0.691
Primary	23 (53.5%)	42 (49.4%)	
Secondary	2 (4.7%)	11 (12.9%)	
High School	12 (27.9%)	20 (23.5%)	
University	5 (11.6%)	10 (11.8%)	
Monthly Income			
550 YTL or less	16 (18.8%)	1 (2.3%)	$\chi^2=6.783$ p=0.079
551-1000 YTL	31 (36.5%)	19 (44.2%)	
1001-2000YTL	24 (28.2%)	14 (32.6%)	
2001-4000YTL	14 (16.5%)	9 (20.9%)	

**Table 1.** Comparison of demographic characteristics of IDP and non-displaced persons.

criteria for PTSD and six items for depression. Responses were scored on a 0-3 point scale. Validity study for TSSC showed that it has high internal consistency and satisfactory sensitivity and specificity in predicting the diagnosis of PTSD and major depression when compared with Clinician-Administered PTSD Scale and the Major Depressive Episode module of the Semistructured Clinical Interview for DSM-IV. The cutoff point for PTSD was 25 for the 17 PTSD items and cutoff point for major depression was 38 for the whole scale. The score of the whole scale in predicting major depression diagnosis was higher than that of the six depression items.<sup>7</sup>

The fourth part of the questionnaire contained the Brief Symptom Inventory (BSI), which is a 53-item reversion of the Symptom Checklist-90 (SCL-90-R), intended to determine mental health problems. The responses were rated on a 0-4 point scale, with higher mean scores indicating greater levels of psychological distress on ten symptom dimensions: somatization,

obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism and additional items.<sup>8</sup>

Finally, the fifth part of the questionnaire included open-ended questions on the Annan Plan and its content, as well as decisions of the participants regarding the plan and the referendum.

#### Statistical analysis

All analysis was performed by using SPSS. 13.0 for Windows. Group differences for continuous variables such as age and test scores were evaluated by means of Student's t-test. Group comparison for categorical variables was calculated by Chi-square test.

#### Results

##### Demographic characteristics

There were 64 (49.4%) female and 65 (50.6%) male subjects. The mean age of the subjects was 53.80±11.62 (range: 35-82). 81.5 percent of subjects were married. 86

Variable	IDP	Non-displaced	p
Relatives murdered			
Yes	56 (65.1%)	20 (46.5%)	$\chi^2=4.099$
No	30 (34.9%)	23 (53.5%)	$p=0.043^*$
Family member forced displacement			
Yes	66 (77.6%)	18 (41.9%)	$\chi^2= 16.211$
No	19 (22.4%)	25 (58.1%)	$P=0.000^*$
Imprisonment of family member			
Yes	51 (60.0%)	14 (32.6%)	$\chi^2=8.603$
No	34 (40.0%)	29 (67.4%)	$P=0.003^*$
Family member murdered			
Yes	37 (43.5%)	10 (23.3%)	$\chi^2=5.051$
No	48 (56.5%)	33 (76.7%)	$p=0.025^*$
Imprisonment			
Yes	19 (22.1%)	3 (7.0%)	$\chi^2=4.631$
No	67 (77.9%)	40 (93.0%)	$p=0.031^*$
Torture			
Yes	13 (15.1%)	2 (4.7%)	$\chi^2=3.055$
No	73 (84.9%)	41 (95.3%)	$P=0.080$

\*)  $p < 0.05$  statistically significant

**Table 2.** Comparison of war-related trauma between IDP and Non-displaced persons.

(66.7%) of them were displaced persons and 43 (33.3%) of them were non-displaced persons. There were no statistically significant differences between displaced and non-displaced subjects in terms of age, gender, marital status, education level or monthly income (Table 1).

#### *Traumatic Experiences*

No significant difference was observed between displaced and non-displaced subjects with respect to effects of traumatic events not related to war during their life time or in the previous six months.

There were however significant differences between displaced and non-displaced persons regarding war-related trauma. Displaced persons experienced and witnessed war-related trauma whereas non-displaced person mostly reported that they heard about war-related trauma. Displaced persons reported significantly higher rates of their relatives being killed (65.1%); family members being forced to displace (77.6%), taken as prisoners and killed (43.5%) (Table 2).

For both female and male subjects, there were statistically significant differences between displaced and non-displaced persons in the mean score of TSSC. Whether female or male, displaced persons' traumatic stress symptom scale-PTSD subscale scores or depression subscale scores were significantly higher than non-displaced persons (Table 3).

There were statistically significant differences between displaced and non-displaced persons in depression and somatization subscales of Brief Symptom Inventory (BSI) (Table 4). Displaced persons had higher mean scores of depression symptoms than non-displaced persons ( $p=0.022$ ). Non-displaced persons had higher mean scores of somatization symptoms than displaced persons ( $p=0.032$ ).

45% of displaced persons believed that their security would deteriorate if they lived together with Greek Cypriots. 20.9% of non-displaced persons shared this opinion. Regarding their opinions about their socioeconomic conditions when living with Greek Cypriots, 31.4% of displaced persons

**Table 3.** Comparison of TSSC score between IDPs and non-displaced persons.

	Displaced persons Mean±SD	Non-Displaced persons Mean±SD	t (p)
Traumatic stress symptoms scale-PTSD subscale			
Female	18.05±11.39 (n=43)	11.28±8.62 (n=21)	-2.400 (0.019)*
Male	10.83±9.68 (n=42)	6.36±4.74 (n=22)	-2.478 (0.016)*
Traumatic stress symptoms scale-depression subscale			
Female	22.58±14.02 (n=43)	14.05±10.96 (n=21)	-2.444 (0.017)*
Male	13.09±12.25 (n=42)	7.36±5.96 (n=22)	-2.035 (0.016)*

\*) p<0.05 statistically significant

**Table 4.** Comparison of mean scores of Brief Symptom Inventory subscales

Subscales	Non-displaced persons Mean±SD	Displaced persons Mean±SD	t (p)
Somatization	5.69±5.35 (n=43)	3.70±4.67 (n=84)	-2.164 (0.032)*
Obsessive-compulsive	3.79±2.63 (n=43)	3.61±2.87 (n=85)	0.342 (0.733)
Interpersonal Sensitivity	1.95±2.25 (n=43)	2.72±2.10 (n=85)	-1.922 (0.057)
Depression	1.95±2.28 (n=43)	3.12±2.89 (n=86)	-2.322 (0.022)*
Anxiety	2.86±2.97 (n=43)	3.87±4.07 (n=83)	-1.452 (0.149)
Hostility	2.88±2.48 (n=43)	2.72±3.30 (n=85)	0.270 (0.787)
Phobic anxiety	1.09±1.37 (n=43)	1.44±2.28 (n=85)	-0.932 (0.353)
Paranoid thought	5.41±3.89 (n=43)	4.70±3.56 (n=85)	1.034 (0.303)
Psychoticism	0.76±1.32 (n=43)	0.98±1.62 (n=86)	-0.771 (0.442)
Additional items	1.67±2.36 (n=43)	1.61±2.11 (n=85)	0.152 (0.879)

\*p<0.05 statistically significant

thought that their socioeconomic condition would worsen. Only 11.6% of non-displaced persons expressed the same concern.

### Discussion

The findings of the present study indicate that displaced persons had higher PTSD symptom scores than non-displaced persons. In this research, 20% of displaced persons had PTSD. Population-based studies report a prevalence of PTSD ranging from 3.5% to 86% among refugee populations (9, 10).

Even though it has been more than 30 years since the war in 1974, the findings of the study reveal that displaced persons have higher PTSD scores than non-displaced

persons. This is consistent with the findings of other similar studies. High rates of PTSD symptoms many years after the traumatic event are reported in numerous studies.<sup>11-13</sup>

PTSD symptoms can also be reactivated by current stressors which remind subjects of a posttraumatic event.<sup>14</sup> In a study about refugees from the former Yugoslavia living in Sweden there was no change in the average symptom levels during the follow up study conducted 3 years later. The author reported that the follow-up ratings were made during the war in Croatia when the mass media carried an abundance of reports on atrocities and that this could well have had a re-traumatizing effect on the subjects, reactivating

symptoms.<sup>15</sup> The present study was made one week before the time of the referendum on the Annan Plan and during that period there were images of the 1963-1964 conflict and 1974 war, and pictures depicting violence toward Turkish Cypriots by Greek Cypriots. This could have had a re-traumatizing effect on displaced persons in North Cyprus.

The present study indicates that displaced persons experienced more war-related traumatic events such as relatives being murdered, family members being forced to displace, being taken as prisoners and murdered than non-displaced persons. Many of the studies on refugees report that the loss of a close relative is a predictor of frequency of PTSD symptoms.<sup>16</sup> Furthermore, the frequency of war-related traumatic events had a dramatic effect on PTSD symptoms.<sup>17</sup>

According to the BSI scores, displaced and non-displaced persons did not show any psychopathology. The results indicated that both groups have the ability to cope with stress. In a study comparing displaced and non-displaced persons' coping strategies in Croatia, the researcher found that displaced and non-displaced persons use coping strategies with similar frequency and effectiveness.<sup>18</sup>

The present study showed that 8(9.4%) of displaced and 1(2.3%) of non-displaced persons had major depression according to TSSC depression subscale. Displaced persons had higher scores from non-displaced persons also at BSI depression subscale. Most of the population-based studies indicate rates of depression ranging from 15% to 80% amongst refugees.<sup>9, 19-21</sup>

The studies which investigated the effect of different life events on disorders revealed that people who have experienced loss of a close relative are especially prone to depression.<sup>22-24</sup> The present study showed that

among displaced persons, 78.8% have suffered loss of a friend, 65.1% loss of a relative and 43.5% loss of a family member during the war. Displaced persons suffered more losses than non-displaced persons. In addition, the psychological response to loss of property could have similar features to the psychological response to loss of a close person and might cause a high ratio of depression symptoms in displaced persons.<sup>25</sup>

The present study indicated that non-displaced persons had higher scores from BSI somatization subscale. The findings of a large-scale international study that used data from 14 countries indicated that the overall prevalence rate for somatization was 19.7%.<sup>26</sup> There are no studies that have evaluated the prevalence of somatization in a large community of recently displaced persons.

However a limited number of studies have dealt with migrant somatic complaints. Pang and Lee<sup>27</sup> reported 7.3% of somatic complaints in Korean migrants.<sup>27</sup> Ritsner<sup>28</sup> reported 21.9% and a high rate of somatic complaints related to distress in Jewish migrants in the U.S.<sup>28</sup> In a study on the psychosocial complaints of people forced into internal displacement in Turkey, it was reported that 10% of displaced persons had somatic complaints.<sup>25</sup>

Another study on the effects of forced internal displacement in the Southeast of Turkey showed that displaced persons had a higher rate of somatic symptoms than non-displaced persons.<sup>19</sup> In contrast, the present study revealed that non-displaced persons had a higher rate of somatic complaints than displaced persons. The explanation for this surprising finding is very hard to establish and requires some examination. Somatic complaints may appear with current psychosocial stressors, or if there has been a chronic somatization the symptom can be

reactivated.<sup>13</sup> People who cannot react to stressful situations in life may use somatic complaints as a defense mechanism. However somatic complaints should be evaluated in four major categories, according to whether the person's current presentation is a normal reaction to a stressful circumstance, an adjustment disorder, somatization due to major depression or an anxiety disorder, or a primary form of chronic somatization.<sup>29</sup>

The present study was carried out close in time to the Annan Plan Referendum and the two communities' responses to the plan would determine whether Turkish Cypriots and Greek Cypriots could live together. This period can be described as a very stressful period for the Turkish Cypriot community. Non-displaced persons reported more positive opinions regarding the future and potentially living with Greek Cypriots, but displaced persons' opinions were more negative. Non-displaced persons who had positive expectations concerning the future revealed somatic complaints regarding the stressful conditions. In contrast, displaced persons who had negative opinions concerning the future might have been expressing their stress through depression symptoms.

Although this study has been conducted more than 30 years after displacement, it is the first scientific examination of the psychological effects of displacement among Turkish Cypriots and it shows that psychological consequences are still being experienced and that further research and psychological support is necessary.

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# Prevalence of PTSD and related factors in communities living in conflictual area: Diyarbakir case

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## Abstract

*Objective:* In this study, we aimed to investigate the distribution of Post-Traumatic Stress Disorder (PTSD) among adults who were living in the Diyarbakir city center.

*Method:* Data was obtained from 708 participants that represented the demographic structure of Diyarbakir. Houses to be visited were determined in collaboration with the Turkish Institute of Statistics.

