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# R A H A T

## M e d i c a l  J o u r n a l

Aims at instructing medical practitioners
on torture, its consequences and treatment





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# EDITORIAL

RAHAT Medical Journal (RMJ) is an effort to provide a sound podium to healthcare professionals, in sharing ideas related to medical experiences from their personal spheres to other fellow professionals. A wide array of contributions articles, research papers, and reports are published in order to address the issues of human rights, torture and the role of medical professionals.

The current issue breaks with an introduction by Dr. Farooq Mehdi, in which he highlights different efforts that are made both at national and international level to help doctors realize and act to denounce inhuman torturous punishments.

Dr. David Senesh tells how being a prisoner of war himself, he had experienced the devastating traumas that were inflicted by the enemy, and what happens to the personality of a person who undergoes such experiences. Consequently, to what extent can such a person, as a therapist, then deal with other such patients in an effective manner.

In her critique, which is a two-part sequel, Dr. Rubya Mehdi discusses Islamic Laws and suggests for healthy interpretations of these progressive laws according to the ever-changing demands of time. The article also explores various forms of Islamic punishments and discusses at length the responsibilities that lie at the shoulders of medical professionals.

Michael A. Bernstein, et al in their article, Long-Term PTSD, the writers bring to light the facts that the psychological trauma experienced by the victims of torture does necessarily persist even for decades. The point is proved by putting a couple of examples of suffering women from the daily life, and the long-lasting effects, such events imprint on the minds of the victims, altogether paralyzing them.

In his article, Shujaat Ali analyses the disadvantaged being usurped at the hands of the advantaged in Afghanistan. The impact of this violent act especially against women, girls and young boys has been presented and then the prevention strategies have also been discussed.

Tehmeed Razvi in her piece of writing intelligently deals with the subtle and specific issue

of male sodomy, bringing to light the negative consequences and impacts of this type of child sexual abuse. Introduction of religious parameters makes it weightier, appealing the morality, hence rendering it more charm.

A commendable effort of Ruth Barnett, exemplifies how deplorable heinous acts like genocide are committed in the name of God, and tries to influence the reader that it is the acknowledgement of the sin, that can only lead to the eradication of it. Scriptures from the holy books have also been cited to hammer the idea of denunciation of this form of torture genocide.

Research studies dealing with East Germany and Gaza Strip have also been included in this journal. All the studies bring forth the consequences, the torture survivors have to face, while still living in the flabbergasting places of torture, may it be one's own home or any other place.

Field report relating to the mass torture carried out against helpless men, where nobody, police, higher administrative authorities or even the judiciary was available to assist the sufferers. It shows a laudable effort on the part of a small team that went to help the victims. Such field studies certainly would inspire others to share their experiences, and providing yet another opportunity to those who wish to come forward in upholding the cause of humanity.

**Editor**

# World Without Torture

Dr. Farooq Mehdi

The purpose of this article is to condemn all forms of torture and to provide information to the medical professionals and those who are working for torture survivors. It is an endeavor to highlight the professional standards and devising mechanisms for the fight against torture.

Many a crimes are prevalent throughout the world, but the most hideous of all is essentially torture, not just because of the nature of the act itself, but because of the purposes for which it is widely employed, and its long-term impacts on the victim's physical, mental, and social identity.

Both international humanitarian laws and numerous international human rights instruments prohibit torture. The prohibition of torture is absolute no circumstance can ever be invoked to justify it, still the practice of torture remains widespread.

The United Nations conventions against cruel, inhuman or degrading treatment or punishments in 1984, define torture as:

"… any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."

The purpose of torture is more often not to kill somebody but to break down the victim's personality through the infliction of severe mental or physical sufferings.

Torturers today are able to create conditions which effectively breakdown the victim's personality and identity, in other words, his ability to live a full life amongst other human beings. Psychological consequences are the worst that are suffered by the torture survivors. Deep feelings of guilt and shame often occur after torture. The feeling of guilt may be caused by the mere fact of survival while friends may have died under torture; or perhaps information was given that could have harmed friends. The deep feeling of guilt may also be produced by the so-called impossible choice, when victims have to choose between, for instance, revealing the names of their friends, or seeing family members tortured. Regardless of what the victim chooses, the net result is a disaster, for which the victim feels himself responsible, and that is exactly what the torturer wants. Scars of torture remain on the mind and body of victim long after the procedure has ended. The

whole personality of the individual is shattered which is the basic purpose of torture infliction.

The United Nations Universal Declaration of Human Rights, 1948, states that "everyone is entitled to all the rights and freedoms without distinction of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and no one shall be subjected to cruel, inhumane or degrading treatment."