*Results:* The prevalence of traumatic life experience was 47.9%. Most prevalent traumatic life experiences were forced emigration and witnessing of a case of murder or injury. The lifelong and current PTSD prevalence was 34.9% and 15.1%, respectively. We concluded that the prevalence of traumatic experiences and subsequent PTSD was high among people who were living in areas of conflict, and treatment opportunities were inadequate.

*Conclusion:* An important finding of this study is the association between the range of prevalence rates of traumatic experiences and risk factors for PTSD in an armed conflict region in Turkey. There is a need for studies that will also include people living in rural areas in order to understand the full picture of problems encountered by those

in areas of conflict. Moreover, we believe in the importance of an effective approach of institutional and occupational organizations not to leave these people alone with their traumatic experiences.

*Key words:* conflict region, trauma, post traumatic stress disorder, social support

## Introduction

The prevalence of PTSD was estimated between 2-15%, according to population based studies,<sup>1</sup> whereas this prevalence was reported to be between 3-58% in the risk groups.<sup>2-4</sup> It is also reported that trauma caused by humans have greater negative effects on mental health.<sup>5</sup> However, there is limited information concerning the prevalence of psychiatric disorders among people living in areas of conflict, especially those with a relatively low income, where trauma caused by humans is more prevalent. On the other hand, in a study conducted in four different regions with conflicts, the prevalence of PTSD was reported between 17.8-37.4%.<sup>6</sup> Cardozo et al.<sup>7</sup> and Cardozo et al.<sup>8</sup> found the prevalence of PTSD just after the Kosovo war and one year later as 17.1% and 25.0% respectively. The same prevalence was reported as 24.0% in another study that was performed in the same region later on.<sup>9</sup>

Experiencing a traumatic event does not in itself necessitate the development of

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PTSD.<sup>10</sup> There are also many factors that trigger improvement or chronic nature of the condition as well.<sup>11</sup> Improvement of the condition or development of chronic illness is generally affected by many factors before, during and after the trauma. For example, women develop PTSD twice as much as men who experience the same traumatic events. The condition shows a chronic pattern in more than half of the affected women.<sup>12</sup> It was reported that anxiety, functional impairment and physical symptoms were more prominent in women.<sup>13</sup> Positive history for previous psychiatric therapy, positive family history for psychiatric diseases, being divorced and exposure to torture or violence were known to have an effect on improvement or chronic nature of PTSD.<sup>11</sup>

It was also reported that patients with PTSD used health services more frequently than other individuals.<sup>14,15</sup> However, many of these studies were performed with refugees in developed countries. It was also ascertained that many patients who were living in areas of conflict and experienced traumatic events did not receive any treatment.<sup>16,17</sup> Two factors that affect the course of treatment were determined as need and accessibility. Severity of the disease was found to be important among factors of need, whereas accessibility was related with having economical resources like employment and health service awareness.<sup>18</sup> It was reported that untreated PTSD took a complicated stance with depression and substance abuse.<sup>19</sup>

Another tragedy encountered in areas of conflict is involuntarily internal displacement. The number of people forced into internal displacement within national borders was 23.7 millions worldwide by 2005 and although this number was twice as high as international refugees, it was reported that national internal displacements were

in worse conditions and received less attention.<sup>20</sup> In the USA it is reported that the highest mortality rates in people under emergency conditions were present among individuals subjected to internal displacement.<sup>21</sup> Studies conducted within the last few decades in developed countries which accepted refugees demonstrated that there was an increase in the relationship between trauma and psychiatric morbidities, and also in information concerning refugee communities who experienced the traumatization of war.<sup>22</sup> Epidemiologic studies demonstrate that the prevalence of PTSD among people who were subjected to involuntary internal displacement was between 4-20%.<sup>8,22,23</sup>

### Background

After the beginning of the 1980s, the South-eastern region of Turkey experienced a period of widespread violence that can lead to psychological traumas. It is still present today although its severity has decreased considerably. Thousands of people died, many people were injured and were exposed to traumatic events due to this conflict while they were trying to survive. On the other hand, from the end of the 1980s to the mid 1990s people living in especially rural areas of this region were obliged to migrate in mass numbers to bigger towns in or out of the region. There are a limited number of studies despite the various traumatic experiences and severe psychiatric disorders encountered in the conflicts areas. Moreover, it was reported that the number of studies that dealt with the prevalence of mental illnesses among people who were living in areas of conflict is limited.<sup>6</sup> All previous studies in Turkey investigated only one aspect of the problem and were performed in people who were subjected to national internal displacement. In a study performed during the earlier years of forced migration, it was shown

that traumatic experiences associated with conflicts were prevalent before and during migration and there was PTSD and other psychopathologies in 66% of the subjects who participated in the study.<sup>24</sup> We assume that the prevalence of psychiatric disorders related to conflicts may be high in our region as it is in other areas of conflict in the world. In this study, we aimed to investigate the distribution of traumatic life experiences and consequent PTSD among people who were living in the Diyarbakir city center that is situated in the area of armed conflict.

#### Materials and methods

The present study was a cross-sectional study. We carried out the study from May to July 2005. The study involved individuals who were older than 18 years of age and were living in the Diyarbakir city center. This number was 285,000 according to the 2000 census. The sample size of 270 subjects was calculated using the Epi Info 2000 software program by assuming the prevalence of PTSD as 0.02 (acceptable 0.03) in a 95% confidence interval. The houses to be visited were determined in collaboration with the Turkish Institute of Statistics. Fifty separate clusters representing the city center were established and 15 houses from each cluster were randomly chosen from the address lists and a list of 750 houses was obtained. One individual older than 18 years from each house was included in the study. The distribution of 15 individuals from each cluster according to age and gender was determined proportionately from the results of the 2000 census in the Diyarbakir city center. The individual to be interviewed was selected according to these criteria.

The questionnaires were administered by final year students from the Psychology Department of the Science and Literature School of Dicle University who were trained

by Psychiatry and Public Health professors, through a face-to-face interview method.

Inclusion criteria were: being older than 18 years, absence of any psychiatric or physical disorder that might affect the interview and acceptance to be a volunteer for the study. A total of 720 families were interviewed and their data were reviewed by the study group. Thirty families did not accept to participate in the study. Twelve subjects were excluded as their forms did not contain any information about PTSD or trauma. Demographic features, trauma experiences and related information were present for the remaining 708 participants.

#### Materials

##### 1. Socio-demographic characteristics

The questionnaire was developed by the Departments of Psychiatry and Public Health. The aim of this form was to demonstrate the demographic characteristics of the interviewed individual. Age, gender, marital status, employment status, language spoken, presence of social insurance, the type and duration of migration if present, presence of a traumatic experience, the type of traumatic experience and the period elapsed after the trauma, number of inhabitants, and total monthly income of the family, were investigated.

##### 2. Post-traumatic stress disorder scale (CAPS)

The CAPS that was administered to the subjects was the PTSD scale which is used for DSM IV. It was used for specific diagnosis of PTSD in three areas.<sup>25</sup> The scale determines the prevalence and intensity of each area as scores between 0-4. Total points between 0-19 were evaluated as asymptomatic, 20-39 were evaluated as mild, 40-59 as moderate, 60-79 as severe and over 80 were evaluated as very severe PTSD. The CAPS was translated into Turkish and reli-

ability and validity studies were performed.<sup>26</sup> The consistency between PTSD diagnoses of two separate interviewers was found to be high in the same study. Moreover it was found to be consistent with the structured SCID.<sup>26</sup>

#### Statistical analysis

Collected data was analysed using SPSS v. 15.00. In groups where frequencies were compared, the student's t test was used for analysis of continuous measurable variables and the chi-square test was used for categorical data. The Alpha value  $p < 0.05$  was considered to be significant.

#### Results

We determined that 15.1% of our participants had current PTSD, 34.88% of them had lifelong PTSD diagnosis according to CAPS and 47.88% of them according to the CAPS diagnosis A criteria. The mean time period that elapsed after traumatic experience was  $9.8101 \pm 6.0078$  years.

In our study, it was determined that the mean age was ( $33.4 \pm 6.48$ ), the mean number of people living in the same house was ( $6 \pm 2.75$ ) and the mean monthly income was ( $264.04 \pm 94.44$ ) Euro. From our participants, we determined that the main issues were migration (28.95%), absence of health insurance (28.1%) and illiterate education (32.4%). The socio-demographic characteristics of participants are presented in Table 1.

The most prevalent traumatic experiences were forced internal displacement without additional trauma (11.72%), traumatic loss (7.49%), being exposed to violence not in detention (6.78), and witnessing a murder or injury of relatives (5.93%). Types of traumatic life experiences of participants are presented in Table 2.

It is determined that predictor factors of

**Table 1.** Demographics variables of participants.

Demographic variable	N=708	%/SD
Gender		
Female	398	56.21
Male	310	43.79
Education		
Illiterate	228	32.20
Primary school	263	37.15
High school/or above	217	30.65
Health insurance		
Absent	199	28.11
Partial	179	25.28
Present	330	46.61
Employed status		
Housewife	328	46.33
Unemployed/unqualified	322	45.48
Public worker	38	5.37
Other	20	2.82
Immigration		
Forced migration	145	20.48
Voluntary migration	60	8.47
Total migration	205	28.95
Ethnic background		
Kurdish	432	61.02
Turkish	266	37.57
Arabic	10	1.41
Mean age	33.4	6.48
Mean monthly income	470.2	169.2
The mean number of people living in the house	6	2.75

**Table 2.** Participants' trauma type.

Types of trauma	N=708	%
Forced internal displacement with no report of additional trauma	83	11.7
Traumatic loss	53	7.49
Being exposed to violence not in detention	48	6.78
Witnessing only the physical violence form relatives	11	1.55
Witnessing the self-relative unrelated conflicts	38	5.37
Earthquake-accident-fire	42	5.93
Torture under detention	23	2.25
Witnessing a murder or injury of relatives	42	5.93
Violence in the family	19	2.68
Receiving death threats	38	5.37
Physical attack/purse-snatching	10	1.41
Sexual violence	10	1.41
Multiple trauma (2 or more)	35	4.94
Total trauma related with the conflicts	266	37.5
Total trauma	339	47.88

Predictor factors	Traumatic Experiences N=339		
	OR	CI	P
Number of people living in the house	1.010	0.941-1.086	0.776
Gender	0.856	0.514-1.426	0.551
Education	2.725	1.344-5.526	0.005
Marital status	2.365	0.963-5.808	0.061
Unemployed/unqualified	0.783	0.436-1.716	0.856
Ethnic group	0.954	0.525-1.737	0.879
Immigration	1.449	0.959-2.190	0.078
Monthly income	0.421	0.076-2.324	0.321
Age	1.000	0.999-1.000	0.543
Absence of health insurance	1.009	0.990-1.028	0.371

**Table 3.** Predictor factors for traumatic experiences.

**Table 4.** Predictors for lifelong and current PTSD.

	Lifelong PTSD			Current PTSD		
	OR	CI	P	OR	CI	P
Number of people living in the house	1.060	0.991-1.133	0.091	0.960	0.880-1.047	0.355
Gender	1.363	0.852-2.182	0.196	0.538	0.245-1.117	0.121
Education	0.332	0.139-0.792	0.013	0.230	0.076-0.695	0.009
Marital status	1.727	1.136-3.544	0.061	2.635	0.904-7.680	0.076
Unemployed/unqualified	0.331	0.098-1.122	0.076	0.349	0.162-0.750	0.007
Ethnic group	1.259	0.840-1.885	0.264	2.366	1.334-4.195	0.003
Forced migration	6.246	3.998-9.758	<0.001	3.391	2.008-5.727	<0.001
Monthly income	1.000	1.000-1.000	0.983	1.000	1.000-1.001	0.470
Age	1.017	0.999-1.035	0.072	1.022	0.998-1.046	0.076
Absence of health insurance	0.310	0.567-1.035	0.045	2.455	2.643-5.735	0.007

the traumatic experience group were forced migration (OR=2.725, CI=1.344 to 5.526, P=0.005), and ethnic group (OR=1.697, CI=1.284 to 4.526, P=0.043). In our study, predictor factors of traumatic experience group is presented in Table 3.

It is determined that predictor factors of lifelong PTSD group were forced migration (OR=6.246, CI=3.998 to 9.758, P<0.001), ethnic group (OR=2.727, CI=1.136 to 6.544, P=0.025), education (OR=0.332, CI=0.139 to 0.792, P=0.013) and absence of health insurance (OR=0.310, CI=0.567-1.035, P=0.045). It is determined that predictor factors of the current PTSD group were forced migration (OR=3.391, CI=2.008 to 5.727, P<0.001), ethnic group

(OR=2.366, CI=1.134 to 4.195, P=0.003), education (OR=0.230, CI=0.076 to 0.695, P=0.009) absence of health insurance (OR=2.445, CI=2.643-5.735, P=0.007), and unemployed/unqualified (OR=0.349, CI=0.904 to 7.680, P=0.007). In our study, predictor factors for lifelong and current PTSD groups are presented in Table 4.

### Discussion

We determined that approximately half of the study population had at least one traumatic experience. This finding was consistent with the information in the literature in which frequent reports of prevalent interrelated traumatic experiences in areas of arms conflict can be encountered.<sup>27-29</sup> There was

lifelong PTSD in more than one third of our participants. Compared with the National Comorbidity Survey in the United State<sup>19</sup> and other studies among western community samples,<sup>30</sup> we found relatively high rates of DSM-IV PTSD. In addition, compared with previous studies in populations affected by conflict and violence, we identified prevalence rates that are comparable in Algeria<sup>6</sup> and higher in Gaza or Kosovo.<sup>6-8</sup> An explanation for the relatively high rate among our participants may be the fact that armed conflict were still taking place during the time of data collection. For example, in Algeria which produced results similar to ours, the conflicts were still continuing during the time data collection. The prevalence of PTSD was found to be over 15% in our subjects despite more than approximately 10 years of traumatic experience. This finding was consistent with the study of Rosner et al.<sup>31</sup> (current PTSD was 18%), that was performed three years after the siege of Sarajevo.

In our study, it is determined that predictor factors of the traumatic experience group were forced migration and ethnic group. This might be due to forced internal displacement, as unemployment and inability to find suitable employments were frequent among refugees.<sup>32</sup> Ethnic minorities were a predictor factor for traumatic experiences in a conflict area. Gender did not appear in predictor factors for traumatic experiences. In general, although women were reported to have more traumatic experiences, there are some studies which report that men were exposed to traumatic experiences more frequently in areas of conflict.<sup>6</sup> Another possible explanation might be due to the cultural characteristics of our region; women were not very much involved in life outside their houses and thus were less exposed to traumas related to conflicts. For

example, approximately 90% of our female participants were housewives.

It is determined that predictor factors of the lifelong PTSD group were forced migration, ethnic group, illiterate education and the absence of health insurance. Studies reported that factors related to minority and language use,<sup>32</sup> lower level education<sup>6,19</sup> and lack of social support<sup>33,34</sup> are some factors for chronic PTSD. Our findings may be related with these factors in the literature.

In our study, it is determined that predictor factors of the current PTSD group were forced migration, ethnic group, illiterate education, absence of health insurance, and employment status. These factors affect the course of treatment to PTSD. It was also reported that patients with PTSD used health services more frequently than other individuals.<sup>14,15</sup> However, many of these studies were performed with refugees in developed countries. It was also ascertained that many patients who were living in areas of conflict and experienced traumatic events did not receive any treatment.<sup>16</sup> Two factors that affect the course of treatment were determined as need and accessibility. Severity of the disease was found to be important among factors of need, whereas accessibility was related with having economical resources like employment and health service awareness.<sup>18</sup> It was reported that untreated PTSD took a complicated stance.<sup>19</sup>

Approximately half of our participants were unemployed or unqualified workers. This might be due to forced internal displacement as unemployment and inability to find suitable employments were frequent among refugees.<sup>32</sup> The determining factors in those with PTSD to seek treatment were reported as accessibility, economic facilities and being informed about health services.<sup>18</sup> It was suggested that psychiatric treatment might decrease the duration and severity of

new or old PTSD.<sup>35</sup> In our study we evaluated forced immigration as traumatic experience and these people formed the largest group among our participants. More than half of our participants did not have any kind of social insurance and the prevalence of traumatic experience was high in this group. Lack of social insurance might be a limiting factor to seek treatment for physical and mental negative consequences of the trauma.

We did not find any gender difference in participants who had both current and lifelong PTSD. This finding was different from the literature as it was reported that chronic PTSD was more common in women.<sup>12,13,19</sup> There might be a few reasons for this finding. First, this finding may be explained by the fact that male respondents in this sample are more likely to have been directly involved in a conflict situation than women. As our study site was in the center of an area of conflict, men experienced far more torture, multiple traumas related with conflict and witnessed more cases of murder or injury than women. The type of the trauma was important in the development and chronic nature of PTSD. Moisander and Ediston<sup>36</sup> found PTSD prevalence as high as 69-92% among refugee victims of torture from six different countries. In another study, Wenzel et al.<sup>37</sup> reported PTSD prevalence as 92% in torture victims after three years.

Secondly, our participants' largest group consisted of those who were forced into internal displacement and those who did not have any additional traumatic experience. The probable speculation for this finding might be the reflection of the decrease in self-confidence in men as they were responsible to provide adequate income for the family and unemployment or the inability to find suitable jobs could create a burden on them. Also, women might earn a rela-

tively easier life in urban areas than in the rural areas where they used to work under difficult conditions. The gender role before migration did not change considerably and daily work was less tedious. In addition, maintaining previous neighborhood relations may also have been an important factor. It was reported that tighter social links and collectivity were related with lower mortality<sup>38</sup> and higher levels of mental health.<sup>39</sup> Lie<sup>34</sup> showed that unemployment and lack of social relations play a role in the chronic nature of PTSD.

#### **The limitations of the study**

Recording traumatic experiences only according to the expressions of the participants and not investigating the type of the trauma resulted in not having detailed information about the prevalence and type of the trauma. In addition a limitation is that without data from other sources, we are not certain about the accuracy of these self-reported data. Disregarding subgroups below the threshold and diagnosing PTSD only according to CAPS constituted another limitation to the study. This study might be suggested as a good reflection of the Diyarbakir city center; however it might not be a good reflection of PTSD prevalence in smaller locations within areas of conflict.

#### **Conclusion**

We studied self-reported symptoms of PTSD among a community sample from low income in a conflict area. An important finding of this study is the association between the range of prevalence rates of PTSD and risk factors for PTSD in an armed conflict region in Turkey. Approximately half of our participants had traumatic experiences and more than  $\frac{1}{3}$  of them had a diagnosis of lifelong PTSD. We found out that the prevalence of current PTSD was 15% in

our participants who had lifelong PTSD diagnosis, despite more than an average of 10 years having passed since the traumatic experience. We also demonstrated that predictor factors of current PTSD were not having health insurance, being unemployed or working as nonqualified employees, ethnic difference, and forced migration. Lack of any institutional treatment approach might lead to the permanent nature of PTSD. As a result, there is a need for more studies that will include people living in rural areas, in order to fully understand the negative effects caused by the conflict environment of the whole region on the mental health of individuals. Moreover, we believe in the importance of effective treatment approaches of institutions for the management of current mental problems. We suggest that people who live in areas of conflict should not be left alone with their traumatic experiences.

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## Justice heals: The impact of impunity and the fight against it on the recovery of severe human rights violations' survivors

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### Abstract

Case studies show that traumatized refugees, who are survivors of serious human rights violations, suffer from persisting impunity in their home countries.

Ongoing impunity – the inability to overcome the legal protection of the perpetrators assured by impunity laws, incomplete truthfinding, missing integral reparation and a lack of the necessary acknowledgement by society – represents an important obstacle for the recovery of survivors of serious human rights violations.

There are reports describing that a high percentage of survivors shows an elevated mental vulnerability caused by impunity. Mental health problems resulting from traumatic experiences can persist or be reactivated by certain events. In particular, family members of the forcibly disappeared suffer from an incomplete mourning due to the uncertain fate of their beloved ones. The ongoing search for the forcibly disappeared under an atmosphere of impunity puts family members under high risk of retraumatization. Studies from other continents also prove that impunity severely affects mental health.

Due to the global character of impunity there can be only little evidence about a positive impact

of justice on mental health. Nevertheless, a few examples, in particular from Latin America, show that the combined implementation of memory, truth and justice can have a healing impact on those who suffer from trauma. They demonstrate that the fight against impunity is not only a legitimate moral struggle for human rights, but also a basic need for the sustainable recovery of survivors.

*Key words:* torture, war crimes, trauma, survivors, human rights, impunity, transitional justice, transnational justice, Truth Commission, memory, reparation, justice heals

### Introduction

The psychosocial impact of man-made disasters has attracted increasing attention during the last three decades. Scientific research work has mostly drawn attention to the mental health of individuals who survived severe human rights violations, to symptoms and diagnostic instruments as well as to different methods of individual or group therapy.

At the same time human rights organizations tried to hold the perpetrators responsible for the crimes that have been committed through wars or by authoritarian regimes. Although there have been trials against the Greek generals and torturers in 1975, and attempts to bring perpetrators to court as for example in post-dictatorship Argentina between 1983 and 1987, a real

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development to combine political transition with justice started, with much delay, with the arrest of Chilean dictator Augusto Pinochet in London less than ten years ago. Since then the necessity of justice in the aftermath of gross human rights violations has been discussed, but only as either a measure of democratization or as a probable danger to peace and reconciliation. Whereas psychological research on trauma and therapy didn't take the social environment and the situation of a society in transition much into account, the role of justice after atrocities has been debated regardless of its impact on survivors' recovery from trauma.

As a human rights organization and treatment center for refugees located in Bochum, Germany, the Medical Care Service for Refugees offers medical, psychosocial and legal support to survivors of torture, war crimes and other severe human rights violations.

During psychotherapy with survivors exiled in Germany we experienced that in several cases ongoing impunity in the countries of origin affected negatively the therapeutic process. We therefore recognized impunity to be an important factor in continuing their traumatic process or causing retraumatization. In some case studies we documented our findings. The case studies included survivors of serious human rights violations from Chile, Argentina, former Yugoslavia and Turkey.<sup>1</sup>

In 2001 Medical Care Service for Refugees started to systematically investigate the influence of impunity on survivors' mental health.

### Methods

We systematized our experience from work with political refugees in exile and after their return to their home countries. From 2004 to 2007 we were able to realize a scientific

research project on different strategies to fight impunity, covering the experiences from 13 countries.<sup>2</sup> Although the study's first aim was to focus on the different efforts that have been undertaken worldwide to deal with atrocities of the past, we included the question of mental health consequences of impunity in our research. The investigation covered literature research as well as personal interviews with survivors, therapy centers and human rights organizations.

The following essentials combine the experiences that have been published by the Chilean therapy centers CINTRAS<sup>a</sup> and ILAS<sup>b</sup>, by EATIP<sup>c</sup> from Argentina, and by SER-SOC<sup>d</sup> from Uruguay.<sup>3-8</sup> Apart from their publications we analyzed a number of interviews we carried out in these three countries, as well as with ATYHA<sup>e</sup> in Paraguay and with the South African Khulumani Support Group. We discussed our findings internationally at the conference "Justice heals", held in October 2005 in Bochum, Germany, where further representatives from human rights groups, therapy centers or survivor's organizations in Cambodia, East Timor, El Salvador, Ex-Yugoslavia, France, Guatemala, Honduras, Peru, Rwanda, Sierra Leone, Turkey and from the Latin American Federation of Family Members of forcibly disappeared (FEDEFAM) followed our invitation to share experiences on impunity and mental health.

During other meetings we had the opportunity to talk to human rights activists or therapists from Algeria, Colombia, Denmark, Greece, Indonesia, Iraq, Liberia,

- a) Center for Mental Health and Human Rights.
- b) Latin American Institute of Mental Health and Human Rights.
- c) Argentinean Psychosocial Working and Investigation Group.
- d) Social Rehabilitation Service.
- e) Center for Alternatives in Mental Health.

Morocco, Mexico, the Russian Federation, Spain and South Korea as well. And as an organization based in Germany we included the German experiences too.

From the discussions on impunity and mental health, as well as from the exchange of different experiences in the fight against impunity, a worldwide "Justice heals-Network" was set up and started work in 2007. Its aim is to deepen the international co-operation and information exchange on the fight against impunity and to support political interventions to bring perpetrators to court.

Here we present the outcomes of our research work on the impact of impunity and the fight against it on the recovery of serious human rights violations' survivors.

#### **What do we mean by "impunity"?**

On first sight and in the most common use of the term, *impunity* means the absence of legal justice, the protection of the perpetrators, mostly assured by impunity laws or other mechanisms to avoid their prosecution.

But impunity includes more than this. It describes a social phenomenon characterizing and affecting society as a whole. Impunity keeps alive the atmosphere of repression throughout society. By denying survivor's access to the truth, impunity continues the historical interpretation of the repressors and denies the necessary acknowledgement and reparation for victims and survivors.