The declaration does raises concerns about the status of a human being to be upheld. It is this exalted status that must be respected and observed.

It is an acknowledged fact that at the international level the doctors are to sign an oath whereby they are to adhere to humane acts and never to encourage, participate or engage in any indecent or inhuman act that is not justified on any human grounds.

The World Medical Association, in its Declaration of Geneva, adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, the doctors are supposed to administer the following oath before they join the noble medical profession:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of Humanity;
I WILL GIVE to my teachers the respect and gratitude, which is their due; I WILL PRACTICE my profession with conscience and dignity;
THE HEALTH OF MY PATIENT will be my first consideration;
I WILL RESPECT the secrets, which are confided in me, even after the patient has died;
I WILL MAINTAIN by all the means in my power, the honor and the noble traditions of the medical profession;
MY COLLEAGUES will be my sisters and brothers;
I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patients;
I WILL MAINTAIN the utmost respect for human life from its beginning even under threat, and I will not use my medical knowledge contrary to the laws of humanity;
I MAKE THESE PROMISES solemnly, freely and upon my honor.

Similarly, there have been a series of efforts throughout the world to provide guidance to medical practitioners, about medical ethics, in order to make them sift between an act that is good and the one that falls below the level of decency. One such convention has been adopted by the world medical assembly, Tokyo, Japan, in October 1975, which states as follows:

Preamble

It is the privilege of the medical doctor to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life

is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

## Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent doctor. The doctor shall explain the consequences of the refusal of nourishment to the prisoner.
6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

World Medical Association Declaration concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment is also a commendable effort in regards to stopping torture.

## Preamble

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are prohibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.

2. Primary among these declarations are the World Medical Association's International Code of Medical Ethics, Declaration of Geneva, Declaration of Tokyo, and Resolution on Physician Participation in Capital Punishment; the Standing Committee of European Doctors' Statement of Madrid; the Nordic Resolution Concerning Physician Involvement in Capital Punishment; and, the World Psychiatric Association's Declaration of Hawaii.

3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit support for, or the obligation to protect, doctors who encounter or become aware of such procedures.

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organized medical profession:

i) to encourage doctors to honor their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task

ii) to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures; and

iii) to extend its support and to encourage other international organizations, as well as the national member associations (NMAs) of the World Medical Association, to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession.

5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon medical doctors to act in contravention to the ethical principles subscribed to by the profession, the WMA finds it necessary:

i) to protest internationally against any involvement of, or any pressure to involve, medical doctors in acts of torture or other forms of cruel, inhuman or degrading treatment or punishment

ii) to support and protect, and to call upon its NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;

iii) to publicize information about and to support doctors reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures; and

iv) to encourage national medical associations to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the

consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Declaration.

Torture survivors need specialized care by doctors, other health professionals, social counselors and legal professionals. Voice Against Torture strives for the following aim to guarantee that the health professionals do avoid contributing in any form of torture:

1) To ensure that doctors do not participate in any procedure of torture, i.e.:
a)They do not participate in cover-up activities such as providing false death certificates or false clinical records of victims of torture.
b)They do not monitor torture by remaining present during any act of torture, or by declaring a person fit for torture, or by advising how far the torturers may proceed, or by reviving victims sufficiently to undergo another bout of torture.
c)They should not use their professional skills to extract information, to control prisoners or simply for punishment.
d)They should strive to provide the best quality treatment to prisoners and people in detention, and do not have a biased attitude towards them.

2) To give support to all the doctors who refuse to participate in acts of torture, so that they and their families are not victimized by different agencies.

3) To collect evidence against doctors who have chosen to become instruments in the procedure of torture. To present these cases to the Medical and Dental Council for necessary action. To take these cases to court so that these doctors may be tried for their criminal acts. To expose these doctors widely in the public and the media.

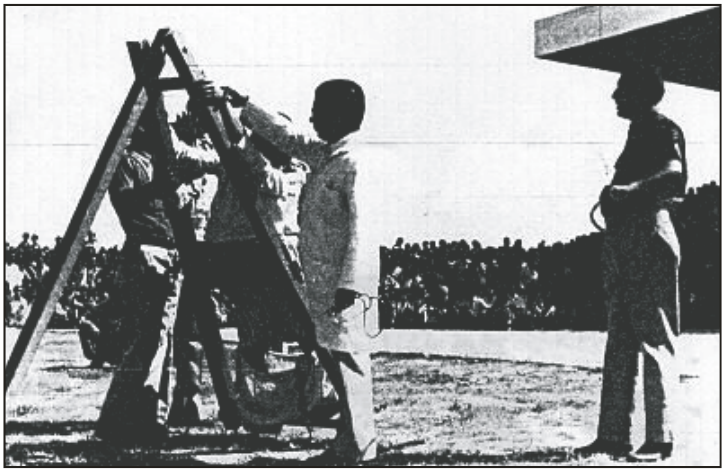
4) To mobilize opinion among the community of scientists in such a way that they refuse to make instruments which could be used in the process of inflicting torture.