So as we will explain later in further details the fight against impunity includes political measures to reveal the truth about the past, to construct a collective memory, to bring the perpetrators to court to derive integral reparation to the survivors, and structural reforms to prevent society from suffering the same kind of atrocities again.

#### **What is our concept of trauma?**

When talking about the impact of the fight against impunity on the recovery of serious human rights violations' survivors we need to explain our concept of traumatic experiences and their impact on the individual and on society as a whole.

As we learnt from the research work realized by the Dutch psychoanalyst Hans Keilson, trauma is not only the result from a single act of atrocity. Keilson developed his theory of sequential traumatization after decades of therapy he provided to Jewish orphans in the Netherlands who had survived the *Shoah*.<sup>9</sup>

The importance of Keilson's findings lies in the new perception of trauma, which is no longer understood as the consequences of a single event, but as a continuing process, even after the atrocities came to an end.<sup>10,11</sup>

In the early 1980s, before he was killed by right wing death squads, the Liberation Psychologist and Jesuit priest Ignacio Martín-Baró, from the Central American University at San Salvador, developed a broader socio-psychological understanding of trauma. According to Martín-Baró's concept, trauma is not only an individual process but a social and political phenomenon that affects society as a whole. He described trauma as a link, which interrelates individual and society in a traumatic process. The *psychosocial trauma* can only be understood within its specific cultural and political context.<sup>12-14</sup>

Martín-Baró's description of psychosocial trauma within the society of El Salvador amplifies the sequential model of trauma by Keilson, and underlines the importance of a survivor's social environment on the further development on the traumatic process.

From 1982 to 1999 the German psychotherapist David Becker lived in Chile, where he attended survivors from torture and family members of forcibly disappeared

people during the last decade of the dictatorship and afterwards. Together with other therapists from ILAS<sup>b</sup> he adapted Keilson's findings to the Chilean situation. Based on the experiences from Chile and other parts of the world, Becker insists that there is no *post-trauma* but a continuous *Socio-political Traumatic Process*, which depends a lot on further developments within society.

According to Becker, trauma can be described as a "normal reaction to an abnormal situation" and he defines trauma on an individual and social level as the 'destruction or fragmentation of memory'. Becker distinguishes between *trauma* as a psychological wound and the *traumatic situation*, which he sees as the "destruction of the social fabric, [...] implying that human relationships and the basic laws that guide them have been attacked, hurt and possibly destroyed". As a consequence Becker claims the necessity of both political change, including the survivors' right for truth and justice, as well as a focus on the individual needs of those who have been victimized.<sup>15,16</sup>

Based on an understanding of trauma as a psychosocial process, with its individual and social implications, we address the question of impunity as a barrier to the recovery of survivors.

The broad variety of possible trauma symptoms is well described and will not be discussed here. At the same time it is well known that not everybody who has experienced severe violence automatically develops symptoms later. When we talk about mental health consequences of impunity, we are referring to the subgroup of survivors that developed symptoms and suffer from trauma.

#### **How does impunity influence the traumatic process?**

Most of the scientific research, which has

been undertaken to investigate the impact of impunity on society and on the mental health perspective of the individual, was realized in the Southern Cone of Latin America, but there were some in South Africa too.<sup>3-8,17-22</sup>

Investigations on the influence of impunity on the traumatic process need to distinguish between survivors of severe human rights violations and a specific subgroup consisting of family members of those victims who have been forcibly disappeared and killed.

Since trauma is a *normal reaction to an abnormal situation*, often traumatized survivors themselves cannot believe the dimension of terror, threat and destruction they had to go through. Because their horrible experiences are exceeding their worst nightmares, it is difficult to share the unspeakable with others, even with family members and friends. Additionally, through periods of authoritarian rule or conflict, perpetrators' ideologies dominate the public discourses, polarize societies and as a result the bystanders avoid breaking the conspiracy of silence. Mostly survivors remain without a safe environment where they can speak out openly and where their stories are heard, understood and recognized. Therefore the most important need of survivors is an acknowledgement from the surrounding society of the atrocities they underwent.

But impunity continues the atmosphere of silence. It obstructs a public debate about the crimes that have been committed and refuses the necessary acknowledgement to the survivors. There are many reports from different countries which demonstrate that under impunity the social stigmata against survivors continue and their exclusion from society is perpetuated.

Apart that, the free movement of perpetrators in the public, their remaining in

powerful economic or political positions and their ability to protect themselves from prosecution, produces not only a continuous loss of trust in justice for survivors, but an ongoing latent or open psychological threat to their future and a permanency of degradation and humiliation.

Since trauma is a continuing process affected by and affecting the social relationships, impunity fuels the traumatic process.

The feeling of powerlessness, which already dominated during the traumatic experiences, persists due to impunity, prevents self-determination and goes hand in hand with a lack of self-confidence.

As a barrier for overcoming the traumatic experiences, impunity raises indignation, distrust, anger, rage and aggression among survivors, but their capacity of developing healthy aggressions has already been damaged during their traumatic experiences. Those who suffered too much from violence often lost the ability to accept their own aggressive potential and feel incapable of canalizing it into rage. Many survivors turn their aggressions against themselves, instead of developing anger against their victimizers.

Due to the ongoing threat, survivors show an elevated mental vulnerability under impunity conditions. Mental health problems resulting from traumatic experiences can persist or be activated any time by certain daily events even years later. In particular, occurrences of repression, for example against present social protests, are reported to trigger traumatic memories.

Survivors who are family members of forcibly disappeared people are considered to be a specific subgroup of survivors.<sup>23</sup> They may suffer the same from impunity, but additionally their situation is harmfully influenced in a specific way:

Family members of the forcibly disappeared suffer from an uncertain loss. The

more time goes by, the more obvious it might become that their relatives have, in fact, been murdered. But it is never definitely sure; the fate of their beloved ones remains unknown. The lack of information makes it difficult to accept the loss. There are reports that when leaving home each time, family members leave messages on a table for the missing relative for up to ten years after the disappearance. There weren't any parting opportunities before the kidnapping of the disappeared took place, no burial after their killing and there are no graves to visit and remember them.

Under the permanent search for the whereabouts of the missing and for the circumstances of their enforced disappearances, there is no opportunity to accept the loss. Acceptance means betrayal of the beloved ones. In such a situation the trauma is ongoing, since all kinds of mourning necessarily remains incomplete. Suffering from the trauma of an uncertain loss means that knowing the truth about the fate of the disappeared becomes a key question for recovery.

But under an atmosphere of impunity the searching relatives become a special target of disinformation and systematic lies by the state, putting them at a high risk for retraumatization. There are family members who participated in hundreds of exhumations whereas others reject exhumations categorically. Other reports mention incorrect identifications of remains that have been revealed later, when genetic examinations were undertaken. Quite often information has been offered to groups of family members in the context of a dirty deal, asking them to grant impunity to the perpetrators in exchange. And time and again the so-called information led to nowhere. During their ongoing search for the whereabouts of their beloved ones, family members stumble

from hope to disappointment. The psychotic situation in between denial and acceptance continues, resulting in frustration, distrust, anger and rage.

Their exclusion from society, which started during the period of repression, remains under impunity conditions. There are numerous examples in which the social descent that resulted from the loss of a family member could not be overcome. And if there were any offers of compensation by the state, many family members refused them, because due to impunity they consider any kind of financial reparation as betrayal.

Although it is the systematic denial of information preventing them from finding the remains or knowing the truth about the fate of their relatives, many family members attribute the failure of their search to themselves. Nearly all the treatment centers know cases of self-accusation by family members of forcibly disappeared people for not having been able to protect or to find the missing relative.

Under conditions of impunity, survivors in general and the subgroup of family members of forcibly disappeared people in their specific manner, keep continuously suffering from trauma. Impunity not only creates a strong barrier to a sustainable recovery, it continues and deepens the traumatic process and elevates the risk of retraumatization.

### **Can Truth Commissions heal the wounds of the past?**

Since 1974, worldwide, more than 30 attempts have been undertaken to heal the wounds of the past by establishing Truth Commissions.

The idea behind most of the commissions was that the access to truth for survivors and the construction of a “historical truth” for the society might lead to reconciliation in the aftermath of trauma. During the 1990s, especially in South Africa,

promises rose that the Truth and Reconciliation Commission (TRC) would have a sustainable healing effect on society, although perpetrators received amnesty in return for their cooperation. So was the hope in other countries as well. But, depending on their mandate, the vast majority of Truth Commissions didn’t have any legal instruments to force perpetrators to reveal the truth. Lots of final reports have never been finished or published and there are only a few examples where Truth Commissions were allowed to make public the names of perpetrators.

Many truth processes failed and also in South Africa there have been harsh criticisms from survivors and family members of victims concerning the TRC-process, especially on the amnesty for truth trade. A healing impact could not be affirmed.<sup>20-22</sup> Comparable critics are reported from East Timor.<sup>24</sup>

Of course, some of the Truth Commissions have been able to define a historical truth. In particular the efforts of the South African TRC, the Argentinean CONADEP<sup>f</sup>, the Chilean Rettig- and Valech-Commissions<sup>g</sup> and the Peruvian CVR<sup>h</sup> did reach the public opinion to a large extent and created a realistic perspective on past human rights abuses. But at the individual level the truth finding had its serious limits, in particular in the disappearance cases. Many witnesses stayed with an incomplete truth after the commissions had finished their work.<sup>2</sup>

In most of the cases the recommendations by Truth Commissions – if there were any – haven’t been fulfilled by the governments of transition. There are only a few positive examples around the globe, espe-

f) National Commission on the Disappearance of Persons.

g) Named by their chairmen.

h) Commission of the Truth and the Reconciliation.

cially if we look at the recommendations for justice and reparation. In most of the cases the inability to overcome the legal protection of the perpetrators assured by impunity laws continued. Recommendations for broad and integral reparation have stayed rare in the history of Truth Commissions.

During the past decade it became more and more evident that Truth Commissions alone cannot provide the promised therapeutic effect. They can be an important but additional instrument in the framework of measures that have to be undertaken to overcome the wounds of the past. Wherever legal impunity continues despite the work of Truth Commissions, a large number of survivors remains dissatisfied and keeps claiming justice.

### **Is there any proof that justice might heal?**

If we take a look at transition, we need to distinguish different forms of bringing perpetrators to court.

At the international level, initially there have been the Nuremberg Trials (1945-1949). Nearly fifty years later transnational justice restarted in 1994. Since then it is carried out by UN-bodies such as the international criminal tribunals for the former Yugoslavia (ICTY 1994-2010) and for Rwanda (ICTR 1997-2010), the International Criminal Court in The Hague (ICC since 2002) and hybrid courts like the Serious Crimes Investigation Units in East Timor (SCIU 2000-2005), the Special Court for Sierra Leone (SCSL 2002-2008) and the Extraordinary Chambers in the Courts of Cambodia (ECCC since 2007).

Parallel to the UN-bodies, transnational criminal justice has been carried out by some national courts too. Since the late 1990s, there have been remarkable international trials according to universal juris-

diction in Argentina, Belgium, Chile, France, Germany, Italy, Senegal, Spain, Sweden and the United Kingdom.

The cases are few in which transitional justice has been carried out by courts in the same countries which have been affected by the atrocities before. Notable national trials took place in Argentina, Bolivia, Bosnia, Chile, East Timor, Germany, Greece, Paraguay, Peru, Rwanda, South Africa and Uruguay, most of them recently or after a long period of pressure by survivors or family member groups. Further national trials as, for example, in Ethiopia, Romania or Iraq, did not fulfill the demands of democratic rule of law.

In total the number of legal trials worldwide is few in comparison to the number of perpetrators.

In general, most of the sentences in national trials were quite low, or the perpetrators could soon profit from pardons and amnesty laws, so that impunity was reestablished after a while. In most of the mentioned countries only high rank repressors have been brought to justice and not even all of them.<sup>2</sup>

Greece is an exception from this tendency<sup>25,26</sup> and recently the number of trials in Chile and Argentina has increased significantly.<sup>2,27</sup> But the impact of the Greek trials on survivors never has been examined under a health perspective and the developments in Chile and Argentina are still too new to derive general lessons.

In order to cope with the large number of perpetrators, Rwanda chose an alternative and community-based model of jurisdiction by implementing traditional Gacaca-tribunals in 2002, which are more comparable to mediation than to trials under the rule of law. The outcome of Gacaca has been critically investigated.<sup>28,29</sup> Of course there were survivors who could benefit from this model;

but in general the doubts grew over time, in particular concerning how Gacaca has been carried out in practice.