5) To conduct research on all forms of torture, their effects and methods of treatment including rehabilitation.

6) To provide free medical facilities for the treatment of victims of torture.

7) To provide necessary specialized professional information to doctors who are treating victims of torture.

In the light of above mentioned declarations that have been passed and ratified by most of civilized nations, countries, and international consortiums, it seems that there would be a world without torture, where peace and harmony prevails, where the rules are upheld and those providing services to humanity will continue doing their duties in a proficient manner. But just visualize if all such efforts do not make a molehill, where could one start from?



# A Former Prisoner of War as Therapist

David Senesh, Ph.D.

I was often asked whether the time that I spent in Egyptian jail was formative in my later becoming a clinical psychologist and a psychotherapist, specializing in trauma and abuse. This far-fetched association between the experience of imprisonment and that of therapy made me curious about my own choices in becoming a psychotherapist and provided me with insights into the striking similarities between intimacy of psychotherapy and the intense feelings that I had some 30 years ago, as captive in prison. Personal encounters between enemies in a battlefield, and in the proximity of captivity, are paradoxically similar in their emotional intensity to those of parties who are actively engaged in psychotherapeutic relationships.

Psychotherapy and prison are worlds apart, and yet, having the opportunity to live through both, empowers me with a unique vintage point. The world view that emerges from traumatic experiences is that there is no barrier between being a parent and a child, a teacher and student, a psychotherapist and a patient in time, they trade in by revolving roles and ever changing tasks, sometimes complementary, sometimes consequential but always conditional, transitory and temporary. The shattering experience of trauma breaks down the mechanism of protective self-deception, a make-belief, that things are permanent and solid, and never transitory. For the traumatized individual, reality turns out always to be fragile and conditional. This is especially valid in the trauma of captivity since the world of invulnerability, omnipotence, and confidence breaks down into chaos. The imprint of such intensive experiences between an omnipotent parental figure in the form of a parent, therapist or a prison guard vis-à-vis the helpless childlike-captive has the potential to form regressive, transference-like relationships that facilitate regression, dependency and a sort of undefined intimacy and acquaintance with the aggressor. Even cruel and abusive parents, harmful therapists, just like guards and torturers are emotionally significant to their subordinate victims. This is probably the reason why abused children continue to attach to their parents, battered wives to their abusive spouses, and traumatized persons to their haunting abusive internalizations from their past. In my mind, despite the pain and bruises, the enemy who captured me was also the one who gave me the gift of life, just as a maltreating, poisoning parent is also the one who gave birth and provision to the abused child. As I emerged from such abusive experiences I became aware of these contradictory sentiments that were unconsciously binding me to these nightmarish experiences, keeping me hostage within a painful narrative. This awareness is in itself a part of the healing process to set oneself free from the clenching chains of humiliation and pain.

Imprisonment simulates a primary scene of bad infancy one of absolute dependency and helplessness, reinforced by total control mechanisms in the form of fear and pain. Hunger and thirst, physical discomfort, ambiguity and confusion, are all means of psychological warfare, similarly, intrusion in the form of psychological brainwash and violent interrogations are all aimed at breaking the victim's spirit, claiming his selfhood and controlling his or her free will. Abusive milieus, whether in infancy or in later life do necessarily distort and cripple the internal working models of attachment among

people. On the other hand, the therapeutic process is one that aims at an optimal level of anxiety and needs gratification, to motivate explorative processes of growth within accepting, empathic and containing relatedness. Just as corrupted relationships in prison can harm the sense of balance and integrity in later life, so is the corrective power of positive emotional experiences in therapy to "mend a broken heart, and a cleaved personality." Such transformations for better or for worse, may only occur within the framework of intense relationships, such as those between agents of complementing roles - a parent and a child, a therapist and a patient, a teacher and a student, and if you will - between a prisoner and his guard. This state of affairs puts the burden on the therapist to handle the therapeutic process with utmost care. The therapist should navigate therapy in between the policy of minimal necessary intervention and the omnipotent wish of salvation, thus aiming too high or too fast might rekindle the patient with overwhelming affect. The therapists who themselves had the experience of trauma, resulting from detention, might be more respectful of the patient's own trauma-protective defenses, that work as a trauma membrane (Lindy & Wilson, 2001) to shield off stimuli that might trigger the re-awakening of the original trauma. In vivo flooding of the patient with traumatic material may abreact the original scene of abuse, identifying the therapist with the abuser. Therapists should therefore match their clients' pace with "appropriate doses" of affect that can be contained in the therapeutic relationship (Lindy, 1996).