Courts in third countries, where transnational lawsuits have been filed, often had to work under restrictions of the local criminal law, since universal jurisdiction hadn't been established yet. Where convictions have been made or extradition demands have been issued the courts were confronted with difficulties in having the perpetrators extradited. There are only a small number of arrests reported for example from Spain and Italy.<sup>30,31</sup>

Few studies measured the impact of UN-Tribunals on the recovery of survivors. One has been carried out by Eric Stover from the Human Rights Center at Berkeley University.<sup>32</sup> Stover interviewed witnesses at the ICTY about their expectations prior to testifying before the court and after their return to the former Yugoslavia. He detected that highly motivated survivors who participated as witnesses came back home from The Hague disappointed. There was a high level of unfulfilled expectations. The main critics considered convictions as being too mild and denounced the lack of extraditions from the former Yugoslavia. Also, security matters under the rule of impunity after their return played an important role for dissatisfaction. Several survivors felt threatened after their arrival back home. In particular the last two findings draw the attention to the fact that the UN-model of extraterritorial justice could not really break with the situation of impunity inside the countries of the former Yugoslavia.

Despite a couple of cases in which perpetrators could be brought to justice, the whole picture remains fragmented. For a long time the widespread global character of impunity was complete. Neither the international efforts nor the few national

trials could really break the dominance of a worldwide culture of impunity. Under these circumstances it is difficult to investigate what impact an end to impunity would have, and to which extent justice could really contribute to a healing process of past atrocities.

Changes, as they occurred recently in Chile and Argentina and to a much smaller extent in Peru and Uruguay too, are far too fresh to give complete evidence on a presumed healing potential of legal justice.

But there are a few examples, in particular from Latin America and South Africa, which show a positive impact of justice on mental health and can give evidence, at least to some degree, that legal justice can have a healing impact on those who suffer from trauma.

The arrest of the former Chilean dictator Pinochet on October 16, 1998, in London was a surprise for the whole world, and even more unexpectedly for the Chilean public. Not the arrest itself, but the House of Lords decision of November 25 when it was confirmed that Pinochet's crimes were not covered by his presidential immunity, had a catalytic effect on survivors in Chile. Reports from therapy centers and human rights groups show that in late 1998, and during the following months, the atmosphere of silence broke. The former untouchable had been touched and while the Chilean government undertook strong efforts to save the former dictator from extradition to Spain, and despite of military threats inside Chile, people started to take side in the Pinochet case.<sup>33</sup> Survivors didn't hide any longer. Therapy centers experienced a strong increase of demand from survivors who decided to talk about their traumatic experiences for the first time.<sup>34</sup>

According to our own observations, survivors who had returned to Chile from exile after 1989 tried to hide their past during

the first years after their arrival. Beginning already in 1995 with the trial against the former Chief of the secret police Manuel Contreras and expanding after the Pinochet arrest in late 1998, they readopted their personal history and began to talk openly of being *ex-political prisoners*.<sup>1</sup> An association of former political prisoners has been set up all over the country and hundreds of survivors filed lawsuits against Pinochet and other military officers for torture, despite the existing amnesty law. So did the family members of the forcibly disappeared. Since that time the number of filed law suits steadily increased, not only against Pinochet but also against his henchmen down to the former torturers. By the end of 2005, 94 repressors had been convicted, 20 of them to life imprisonment. Another 405 court cases were still under trial.<sup>35</sup>

Reports from Uruguay and Argentina confirm that the Pinochet-Effect spread to the neighboring countries as well.

The breakdown of impunity in Argentina goes back to a continuous fight against impunity. After a series of trials during the first years of return to democracy, the elected governments granted impunity step by step and released the already convicted generals. It was the family members of the disappeared, the Mothers and Grandmothers of Plaza de Mayo, who played the leading role in overcoming impunity by their steady struggle, which lasted over three decades. The way the Mothers of the disappeared organized their struggle, beginning in the second year of dictatorship and continuing after return to formal democracy, has been the topic of a couple of controversy debates. While some authors consequently pathologized the Mothers' refusal of any kind of reconciliation without justice, others classified their collective struggle as a method of developing a Sense of coherence, according

to Antonovsky's model of Salutogenesis. The collective search for their children and grandchildren triggered this development and helped to overcome isolation and fear. Taking up the struggle against the dictatorship and continuing it afterwards allowed them to regain activity despite the traumatic loss of their children. And their sometimes radical political demands for a different society, in particular their consequential fight against impunity, provided a sense of life.<sup>20</sup>

Until 2006 the Mothers of Plaza de Mayo clearly denied any cooperation with the different civil governments and repeated demanding the "return with life" of their children. Most of them denied exhumation, official acts of memory and reparations categorically. And they never did stop their continuous and often frustrating attempts to bring perpetrators to court. In 2000 the Grandmothers of Plaza de Mayo reached a partial success by cracking down the impunity laws in a specific case of abduction. Three years later, with the support of the recently elected president Nestor Kirchner, they achieved the complete abolition of the impunity laws and since then more than 1,000 cases had to be reopened and hundreds of perpetrators were taken into custody.<sup>1,27,35</sup>

After the breakdown of impunity, and with the support they had received by the Kirchner government, Mothers of Plaza de Mayo slightly changed their strict rejection of the state policies. From 2004 Mothers in fact began to accept memorials and from 2006 they started to cooperate with the Kirchner government, which could be understood as a hint that, with the rise of credibility of political and legal institutions, the psychological necessity for a role of fundamental opposition had decreased.

Uruguay is still far from the Chilean or Argentinean developments. Impunity is yet in power, but some lawyers have overcome

amnesty laws in certain cases. Their first heavy strike against impunity was to put former dictator Juan María Bordaberry under trial in early 2006. And by chance the news of the High Court's decision appeared in the media the same day as the burial of the first identified remains of a Uruguayan victim who had been forcibly disappeared 30 years before, took place. The funeral had a catalytic effect on Uruguayan family members and survivors. About 10% of the inhabitants of Montevideo were participating in the burial and newspapers reported that several disappearances from 30 years ago have been made public by family members for the first time. Several court cases were opened subsequently. Therapists reported an increase of demands by new clients. Former political prisoners started to tell their stories to their grandchildren, although before they had never shared their traumatic experiences, not even with their children.

There is only little evidence that legal justice has a healthy impact on the recovery of survivors. The examples illustrate that in some cases, in which perpetrators have been brought to court, positive effects could be recognized. Some other court cases didn't have the same impact, in particular when they took place in far away courts while impunity inside the countries persisted. Also Truth Commissions were not able to fulfill the goal of healing the wounds of the past, at least for a relevant minority of survivors. Nevertheless, healing of extreme traumatic experiences is never a simple linear and straightforward mechanism. Since survivors keep claiming justice, legal justice is a necessary start but not the one and only step to be undertaken. Unfortunately it is the most missing piece in the complex multitude of necessary individual, social, political, legal and cultural measures in the aftermath of trauma. And without justice the traumatic process continues.

### **Which measures can contribute to the stabilization of survivors?**

Sustainable recovery of individual and society needs responses to the past at different levels, which are not only linked, but inter-related to each other.

Truth finding, the creation of a collective memory, legal justice, rehabilitation and reparation are indivisible parts of an integral strategy to overcome the legacies of a violent past. They have to be complemented by structural reforms that prevent society from a reappearance of past conflicts.

Impunity denies these necessities partly or to a larger extent. None of the measures can be turned down without affecting survivors' perspectives of recovery.

Truth finding allows survivors to speak the unspeakable publicly, and it socializes individual grief and pain. The revealed information can help family members to know about the fate of their forcibly disappeared beloved ones. The construction of an historical truth changes the discourse within society and contributes to social rehabilitation of survivors by providing an important part of the necessary acknowledgement by the public. Finding a historical truth prepares the construction of a society's collective memory.

Creating a collective memory means more than only declaring the final report of a Truth Commission an historical truth. Elaborating a collective memory needs to provide public access to archives, to investigate on different subjects of the past and distribute them in scientific publications as well as in school books and in popular media. Narrative history has to be continued even when the mandate of a Truth Commission might be over. Memories can become part of literature, music, theatre, movies and fine arts. Documentaries, newspaper background articles, exhibitions, memorials, museums as

well as signs, indications and explanations at locations of importance, street names and wall paintings can keep the memory alive and prevent the past from amnesia.

However, truth and memory cannot stand alone. How can there be a definite truth about atrocities if those who committed the crimes are not held responsible? Criminal Justice is an elementary tool in dealing with the past. Just bringing the perpetrators to court can reestablish the rule of law, restore survivors' trust in the institutions of society and rebuild a common sense about ethical values among the citizens.

Only by equality before the law can the perception of repressors as omnipotent untouchables be destroyed. By redefining who is perpetrator and who is victim, in all the complexity of this problem, legal justice contributes to the destruction of the propagandistic moral values implemented by past dictatorship or conflict parties.

Even survivors, who are not willing to participate actively in court cases can profit from the changes in public discourse and a conversion of public perception. The shift in the public discourse goes ahead with a shift of the roles attributed to survivors, not only if they were considered to be terrorist or criminals before. Role transformation is created actively when survivors become involved. Those who bring their cases to court leave former victim roles and play an active part in the construction of the future. In this way legal justice can lead to an empowerment of survivors of serious human rights violations regaining self-confidence and self-determination by taking responsibility and playing an active role in society. Years after the traumatic experiences they have the opportunity to overcome powerlessness and hold the perpetrators responsible.

Of course, due to the risk of retraumatization in court, psychological support for

witnesses is inevitable. However, with the necessary assistance, this approach to the traumatic memories can contribute to the integration of the traumatic experiences in survivors' biographies.

A court decision to convict the perpetrator under the rule of law represents an important factor of acknowledgement for survivors and relatives of the forcibly disappeared. Holding perpetrators responsible can facilitate the acceptance of reparation and cannot be misunderstood as bribery.

For many survivors their trauma was not only physical, psychological or social, but economic as well. Suffering from torture or war crimes, having lost a family member, returning from prison or detention camps, or coming home from exile quite often goes hand in hand with a social descent. Jobs have been lost, education hasn't been finished or other living conditions might be destroyed. Civil rights could have been suspended for a long time, and several social obstacles or maybe trauma symptoms can inhibit survivors from a new start.

Therefore, there is a high need for reestablishing the living conditions of survivors. They are entitled to full and unconditional compensation; which means that reparation schemes must be designed in an integral way, and, besides the necessity of material compensation, must lead to a comprehensive psychosocial, political and cultural rehabilitation and reintegration into social life.

*Healing*, in the full meaning of the word, includes the security that the past will never happen again. There is a high risk that the traumatic experiences might reoccur if there is no truth finding, no legal justice and if there hasn't been established a culture of memory, which keeps the past awake and future generations alerted.

Therefore the construction of a sustainable stability in the aftermath of man made

disaster has to be based on an analysis of the roots of past escalation of conflicts or repression. From this analysis measures can be derived to prevent society from repeating the past. Institutional reforms, such as military reforms, strengthening democratic structures, especially the independence of jurisdiction, developing a non-violent practice of conflict resolution, dissolving social injustice, developing an open and democratic culture within society and the integration of international law into the national penal code, can help to prevent a comeback of atrocities.

### Conclusion

There is not one single and magic solution to the problem of dealing with the legacies of manmade disasters. Healing of psychosocial trauma is inevitably a lengthy and complex process. Under the atmosphere and culture of impunity a recovery of society is impossible and the recovery of individual survivors faces insurmountable barriers. Bringing perpetrators of gross human rights violations to court and holding them responsible for their crimes is a need, which has been expressed by survivors all over the globe. There can only be little evidence about the healing impact of legal justice, since impunity is still widespread. But where impunity broke down, some reports about serious improvements indicate the essential role of justice for the recovery from extreme trauma. Of course, criminal justice cannot stand alone and has to be combined with other measures of dealing with the past, such as truth finding, creation of a collective memory, integral reparation and rehabilitation and structural reforms. But the absence of justice is still a key problem in all parts of the world.

As long as there is no justice in the aftermath of conflicts, the fight against impunity is not only a necessary moral struggle for

human rights, but also a basic need for the sustainable recovery of survivors.

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# The role of jurisdiction on persistence of torture in Turkey and public reflections

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## Abstract

Torture still is a serious problem in Turkey. There has been a very effective struggle against torture, particularly for effective documentation by health professionals. The Istanbul Protocol has been taken into consideration by the ministry of health, and procedural safeguards with standardized medicolegal documentation had been a part of daily medicolegal practice. However, measures taken on the basis of effective documentation is not sufficient without effective investigation of which the role of jurisdiction is most prominent. Impunity is highly responsible for the persistence of torture, although procedural safeguards on medical examination and medicolegal documentation have had an influence for the decrease of the total number of cases. The Anatolia Agency had distributed information on the total number of punishments in 2007, which drew a more hopeful picture with 5,082 punishments among 33,000 law enforcement officials who had been taken to court. Nevertheless, a press conference held by the Human Rights Foundation of Turkey revealed that this information was not true. They revealed that the cases taken to the court were mostly because of ill treatment instead of torture, and a great majority of these officers had been acquit-

ted between the years 1989-2005. Administrative measures had also been highly insufficient, and among 922 personnel who had been under investigation, only 8 of them had had punishment. The Human Rights Association has had a research on impunity, and only 15% of law enforcement officials who had been taken to the court were ever convicted of their crimes, and all of these punishments had been suspended.

Research on cognitive behaviour of judges and prosecutors revealed that they think human rights might threaten the security of the state. This result only clarifies the cause of impunity, thus persistence of torture.

The Istanbul University Istanbul Faculty of Medicine, Department of Forensic Medicine, has an outpatient clinic in which torture survivors are examined, and alternative medicolegal documentation is carried out. These patients who were able to have a medicolegal document are observed to benefit from psychotherapy, thus impunity should not only be surmounted for the eradication of torture, but also the healing of the wounds of torture survivors.

*Keywords:* torture, impunity, medicolegal, documentation

## Introduction

Torture is a worldwide public health problem, and impunity is one of the major reasons in the persistence of this widespread practice. The prohibition of torture is generally regarded as having the special status of a

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“peremptory norm” of international law, and states cannot choose to disregard or derogate from it. In addition to international law, many national laws will also include a prohibition of torture. However, even the lack of a clear prohibition in domestic law will not release the state from its international legal obligations to refrain from and prevent torture under all circumstances, and to investigate allegations, punish perpetrators, and provide reparation to victims.

Torture and ill treatment have long been criminal acts and quoted in two separate articles in The Criminal Code of the Republic of Turkey. A clear definition of torture which is similar to the definition in the Convention Against Torture (CAT) was included with the amendment of the criminal code in 2005; in addition a significant increase of punishment had also been ensured.<sup>1,2</sup>

## SECOND VOLUME

### *Special provisions*

## SECOND CHAPTER

### *Offenses against individuals*

## THIRD SECTION

### *Torture and torment*

### *Torture*

#### ARTICLE 94

(1) Any public officer who causes severe bodily or mental pain, or loss of conscious or ability to act, or dishonors a person, is sentenced to imprisonment *from three years to twelve years*.

(2) The punishment may not be reduced in case of commission of offense;

- a) Against a child who cannot protect himself due to corporal or spiritual disability,
- b) Against an attorney or another public officer by virtue of office, the offender is sentenced to imprisonment *from eight years to fifteen years*.

(3) In case of engagement in any act defined as *sexual harassment*, the offender is punished with imprisonment *from ten years to fifteen years*.

(4) Other persons who participate in commission of an offense are punished likewise the public officer.

(5) The punishment to be imposed may not be reduced even if the offense is committed by negligence.

#### *Consequential severe torture*

#### ARTICLE 95

(1) Punishment determined according to the above article is *increased by one half* if the offense results with;

- a) Weakening of sensual or bodily functions of the victim
- b) Continuous difficulty in speaking
- c) Distinct facial mark
- d) Risk of life
- e) Premature birth of a child.

(2) Punishment determined according to the above article is *increased by one fold* if the offense results with;

- a) Incurable illness or causes vegetative existence of the victim
- b) Loss of sensual or bodily functions
- c) Loss of ability to speak and to give birth to a child
- d) Distinct facial change
- e) Abortion, if the offense is committed against a pregnant woman.

(3) In cases where the torture causes *break of bones* in the body, the offender is sentenced to imprisonment *from eight years to fifteen years* according to affects of broken bone on vital functions.

(4) In case of *death of a person from torture*,

the offender is sentenced to *heavy life imprisonment*.<sup>2</sup>

Impunity is common practice in Turkey and torture has always been a serious problem, despite the fact that there has been, and still is, a domestic law. The failure to bring perpetrators of human rights violations to justice and, as such, a denial of the torture survivors' right to justice and redress, interferes with the well being of these patients.

The amended Set of Principles for the Protection and Promotion of Human Rights Through Action to Combat Impunity, submitted to the United Nations Commission on Human Rights on February 8, 2005, defines impunity as:<sup>3</sup>

“the impossibility, *de jure* or *de facto*, of bringing the perpetrators of violations to account – whether in criminal, civil, administrative or disciplinary proceedings – since they are not subject to any inquiry that might lead to their being accused, arrested, tried and, if found guilty, sentenced to appropriate penalties, and to making reparations to their victims.

The First Principle

Impunity arises from a failure by States to meet their obligations to investigate violations; to take appropriate measures in respect of the perpetrators, particularly in the area of justice, by ensuring that those suspected of criminal responsibility are prosecuted, tried and duly punished; to provide victims with effective remedies and to ensure that they receive reparation for the injuries suffered; to ensure the inalienable right to know the truth about violations; and to take other necessary steps to prevent a recurrence of violations.”

Legislative measures necessary to ensure

protection of human rights and to safeguard democratic institutions and processes must be enacted. There are several reasons for impunity of law enforcement officials in such torture cases, and these need to be revealed and discussed in order to solve the problem. The main objective of this article is to define the situation and consequences of impunity, improvements achieved, and necessary further steps in Turkey.

### Background

There has been a very effective struggle against torture in Turkey for many years, particularly for effective documentation by health professionals. A manual on effective investigation and documentation of torture, the Istanbul Protocol (IP), had been put on paper with great efforts from a wide circle of human rights activists, academics and scientists, particularly with active involvement from Turkey.<sup>2</sup>

The Turkish Medical Association (TMA) and Human Rights Foundation of Turkey (HRFT) have supported getting a second opinion for medicolegal examination of torture survivors, since an existing official institute of forensic medicine which is considered as the main source for medicolegal expertise to the courts could easily be considered as biased. Alternative reports for some of the well known torture cases have occasionally been considered and reflected in court decisions. However, the common practice for medicolegal evaluation of detainees had many inadequacies for years.

There was a limited number of forensic medicine specialists, and most of the cases had been examined by general practitioners who did not have any experience with medicolegal evaluation. Most of the faculties of medicine did not even have training courses on forensic medicine. The general practitioners were vulnerable to any kind of

intimidation due to inexperience, and lack of knowledge caused them to write inappropriate medicolegal reports. The TMA decided to organize postgraduate training courses for general practitioners, and implemented these trainings with close collaboration of the Society of Forensic Medicine Specialists (SFMS) from 1996 to 1998 in 11 different cities, while in the meantime a basic textbook of forensic medicine for general practitioners had also been published. The TMA, HRFT and SFMS had also organized postgraduate IP trainings for both medical and legal professionals.

The TMA had also strongly advocated for undergraduate forensic medicine training in the faculties of medicine, and all of them now have departments of forensic medicine with effective curricula, except for six faculties out of 21 in the early 1990's.

The IP has been promoted in Turkey by these three organizations, and the principles of the IP have been taken into consideration by the ministry of health after several workshops. Procedural safeguards with standardized medicolegal documentation had been a part of daily medicolegal practice. However, measures taken on the basis of effective documentation is not sufficient without effective investigation of which the role of jurisdiction is most prominent. Impunity is highly responsible for the persistence of torture, although procedural safeguards on medical examination and medicolegal documentation have had an influence for the decrease of the total number of cases.<sup>4</sup>

The Anatolia Agency had distributed information on the total numbers of punishments in 2007, which drew a more hopeful picture with 5,082 punishments among 33,000 law enforcement officials who had been taken to court from 1989 to 2007. Nevertheless, a press conference held by the Human Rights Foundation of Turkey

revealed that this information was not true. They revealed that the cases taken to the court were mostly because of ill treatment instead of torture regarding the criminal code before 2005, and a great majority of these officers had been acquitted between the years 1989-2005. The news of the Anatolia Agency was based on a file which is maintained through intensive efforts of HRFT in the parliament. However, giving a total sum without any explanation leads to misinterpretation of the results. The documentation of court decisions for torture and ill treatment cases did not exist from 1989 to 1993. The total number of cases taken to the court from 1989 to 2005 was 17,517, and the total sum of officers who had been sued was 33,281.<sup>5</sup>

Torture cases consisted of 20% of all cases, and the majority of cases could be defined as ill treatment cases by the public prosecutor. Since court decisions of the years 1989 to 1993 are not known, the only numbers that could be revealed are 12,215 court cases with a final decision from 1994 to 2005. Nevertheless, court decisions of the cases from 1994 to 2001 did not contain the number of officers who had undergone trials, but only the number of court cases of which 2,422 had been found guilty. The only data including the numbers of officers belongs to the years after 2002 with a number of 2,660 officers who had been convicted for torture or ill treatment.<sup>5</sup>

Although these court decisions seem to comprise convicted crimes, there are no law enforcement officials put into prison, or punished by any means. Nearly all of these punishments have been suspended because they were reported to be the first criminal act of the person, though some of them are well known to have had several court cases throughout many years.<sup>5,6</sup>

Administrative measures had also been

highly insufficient, and among 922 personnel who had been under investigation, only eight of them have had punishment.<sup>5</sup> The Human Rights Association (HRA) has also conducted research on impunity, and only 15% of law enforcement officials who had been taken to the court were ever convicted of their crimes, and all of these punishments had been suspended.<sup>6</sup> Both HRFT and HRA data indicate a more than 80% rate of impunity.

Research on cognitive behaviour of judges and prosecutors revealed that more than two thirds of them consider human rights as a threat to the security of the state. They describe their position as a state officer, and emphasize their responsibility to protect the state rather than the community.<sup>7</sup> This result sheds light on the cause of impunity, and the resulting situation of persistence of torture in spite of procedural safeguards and enhancement in medicolegal care services.

### Conclusion

There are three cornerstones of evaluation for torture cases: Investigation, documentation and a fair trial. These three should be combined in order to struggle against impunity. Impunity has a significant influence on the persistence of torture, since this result indicates a state policy for torture, despite ratified international treaties, and the expression of "zero tolerance for torture". Besides, impunity not only should be surmounted for the eradication of torture, but also for healing the wounds of torture survivors.

The Istanbul University Istanbul Faculty of Medicine, Department of Forensic Medicine, has an outpatient clinic in which torture survivors and/or their lawyers can apply for a secondary opinion. They are either examined, or the documents are reviewed, and an alternative medicolegal documentation is carried out. These patients who were

able to have a medicolegal document regarding their findings are observed to benefit from psychotherapy more than some of the cases followed up by the department of psychiatry that had not been admitted for a medicolegal documentation, and did not have an appropriate medicolegal evaluation in the past. These results need to be considered in future studies. Nevertheless, this sole observation, although limited, is consistent with the studies on the role of impunity on rehabilitation and recovery of torture survivors.<sup>8,9</sup>

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## Solitary confinement

*An introduction to The Istanbul Statement on the Use and Effects of Solitary Confinement*

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The use of imprisonment has been on the rise in many states during recent years and it has been estimated that more than nine million people are currently incarcerated worldwide.<sup>1</sup> This poses many problems in terms of monitoring prison conditions and inmate treatment, since human rights violations tend to occur in this type of institution. Another obvious problem is the possible side effects of imprisonment and the risk of isolating, marginalizing, and alienating large groups in society.

However, even within prison communities there are those who are marginalized and isolated even further than most of their fellow inmates. One such group is prisoners who are kept in solitary confinement. Here they often spend around 23 hours in their cells each day, only interrupted by a short period of exercise, which is typically also carried out in isolation. Such prisoners are in a sense *in a prison within a prison* and thus suffer an extreme form of exclusion, which clearly supersedes normal imprisonment. This is especially the case when the use of solitary

confinement is prolonged. Furthermore, due to their isolation, these prisoners can easily slip out of sight of justice, and safeguarding their rights is therefore often difficult, even in societies traditionally based on the rule of law.

Unfortunately, recent years have seen an increase in the use of strict and often prolonged solitary confinement practices in prison systems in various jurisdictions across the world. Even to the point where whole prisons have been created based upon a model of strict isolation of prisoners. Paradoxically, at the same time a growing number of studies have substantiated that large groups of those subjected to solitary confinement will suffer detrimental health effects. An increasing number of inmates are, in other words, placed in a position where they risk having their rights violated and their health damaged.