Freud, in his essay, "Beyond the Pleasure Principle," written in the year 1955, asserted that at the moment of trauma and very soon thereafter, there is a breach of the stimulus barrier leading to affective flooding and a total breakdown in all bio-psychosocial aspects of the experience. At that very moment, when self-integrity and self-continuity are at stake, there is a growing tendency for hypercathexis to occur that increases the valence of others, empowers them with unreal significance for the patient. The crucial question then is who are the other persons that the survivor meets? Is that the enemy who is about to take advantage of his psychological defeat, to interrogate or dispose off his identity and dignity? Are those people too terrified to help or rather indifferent to his pleas? Are those people who respond to his painful stories or rather discredit his experiences? Are those caring individuals family, friends, or professionals, who take over some self-organizing and self-soothing functions for the patient and are willing to nurture him as much and as long as needed? It is quite possible for a traumatized patient to relate suspiciously even to the well-intending professional who is genuinely trying to help, to the despot still haunting his memories. Traumatized patients might consider routine procedures such as a diagnostic interview or a psychological assessment as an attack on their integrity, a threat on their sense of autonomy and an intrusion on their right for privacy. Likewise, a psychiatrist or a psychologist inquiring about the trauma, may provoke an alarming sense of attack on the defenses of the traumatized patients, while searching for their underlying best-kept secrets. An assuming, all-knowing, high-status professional who uses impersonal procedures may run the risk of reviving in his patients' earlier experiences of abuse, imprisonment and interrogations. A defensive stand of the patient might well be a maneuver against his or her own persecutory projections, for surviving also means betraying the dead, failing a mission, giving away secrets, etc, resulting in what is best known as "survivors' guilt." Patients may consciously defend to keep their secrets, but at the same time subconsciously expect their persecutory therapists

to reveal their pathogenic secrets and finally punish them. In the absence of such a 'relief,' self-hatred and self-harm may prevail. Therapists who have themselves been through such experience might be in a better position to handle such delicate materials with utmost care to gradually untangle their patients and relieve them off the unnecessary burden.

The moment of surrender is a moment of complete helplessness and hopelessness. It is the certainty of an unavoidable end that unexpectedly marks a new beginning altogether. Some patients come to treatment at that very moment of despair. Such a moment has a unique power to imprint a sense of attachment and trust that will organize later experiences. As traumatized patients start to form the therapeutic alliance with their therapists, they are courageously willing once again to run the risk of losing their newly found love and sense of trust in themselves and in others. A former prisoner of war now working as a therapist knows best how to appreciate such a formidable task, and will hopefully be empathic and tolerant of his patient's setbacks in the process. This therapist might be more conscious of his own and his traumatized patient's anxiety and transference responses that are suspicious and at times even paranoid. Such responses may appear in verbal discourse, dream material, works of art, and in acting out. In accepting, containing and interpreting such expressions, the therapist provides his patient a safe place to work out his fears, losses confusions, and conundrum.

Surviving the traumatic experiences marks the victory of life over death. However, physical survival in and for itself just won't do unless complemented by a sense of meaningful existence that transcends the trauma, on both cognitive and experiential levels. Therapy is one way of making such a victory meaningful and worthwhile. A therapist who himself survived the trauma is well aware that it is the working relationship that can make the difference. He has already been through the experience of physically surviving a life-threatening event, now he may recognize the same existential need for meaning-making in his patient. Only for such a therapist, his patients' reflections on an inner world that has been tattered, shattered, or fragmented is all too familiar an experience. In sharing that commonality, therapist and patient may then embark upon the painstaking task of collecting, reconstructing and reframing the pieces together.
A prisoner of war never serves his full term in jail, because he doesn't have one. Upon his release, he starts his journey liberating himself from the clutches of his past, and from anything that might keep him in an internal prison. Committing oneself to a secure base in ideology or in relationships, means once again making a hostage of oneself to a psychological prison, while at the same time running the risk of once again losing it all at once due to another traumatic assault. This paradoxical position of ever searching a safe place but never running the risk of finding one, may also characterize the therapist's own quest for meaning and belonging to the post-traumatic era. A therapist who has borne the hardships at one time, is most likely to be understanding his or her patients' frustration and pain in realizing that there is no such “promised land” where security, freedom, reason and fairness rules. However, it is still possible for both the patient and such a therapist to find these qualities within the framework of their own mutual relationship while in the course of therapy. Such realization is in itself the central block in braving their own separate routes in a posttraumatic world.

References

1. Freud, S. (1955).Beyond the Pleasure Principle. (pp. 29-33).
2. Standard Edition, Vol. 18. London: Hogarth Press (original pub. 1920).
3. Lindy, J. (1996). Psychoanalytic psychotherapy of Posttraumatic Stress Disorder:
4. The Nature of the Therapeutic Relationship. In: B. van der Kolk, A. McFarlane,
5. L.Weiseaeth (Eds.). Traumatic Stress: The effects of overwhelming experience
6. on mind, body and society. (pp. 525-536) New York: The Guilford Press.
7. Lindy, J. & J.P. Wilson (2001). Respecting the Trauma Membrane: Above all, do no harm. In: Wilson's J.P., Friedman, M.J. & J. Lindy (Eds.). Treating Psychological Trauma and PTSD. (pp. 432-446). New York: The Guilford Press.

# Cruel and Torturous Punishments in Islamic Law and Role of the Medical Professional

Dr. Rubya Mehdi

In the previous article we looked at torture used in the 'procedure of Islamic law' and the participation of medical professionals in supporting such judicial procedures. The following article deals with the awarding of torturous punishments and the role of medical professionals in implementing them. It is clear that medical professionals were used in this process in order to both inflict torture to extract confessions, and to inflict punishments.

This article describes various punishments that as well amount to torture, for example flogging, amputation of limbs, and stoning to death still being prescribed by some Muslim countries such as Saudi Arabia, Iran, Afghanistan, Sudan and Pakistan. We will discuss how far these punishments are justified in the name of Islam, and would see if there is any justification for the use of medical professionals to inflict such punishments.

## Examples of the Torturous Punishments from Pakistan and other Muslim Countries

### Flogging

Flogging as a method of inflicting judicial punishment has a long history. In Islam, during the time of Prophet Muhammad and in the early Muslim rule, corporal punishment meant beating with hands, shoes and clothes; the practice later took the form of lashing. In India corporal punishment including whipping was widespread under the Muslim rule and also during the British period (Scott 1938:11). The whipping Act 1909, instituted by the British, was in force in Pakistan (with periodic amendments) until the promulgation of the Execution of the Punishment of Whipping Ordinance, 1979.

George Ryley Scott distinguishes between 'flagellation as judicial punishment' and 'flagellation as a species of torture'. In other words, there is a possibility that flogging as judicial punishment may develop into a species of torture depending on the blows, the nature of the instruments used, the period of punishment, and/or the condition of the culprit.

'The Executions of the Punishment of Whipping Ordinance (IX of 1979)' provides a specification of the whip, the conditions and modes under which punishment is to be carried out, and finally how it is to be administered. According to the ordinance, the whip (excluding the grip) should consist of one single piece without any knob or joint in it (as a joint or knob could add to the severity of whipping). The length and thickness of the whip may not exceed 1.22 meters and 1.25 centimeters (Section 4) respectively. A medical officer must examine the convict before execution of the punishment to make

sure that the convict is medically fit to undergo the awarded punishment. A medical officer is to be present during the flogging and if it is feared that the convict might die, flogging is to be halted and the remainder of the punishment postponed until the convict is physically fit to undergo it (section 5(a), (f), (m)). However, if the convict is too old or too weak, flogging should be carried out in such a manner and at such intervals that it does not cause the death of the convict. In the case of Nazir Ahmad and other vs. The State, the court included 'minor' in the expression 'weak'; the question was whether punishment by flogging included juvenile offenders or not.

It was held that the ordinance did not exempt a minor from such punishment. It merely provided that, in case the convict was too weak (a term including juvenile offenders, according to the court), the manner and the intervals of flogging should be such as not to cause the death of the convict. In case of illness, flogging was to be postponed. It was also to be postponed, if the convict was pregnant, until two months after she had given birth, or suffered a miscarriage (Section 5 (c), (d)). The Ordinance also lays down that flogging should be carried out in moderate weather (neither too hot, nor too cold) (Section 5(e)). Moreover, the Ordinance requires the impartiality and mature understanding of the person executing the punishment, for example, while applying the whip, the executioner should not raise his hand above his head, thus ensuring that the whip is applied with moderate force, so as not to lacerate the skin of the convict. Lashes should not be applied to head, face, stomach, chest, or other delicate parts of the body but to be spread out over the body. In case of a male, the lashes are to be administered while he is standing and, in the case of a female, while she is sitting. The Ordinance does not give a description of the clothes to be worn by the convict at the time of flogging, but merely says that they should be as required by the injunctions of Islam (Section 5 (g), (h), (i), (j), (k), (l)). A person sentenced to punishment by flogging is put into prison until the execution of the punishment (Section 6).