Inspired by this development, a number of experts on solitary confinement have for some years been involved in various attempts to address this issue in different parts of the world. One way to go about such matters is to produce declarations in

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1) Estimate made by Andrew Coyle (Professor in Prison Studies, Kings College, London) during a talk given at The Danish Institute for Human Rights, 9. May 2005.

international contexts and thus attempt to change standards and influence both relevant international legal paradigms and national penal policies. Last spring, 2007, I was approached by the Human Rights Foundation of Turkey who asked me to participate in arranging a conference “task group” on solitary confinement, and I decided that it was time to attempt to produce an international expert statement on the use and effects of solitary confinement. Together with Dr. Sharon Shalev from The London School of Economics I wrote a draft statement, which we presented at the International Psychological Trauma Symposium in Istanbul in December 2007. Through a number of extensive “task group” working sessions, together with several prominent experts in the field of solitary confinement, prisons, and torture, we discussed the statement and the relevant issues in great detail. After an intense three days and a lot of hard work we were able to produce a finished statement on the final day of the conference. I would very much like to thank all the “task group” participants for their spirited and professional contributions.<sup>2</sup>

In the following I will provide a brief introduction to the subject of solitary confinement and thereby to the actual Istanbul Statement on the Use and Effects of Solitary Confinement, which is printed as the following piece in this issue of Torture.

2) For great help during the conference in the final process of finding relevant references, criticizing, and writing up the final version of the statement I would very much like to thank, especially, Sharon Shalev, Jonathan Beynon, Monica Loyd, Türkcan Baykal, and Manfred Nowak.

3) Peter Scharff Smith “A religious technology of the self. Rationality and religion in the rise of the modern penitentiary” in *Punishment and Society* vol. 6(2), 2004, p. 206

### The history of solitary confinement

Historians generally agree that the so-called *modern penitentiary system* broke through internationally from the later decades of the 18th century until the around the middle of the 19th century. A central feature of this system was a belief in the ability to rehabilitate criminals through, among other things, the use of isolation. With the construction of the Auburn and Pennsylvania prison models in the United States in the 1820s the modern penitentiary found its most characteristic institutional form, which was copied all over the western world. While inmates in Auburn facilities were allowed to work together during the day (under a regime of total silence) there was no compromise with the ideal of isolation in Pennsylvania-model institutions, and the prisoners spent almost all their time in the cell, where they also did their work. Here the inmate was supposed to turn his thoughts inward, to meet God, to repent his crimes and eventually to return to society as a morally cleansed Christian citizen.<sup>3</sup> Prisoners had to wear hoods when transported around the prison and in many Pennsylvania facilities the prison church was constructed with isolation booths. In principle, inmates were not allowed to even see the face of another prisoner during their incarceration.

The Auburn model became the most popular in the United States, but the Europeans on the other hand favoured the Pennsylvania system and thereby the most severe form of isolation. A large scale use of solitary confinement therefore became the reality in many European states during the 19th century, as well as in Pennsylvania in the United States and in a number of states in South America.<sup>4</sup>

The Pennsylvania model received quite intense criticism and was on the way out in some places during the second half of the nineteenth century, but in other places it

persisted throughout the 19th century and even well into the following century. This was the case in Scandinavia, Holland, and Belgium where large scale isolation was practiced according to the Pennsylvania system, and thereby as an integral part of a rehabilitative regime, way into the 20th century.<sup>5</sup>

From the 1950's and onwards large scale solitary confinement has not been perceived as a tool in a process of rehabilitating criminals. But different kinds of isolation practices have been used in different prison contexts for the last couple of centuries. Solitary confinement has, for example, traditionally been used as a disciplinary punishment involving different conditions and different time spans. Furthermore, some countries have a practice of using solitary confinement during pre-trial, while others isolate prisoners on death row. Another variant can be found in some prison systems where a number of prisoners, for example sex offenders, are allowed, or encouraged, to choose voluntary solitary confinement in order to protect themselves from fellow inmates. Some of these solitary confinement practices, along with a few others, have been used in various ways and with varied intensity throughout the history of the prison.

### Current practices – a few examples

Most prison systems feature solitary confinement among their repertoire of disciplinary punishments for prisoners. There are countless variations in this regard but typically, although not always, such punishment will last for a limited number of days or perhaps weeks. In Denmark, for example, the maximum duration of placement in isolation as a punishment for violating prison rules is four weeks.<sup>6</sup> In addition to that there will often be a limited number of inmates in a given prison system, which authorities continuously find it very difficult to handle and do not wish to accommodate under normal conditions. Special regimes involving prolonged solitary confinement are often designed for this particular group of prisoners. Such a practice is technically speaking not punishment but is typically referred to as administrative isolation of inmates who are deemed at risk of escaping or disturbing prison order.<sup>7</sup> Reasons for being thus segregated may vary but the level of psychiatric morbidity tends to be high among this group of inmates. Recent years have in some jurisdictions has witnessed a tendency towards an increasing use of solitary confinement as an administrative tool for managing specific groups of prisoners. The probably most well

4) See for example Peter Scharff Smith "A religious technology of the self. Rationality and religion in the rise of the modern penitentiary" in *Punishment and Society* vol. 6(2), 2004, p. 205 ff. See also Ricardo D. Salvatore and Carlos Aguirre "The birth of the penitentiary in Latin America" in Salvatore and Aguirre (ed.) *The birth of the penitentiary in Latin America. Essays on criminology, prison reform, and social control, 1830-1940*", p. 9ff.

5) Concerning Holland see Pieter Spierenburg "Four centuries of prison history" in Norbert Finzsch and Robert Jütte (ed.) *Institutions of Confinement*, Cambridge 1996, p. 30, and concerning Belgium see Norman Johnston *Forms of Constraint: a history of prison architecture*, Chi-

cago 2000, p. 104. Concerning Scandinavia see Peter Scharff Smith "Prisons and human rights: the case of solitary confinement in Denmark and the US from the 1820s until today" in Stéphanie Lagoutte, Hans-Otto Sano and Peter Scharff Smith (eds.) *Human Rights in Turmoil. Facing threats, consolidating achievements*. Martinus Nijhoff Publishers, 2006, pp. 221-248.

6) Hans Jørgen Engbo "Straffuldbyrdsesret" 2. edition, Copenhagen 2005, p. 264.

7) Peter Scharff Smith "The effects of solitary confinement on prison inmates: a brief history and review of the literature" in Michael Tonry (ed.) *Crime and Justice*, vol. 34, 2006, p. 451ff.

known example of this are the so-called Supermax prisons in the United States.

The history of the American Supermax is normally traced back to the October 1983 lockdown in the federal Marion penitentiary. A lockdown, which followed the killing of two prison guards, was never lifted and led to the creation of a regime of continuous solitary confinement, later termed Supermax.<sup>8</sup> This inspired state jurisdictions and today there are more than 50 Supermax prisons in the United States.<sup>9</sup> Conditions in these facilities typically include solitary confinement 22.5 to 24 hours each day in a barren environment, under constant high-tech surveillance, with exercise being carried out in isolation and without access to recreational equipment. Inmates are sometimes able to shout to each other but otherwise have no social contact. Visits and phone calls are infrequent and severely restricted, if allowed at all. Placement in Supermax can be indeterminate and go on for years and even decades.<sup>10</sup> Supermax prisons have been described as “the ultimate form of exclusion”<sup>11</sup> in which “inmates are immobilized, infantilized, and subjected to arbitrary rules and decisions”.<sup>12</sup>

Solitary confinement is sometimes also found to be an integral part of regimes on death row. Such a situation was uncovered by the CPT (The European Committee for the Prevention of Torture) during their 1995 visit to Bulgaria. In a specific prison two death row inmates were kept isolated in their cells and only allowed one hour exercise and 15 minutes use of sanitary facilities each day, while visits were limited to one per month. In addition, the prisoners were not allowed to work, to go to the library or attend communal activities. The CPT has similarly criticised death row arrangements in Ukraine.<sup>13</sup>

Other groups of prisoners can also be singled out for solitary confinement. According to Human Rights Watch this has, for example, been the case with a group of political prisoners in Tunisia. In 2005 it was thus described how forty political prisoners had been subjected to prolonged solitary confinement for several years and up to eleven years in one particular case.<sup>14</sup>

Another well known use of solitary confinement is during pre-trial where isolation of individuals can be instigated in order to protect an ongoing criminal investigation.

8) Sharon Shalev Solitary control and punitive isolation: “new” forms of solitary confinement in Supermax prisons of the USA, Ph.d. thesis, London 2005, p. 48. See also Roy King “The rise and rise of supermax: an American solution in search of a problem?” in *Punishment and Society* (1), 1999.

9) Different authors cite various numbers: 57 (Brief of Amici Curiae Human Rights Watch et al., *Wilkinson v. Austin*, 8), more than 60 (Lorna Rhodes *Total Confinement. Madness and reason in the maximum security prison*, 2004).

10) Concerning Supermax conditions see, for example, Shalev 2005, p. 9. See also Jesenia Pizarro and Vanja M.K. Stenius “Supermax prisons: Their rise, current practices, and effect on inmates” in *The Prison Journal* 84(2), 2004. Leena Kurki and Norval Morris “The purposes, practices, and problems of supermax prisons” In Michael Tonry

(ed.) *Crime and Justice: A review of Research*, Chicago, vol. 28, 2001. Craig Haney “Mental health issues in long-term solitary and ‘supermax’ confinement” in *Crime & Delinquency* 49(1), 2003.

11) Shalev 2005, p. 10.

12) Lorna Rhodes “Supermax prisons and the trajectory of exception” 2007 (forthcoming – manuscript which will be published in Austin Sarat (ed.) *Studies in Law, Politics & Society*).

13) See Jim Murdoch *The treatment of prisoners. European standards*, Strasbourg 2006, p. 236f.

14) Human Rights Watch “Tunisia. Crushing the person, crushing a movement. The solitary confinement of political prisoners”, April 2005, vol. 17, No 4(E).

While it is normal that restrictions are applied on a remand prisoners regime for exactly this reason, it is not standard practice to use prolonged solitary confinement. However, some nations apparently have a special history in this regard. In a European context the practice of pre-trial isolation has thus been termed a “Scandinavian phenomenon”,<sup>15</sup> and Denmark, Norway, Sweden, and to some extent Iceland, has received international human rights criticism on that account during the last decades.<sup>16</sup> In Denmark the use of strict solitary confinement during pre-trial was originally adopted following the Danish 1846 jail regulations, which prescribed the construction of single cells in jails nationwide. By the 1870s most Danish jails were able to isolate their remand prisoners and this practice continued more or less unchanged during the next 100 years. Since the 1970s the use of solitary confinement in pre-trial detention has declined, but it remains a feature of Danish prison practice. Between 2001 and 2006 between 7.7 and 9.8 % of all Danish remand prisoners have each year been subjected to strict solitary confinement for a yearly average period ranging from 28 to 37 days, but sometimes for periods exceeding half a year.<sup>17</sup>

15) Malcolm Evans and Rod Morgan describe pre-trial solitary confinement as a “... peculiarly Scandinavian phenomenon...” in *Preventing Torture*, 1998, p. 247.

16) Peter Scharff Smith “Varetægtsfængsling i isolation – en besynderlig Skandinavisk tradition?” in *Social Kritik*, no. 99, June 2005.

17) See “Statistik om isolationsfængsling”, Justitsministeriets Forskningsenhed, April 2007 (statistics from the Ministry of Justice); “Rigsadvokaten informerer. 19-2007. Statistiske oplysninger om isolationsfængsling”, appendix B.2 and C.1 (downloaded 110208 from [www.rigsadvokaten.dk/Default.aspx?id=62&recordid=62=1122](http://www.rigsadvokaten.dk/Default.aspx?id=62&recordid=62=1122)).

When used during pre-trial, solitary confinement can sometimes pressure prisoners into confessing or giving evidence regardless of the motives behind imposing the isolation. This is, technically speaking, illegal in the case of Denmark, where the above described use of solitary confinement is subject to judicial supervision and can only be imposed to avoid collusion.<sup>18</sup> But solitary confinement can also be used purposely as a part of coercive interrogation. This can be during pre-trial detention, as was sometimes the case in the former Soviet Union and in South Africa during Apartheid. Such practices are also used together with other forms of detention, for example, in connection with war scenarios and various kind of covert intelligence work. It is well known how the United States, during recent years, have used solitary confinement, along with several other techniques, as a coercive measure in order to gain intelligence from detainees at Guantanamo and in facilities in Iraq and Afghanistan.<sup>19</sup>

#### **The debate over the effects of solitary confinement**

Historically speaking one could say that an international debate over the effects of soli-

18) Unfortunately this does not remove the element of pressure since pre-trial detainees subjected to judicially supervised solitary confinement in Denmark can still relieve themselves of this regime – which can damage their health – by confessing and giving evidence. Because if the case is solved in this manner there will no longer be any legal grounds for upholding their solitary confinement.