The Ordinance is praised on the grounds that it shows an improvement, upon the one introduced during the British rule, and happened to be prevalent before this ordinance was passed (Iqbal, Javid: 1984). It should, however be noted that the provisions of the British Whipping Act of 1909, rather than the Ordinance of 1979, are still sometimes observed by prison officials (Faruki 1987).

In Saudi Arabia, the number of lashes is not clearly prescribed by law but varies according to the discretion of judges and ranges from dozens of lashes to several thousand. Lashes usually are applied over a period of weeks or months. In April 2000, a court in Qunfuda sentenced nine Saudi transvestites; five drew prison terms of six years and 2,600 lashes, and the other four were sentenced to five years and 2,400 lashes. Flogging was to be carried out in fifty sessions, with a fifteen-day hiatus between each punishment (Human Rights Watch Backgrounder, Dec 2001 “Human Rights in Saudi Arabia: A Deafening Silence”).

In a well-publicized case, a 17-year-old girl in Zamfara State (Nigeria) was given 100 lashes in public with a leather whip for having premarital sex (The New York Times Jan 27, 2002).

Pakistan Medical Association has protested against the involvement of the medical profession in the process of flogging on the grounds that it is not only inhuman and against the dignity of man but can also cause serious physical damage and irreversible psychological traumas, especially in young people. Moreover, this punishment may activate latent diseases like tuberculosis and precipitate cardiovascular accidents, besides permanently damaging the personality of the victim. Dr. Mahboob Mehdi, the former medical director of RAHAT (Rehabilitation and Health Aid Center for Torture Victims) while condemning the role of a medical doctor to examine a person before flogging says "No body is medically fit for flogging." It is to be underlined that doctors are employed to revive the person so that the remaining lashes are carried out. It should also be noted that flogging is prohibited under International law.

Amputation of the Limbs

Section 9 of the Offences Against Property (Enforcement of Hudood) Ordinance, VI of 1979 provides that the punishment for theft is liable to hadd. If the theft is for the first time, offender's right hand below the joint of the wrist is to be amputated; in case of a second theft the left foot below the ankle is to be amputated, and for a third theft the wrongdoer is to be imprisoned for the rest of his natural life. Amputation of hand and foot is to be carried out by an authorized medical officer and it can be postponed if the medical officer has reason to believe that the prescribed amputation might cause the death of the convict. Voice Against Torture considers it against medical ethics, for doctors, to carry out such operations and strongly condemns it (Mehdi, Mahboob 1990).

In Saudi Arabia in 1992, all theft penalties were made punishable by amputation of the right hand. Earlier, 45 amputations were carried out from 1982 to 1991 (Vogel 2000: Appendix B). According to the statements of the Ministry of Interior, in September 2000, the right hand of a Bangladeshi man was removed after he was convicted of robbing pilgrims in Mecca's Grand Mosque. In August 2000, Okaz reported that a court ordered the surgical removal of the left eye of an Egyptian Abd al-Muti Abd al-Rahman Muhammad, after he was convicted of throwing acid on the face of another Egyptian. The operation was performed in a hospital at Medina. In addition to this punishment, Abdel Rahman was fined U.S $68.800 and sentenced to an undisclosed prison term (Human Rights Watch Backgrounder, Dec 2001 "Human Rights in Saudi Arabia: A Deafening Silence"). In July 2002, a young man in Sokoto (Nigeria) had his right hand

amputated for stealing a goat. The amputation was carried out under anaesthesia by a qualified surgeon. In Katsina state, a man was sentenced to have his right eye removed in retribution for blinding another man in an assault (The New York Times Jan 27, 2002).

Stoning to Death

From 1982 to 1991, judgements of stoning to death were passed in four cases of adultery in Saudi Arabia (Vogel 2000: Appendix B). Stoning to death was practiced in Iran as well, where in 1997, the theocracy executed at least 200 persons in public. In one case in Nigeria, Sufiya became pregnant as a result of illicit relationship with Abubakar, who promised to marry her. Abubakar denied everything. The court decided that pregnancy alone was a sufficient evidence of adultery, whereas Abubakar was acquitted for lack of witnesses. The judge sentenced Sufiya to death by stoning. Similar cases have also been reported from Pakistan.

Interpretations of Punishments

Punishments are interpreted in a different manner by the Islamic penal code in modern Muslims societies. Modernists, one category of Muslims, believe that Islamic law can be interpreted in a more humane way. It is believed that torturous punishments originated in pre-Islamic period and have continued from then on, whereas the Islamic ideals should be to stop aggression and revenge. Fundamentalists, on the other hand, continue to prescribe such punishments.

Both sides have a variety of arguments for and against applying the Islamic penal system in contemporary Muslim societies; the most important being that since the 'ideal Muslim society' i.e. a society also without crimes, is a utopia and its penal system cannot be applied to contemporary societies. For example, it is irrational to amputate the hand of a person who has committed a petty theft, when the society has never been able to provide him with sufficient means for supporting himself and his dependents (El-awa, Mohamed. S: 1982).

Islamic Punishments used in “Political Islam”

It should also be noted that the Islamic politicians while reigning under the banner of “political Islam” i.e; Islam employed by a powerful group of people to achieve their political ends, often used torturous punishments. One good example is from Pakistan where General Zia began the process of Islamization after coming into power as a result of a military coup. He had promised to hold elections within 90 days but changed his mind with the excuse that God had appointed him to 'Islamize' Pakistan. Flogging, as an Islamic punishment, was used as a vehicle to subjugate political opponents and was applied publicly to terrorise public at large. Some of the Hadd punishments such as amputations and stoning were not applied in Pakistan. Hadd punishments however, remained in the statute books as a symbol of Islamization. Perhaps these punishments were never meant to be applied in modern day Pakistan due to the public opinion but one cannot ignore the intimidating effect of having them in the law of the land.

Muslim history reveals that in less than two centuries after the Prophet's time, circumstances had made it necessary to relax the enforcement of the Islamic penal system. This was due to the fact that the system in which those punishments emerged no longer existed.

## Corrupt Systems

Harsh punishments have been criticized in Pakistan on the following grounds:
Harsh punishments were primarily applied to the poor and voiceless sections of society. In most situations, people did not have the resources to hire a counsel to obtain proper legal advice.
During enforcement of harsh punishments, convicts confess on account of an ignorance of the law because in countries like Pakistan literacy levels are low and legal information is hardly accessible to general public.

## Torturous Punishment in Shariah

The classical Islamic law of punishments is provided in the Shariah. It divides crimes into three types: Hadd, Tazir and Quasas.

Hadd is defined as crimes against God and are prescribed for 'crimes' such as homosexuality, and drinking alcohol. Punishments for such crimes are flogging, stoning to death and amputation of limbs etc. The state as an agent of God, initiates the process where a Qadi looks at the proofs. It must be noted that the standard of proofs in such crimes is very high and it is almost impossible to fulfil it in practice.

If the Hadd standard of proofs is not fulfilled, the crime falls to Tazir crimes where penalties are not fixed by the Quran but are to be decided by the Qadi. Tazir crimes are considered crimes against human beings.

The third category of crimes is called Quesas crimes. Quesas are crimes of physical assault and murder, which are punishable by retaliation "the return of life for a life in case of murder". The victim or the surviving heirs may waive the punishment and ask for compensation (blood money, or diyyat) or pardon the offender.

The applicability of hadd has been greatly narrowed by numerous exceptions and conditions including difficulty of proof, recommendation of forgiveness, and possibility of repentance. But most important is the principle where doubt nullifies the hadd penalty, replacing it by the Tazir punishment. This is indicative of the general deterrence policy of Hudud. It is also significant in this regard that repentance after commission of the crime nullifies the hadd of rebellion, and some jurists hold that repentance also nullifies other hadd offences.

## Conclusion

The above discussion shows that torturous punishments in Shariah should be reinterpreted by Muslims or taken out of the prevalent legislation on criminal laws in various Muslim countries. It should be noted that over time, these punishments were almost abolished from most Muslim countries but the emergence of "political Islam" has caused their enactment again in some countries. If Shariah is interpreted in a modernistic way, then there is flexibility to abolish torturous punishments, since the essence of such punishments is to strive not to implement them due to higher standard of proof, recommendation of forgiveness, and possibility of repentance, etc.In the past, such harsh punishments were prevalent all over the world and like a lot of other pre-Islamic practices, it continued after the advent of Islam. Now criminology has further evolved and out-dated criminal law should not be practiced in the name of Islam. All reasonable Muslims believe and know that Islam has to develop with the world as it is projected to be a religion that is good for all times.