19) See for example Physicians for Human Rights “Break them down. Systematic use of psychological torture by US forces” 2005; Center for Constitutional Rights (CCR) “Report on torture and cruel, inhuman, and degrading treatment of prisoners at Guantanamo Bay, Cuba” July 2006.

tary confinement seems to have been settled sometime around the 1930s, where both psychiatrists and prison experts described the detrimental effects of this practice.<sup>20</sup> During the preceding hundred years, evidence had mounted in that regard and it can be argued that in the United States relatively widespread agreement was reached on this issue already in the 1840's.<sup>21</sup> Nevertheless a discussion on the effects of isolation was reopened after WWII, apparently without reference to the historical material from the experience with Pennsylvania model imprisonment. This happened especially in connection with experimental psychological research on sensory deprivation, which was carried out at universities all over the world. But the specific issue of solitary confinement in prisons has also become a debated and contested issue.

During recent decades a number of studies on the effects of solitary confinement have been carried out in places like Norway, Denmark, Switzerland, South Africa, Canada, and USA. The vast majority of these studies have argued that solitary confinement has negative health effects but a number of practitioners and researchers have disputed whether or not the gathered data and especially the way they have been analysed were correct. Several authors have

argued that this disagreement has been methodological in nature,<sup>22</sup> i.e. essentially a question of who has been adopting on the one hand a strictly positivistic approach or on the other hand a cross-disciplinary or hermeneutic approach. Research and statements by the later group has to some extent been distrusted by the former and vice versa.

Recent thorough attempts to gather and review the available studies have however reached conclusions which in terms of health effects disfavour the use of solitary confinement.<sup>23</sup> Especially by extensively covering material from not only North America but also Europe and other regions it has now become clear that both qualitative and quantitative studies in fact do exist, which a) can satisfy not only qualitative/hermeneutic but also positivistic scientific standards, and b) clearly document how solitary confinement practices in prison have detrimental health effects.<sup>24</sup> In that sense the debate can now be considered settled in so far as the basic issue is concerned and it can be concluded that "solitary confinement – regardless of specific conditions and regardless of time and place – causes serious health problems for a significant number of inmates. The central harmful feature is that it reduces meaningful social contact to an absolute minimum: a level of social and

20) Peter Scharff Smith "The effects of solitary confinement on prison inmates: A brief history and review of the literature" in Michael Tonry (ed.) *Crime and Justice*, vol. 34, 2006, p. 466f.

21) Smith 2006, p. 459 ff. Pennsylvania was the only state which kept using the Pennsylvania model and thereby large scale solitary confinement of sentenced prisoners.

22) Morris and Kurki 2001, p. 113, and Michael Jackson *Justice behind the Walls. Human rights in Canadian prisons*, available online at [www.justicebehindthewalls.net/](http://www.justicebehindthewalls.net/) (accessed 2004). See also Smith 2006.

23) Haney 2006; Smith 2006; Henrik Steen Andersen "Mental health in prison populations. A review – with special emphasis on a study of Danish prisoners on remand" in *Acta Psychiatrica Scandinavica Supplementum*, 110(424), 2004.

24) Smith 2006.

psychological stimulus that many individuals will experience as insufficient to remain reasonably healthy and relatively well functioning".<sup>25</sup>

#### **Policy changes and new legal standards**

Given the facts above, reform and policy changes are obviously needed with regard to solitary confinement practices in a number of jurisdictions in different places of the world. To accomplish this, penal policy has to be influenced on many different levels and law makers, prison authorities, and courts can be relevant in that regard. Causes for inadequate protection of isolated and segregated inmates may be found in different parts of the system. Just to mention one example, expert commentators have argued that some courts have been too reluctant to acknowledge the psychological effects of imprisonment, including specifically the effects of solitary confinement.<sup>26</sup>

The potential for accomplishing reform could be strengthened by both using and improving the existing international human rights standards with regard to solitary confinement. This can be done by promoting existing soft law standards and human rights documents from CAT, CPT, relevant committees, and special rapporteurs, as well as international and regional prison rules, principles etc., in order to gain an increasing impact on actual international and national case law, through which policy makers and prison managers could be influenced. But furthermore there is also a need to align the relevant human rights standards with the latest research in the area of solitary confinement. This arguably entails creating new

standards. In The Istanbul Statement on the Use and Effects of Solitary Confinement we have attempted to do both: promote existing standards and create new standards based on relevant research. The Statement is meant to be used by relevant organisations and individuals in international and national settings. Hopefully the result in the long run will be reduction or abandonment of existing solitary confinement practices and better treatment and protection of those still subjected to isolation regimes.

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25) Smith 2006, p. 503.

26) See for example Murdoch 2006, p. 255.

## The Istanbul Statement on the Use and Effects of Solitary Confinement

*Adopted on 9. December 2007 at the International Psychological Trauma Symposium, Istanbul.*

### The purpose of the statement

Recent years have seen an increase in the use of strict and often prolonged solitary confinement practices in prison systems in various jurisdictions across the world. This may take the form of a disproportionate disciplinary measure, or increasingly, the creation of whole prisons based upon a model of strict isolation of prisoners.<sup>1</sup> While acknowledging that in exceptional cases the use of solitary confinement may be necessary, we consider this a very problematic and worrying development. We therefore consider it timely to address this issue with an expert statement on the use and effects of solitary confinement.

### Definition

Solitary confinement is the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a mini-

mum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.

### Common practices of solitary confinement

Solitary confinement is applied in broadly four circumstances in various criminal justice systems around the world; as either a disciplinary punishment for sentenced prisoners; for the isolation of individuals during an ongoing criminal investigation; increasingly as an administrative tool for managing specific groups of prisoners; and as a judicial sentencing. In many jurisdictions solitary confinement is also used as a substitute for proper medical or psychiatric care for mentally disordered individuals. Additionally, solitary confinement is increasingly used as a part of coercive interrogation, and is often an integral part of enforced disappearance<sup>2</sup> or incommunicado detention.

1) For the purpose of this document we use the term prisoner as a broad category covering persons under any form of detention and imprisonment.

2) The International Convention for the Protection of All Persons from Enforced Disappearance of December 2006 defines enforced disappearance

as "...the arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons acting with the authorization, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law."

### The effects of solitary confinement

It has been convincingly documented on numerous occasions that solitary confinement may cause serious psychological and sometimes physiological ill effects.<sup>3</sup> Research suggests that between onethird and as many as 90 per cent of prisoners experience adverse symptoms in solitary confinement. A long list of symptoms ranging from insomnia and confusion to hallucinations and psychosis has been documented. Negative health effects can occur after only a few days in solitary confinement, and the health risks rise with each additional day spent in such conditions.

Individuals may react to solitary confinement differently. Still, a significant number of individuals will experience serious health problems regardless of the specific conditions, regardless of time and place, and regardless of pre-existing personal factors. The central harmful feature of solitary confinement is that it reduces meaningful social contact to a level of social and psychological stimulus that many will experience as insufficient to sustain health and well being.

The use of solitary confinement in remand prisons carries with it another harmful dimension since the detrimental effects will often create a de facto situation of psychological pressure which can influence the pre-trial detainees to plead guilty.

When the element of psychological pressure is used on purpose as part of isolation regimes such practices become coercive and can amount to torture.

Finally solitary confinement places individuals very far out of sight of justice. This can cause problems even in societies traditionally based on the rule of law. The history of solitary confinement is rich in examples of abusive practices evolving in such settings. Safeguarding prisoner rights therefore becomes especially challenging and extraordinarily important where solitary confinement regimes exist.

### Human rights and solitary confinement

The use of torture, cruel, inhuman or degrading treatment or punishment is absolutely prohibited under international law (Article 7 of the UN convention on Civil and Political Rights (ICCPR) and the UN convention against Torture (CAT), for example). The UN Human Rights Committee has stipulated that use of prolonged solitary confinement may amount to a breach of Article 7 of the ICCPR (General comment 20/44, 3. April 1992). The UN Committee against Torture has made similar statements, with particular reference to the use of solitary confinement during pre-trial detention. The UN committee on the Rights of the Child has furthermore recommended that solitary confinement should not be used against children.<sup>4</sup> Principle 7 of the UN Basic Principles for the Treatment of Prisoners states that 'Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged'. Jurisprudence of the UN Human Rights Committee has previ-

3) For studies on the health effects of solitary confinement, see Peter Scharff Smith "The effects of solitary confinement on prison inmates. A brief history and review of the literature" in *Crime and Justice* vol. 34, 2006 (pp. 441-528); Craig Haney "Mental health issues in long-term solitary and 'supermax' confinement" in *Crime & Delinquency*

49(1), 2003 (pp. 124-56); Stuart Grassian "Psychopathological effects of solitary confinement" in *American Journal of Psychiatry* 140, 1983 (pp. 1450-4).

4) CRC/C/15/Add.273, "Denmark", 30 September 2005, para. 58 a.

ously found a specific isolation regime to violate both article 7 and article 10 of the IC-CPR (*Campos v. Peru* 9. January 1998).

On a regional level, the European Court and former Commission on Human Rights, as well as the European Committee for the Prevention of Torture (CPT), have made it clear that the use of solitary confinement can amount to a violation of Article 3 of the ECHR (i.e. constitute torture, inhuman or degrading treatment), depending on the specific circumstances of the case, and the conditions and duration of detention. It has been recognised that "...complete sensory isolation coupled with total isolation, can destroy the personality and constitutes a form of inhuman treatment which cannot be justified by the requirements of security or any other reason".<sup>5</sup> The CPT has also stated that solitary confinement "can amount to inhuman and degrading treatment" and has on several occasions criticized such practices and recommended reform – i.e. either abandoning specific regimes, limiting the use of solitary confinement to exceptional circumstances, and/or securing inmates a higher level of social contact.<sup>6</sup> The importance of developing communal activities for prisoners subjected to various forms of isolation regimes has for example been stressed (CPT, visit report Turkey, 2006, para. 43). Furthermore, the revised European Prison Rules of 2006 have clearly stated that solitary confinement should be an exceptional measure and, when used, should be for as short a time as possible.<sup>7</sup> The Inter-Ameri-

can Court of Human Rights has also stated that prolonged solitary confinement constitutes a form of cruel, inhuman or degrading treatment prohibited under Article 5 of the American Convention on Human Rights (*Castillo Petruzzi et al.*, Judgment of May 30, 1999).

### Policy implications

Solitary confinement harms prisoners who are not previously mentally ill and tends to worsen the mental health of those who are. The use of solitary confinement in prisons should therefore be kept to a minimum. In all prison systems there is some use of solitary confinement – in special units or prisons for those seen as threats to security and prison order. But regardless of the specific circumstances, and whether solitary confinement is used in connection with disciplinary or administrative segregation or to prevent collusion in remand prisons, effort is required to raise the level of meaningful social contacts for prisoners. This can be done in a number of ways, such as raising the level of prison staff-prisoner contact, allowing access to social activities with other prisoners, allowing more visits, and allowing and arranging in-depth talks with psychologists, psychiatrists, religious prison personnel, and volunteers from the local community. Especially important are the possibilities for both maintaining and developing relations with the outside world including spouses, partners, children, other family and friends. It is also very important to provide prisoners in

5) *Ramirez Sanchez v. France*, Grand Chamber, 4. July 2006, para. 123.

6) Rod Morgan and Malcolm Evans "Combating torture in Europe", 2001, p. 118. See also Recommendation Rec(2003)23 Committee of Ministers under the European Council, para. 7, 20, and 22.

7) Committee of Ministers – Rec(2006)2E (Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies). Article 60.5. See also CPT, GR2, § 56.

solitary confinement with meaningful in cell and out of cell activities. Research indicates that small group isolation in some circumstances may have similar effects to solitary confinement and such regimes should not be considered an appropriate alternative.

The use of solitary confinement should be absolutely prohibited in the following circumstances:

- For death row and life-sentenced prisoners by virtue of their sentence.
- For mentally ill prisoners.
- For children under the age of 18.

Furthermore, when isolation regimes are intentionally used to apply psychological pressure on prisoners, such practices become coercive and should be absolutely prohibited.

As a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort.

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