Bibliography


1. Al Alfi, Ahmad Abd al-Aziz (1982) Punishment in Islamic Criminal Law In: M.Cherif Bassiouni (eds) The Islamic Criminal Justice System, Oceana Publications, INC, London.
2. Ahmed, Ishtiaq (2003) Islam and Human Rights In Daily Times, Sunday, 17 August.
3. El-awa, Mohamed. S (1982) Punishment in Islamic Law, American Trust Publications, U.S.A.
4. Faruki, Kemal A: (1987) Pakistan: Islamic Government and Society, In John L. Esposito (ed.): Islam in Asia, Oxford University Press, New York.
5. Iqbal, Javid: (1984) 'Islamization in Pakistan', PLD, Vol. XXXVI, pp. 65-74.
6. Jahangir, Asma, Jilani, Hina (1990) The Hudood Ordinances: A Divine Sanction? Rhotas Books, Lahore.
7. Lippman, Matthew, Sean McConville and Mordechai Yerushalmi (1988) Islamic Criminal Law and Procedure: An Introduction, Praeger, New York
8. Malekian, Farhad (1994) The Concept of Islamic International Criminal Law: A Comparative Study, Graham and Trotman Limited London.
9. Mehdi, Mahboob (1990) Death penalty, inhuman punishments and doctors in Pakistan.
10. Mehdi, Rubya (1990) Legemsstraffe Efter Islamisk Lov, In: Kriminalistisk Instituts Stencilserie nr, 57.
11. Mehdi, Rubya (1990) The Offence of Rape in the Islamic Law of Pakistan, International Journal of the Sociology of Law, 18, 19-29.
12. Mehdi, Rubya (1994) The Islamization of the Law in Pakistan, Curzon Press, UK.Siddiqi, Muhammad Iqbal (1979) The Penal Law of Islam. Pakistan.
13. Shehab, Rafi Ullah (1989) Islamic Concept of Criminology, Pakistan Times May 10.
14. Souryal, Sam S (1988) The role of Shariah law in deterring criminality in Saudia Arabia, International Journal of Comparative and Applied Criminal Justice, Spring, vol 12, No. 1.

15. Vogel, Frank E. (2000) Islamic Law and Legal System: Studies of Saudi Arabia, Brill: Leiden, Boston and Koln.

# Long-Term Unresolved PTSD Among Survivors of Torture: Implications for the Medical and Helping Communities

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Research evidence has clearly shown that major psychological trauma experiences by victims of torture can persist even for decades. The effects of torture result from an accumulation of physical violence, conditions of detention, and the psychological consequences of one's own experiences and witnessing others' experiences.

The impact of extreme trauma and torture, whether it be psychological, physical, or both, are well documented. Often, torture victims experience subsequent deterioration of their mental and physical health. For example, symptoms may include muscle, joint, and internal organ pain; neurological symptoms; concentration or memory problems; feelings of guilt and shame, withdrawal from contact with others; distrust of or anger towards others; depression; anxiety; sleep problems; and temper or anger problems. Torture effects may be present as Post Traumatic Stress Disorder (PTSD), which is well documented among survivors.

In general population studies, PTSD has been found to be present for years and often was associated with exposure to multiple traumas. Studies of refugee populations clearly show that those exposed to extreme trauma have a higher risk of PTSD, in contrast to trauma victims in developed countries. Refugees, especially if they experienced torture, exhibited high rates of PTSD, depression and other psychiatric problems.

In a well-known controlled study, conducted in Turkey, of 55 tortured non-refugee political activists compared with 55 non-tortured political activists and 55 individuals who had no history of torture or political activism, the authors found that torture has "long-term effects independent of any other stressors." They noted that the passage of time since exposure to trauma, which for some was about 15 years, had no significant relationship to subsequent post-torture stress symptoms. They found PTSD symptoms were present in many torture survivors, regardless of the time lapsed since their exposure to trauma.

Numerous studies of prisoners of war (POWs) and those imprisoned in concentration camps show they have a high rate of chronic and persistent PTSD. Forty years after World War II, nearly half of the survivors of Japanese imprisonment, in one study, exhibited PTSD such as sleep disturbances, nightmares, and anxiety. In another 40-year follow up study of prisoners of war two-thirds exhibited PTSD symptoms with about one-third having moderate-to-severe symptoms. These results are consistent with other long-term studies finding 55% of POWs had PTSD symptoms 40 years later, with the most severely traumatized exhibiting rates of PTSD as high as 84%. A significant

literature also exists concerning the long-term impact of Nazi atrocities on survivors of concentration camps, showing that even 60 years after World War II those victims still exhibit significant PTSD symptoms.

Studies conducted with refugees from Southeast Asia show there is a cumulative effect of trauma on mental health years after the end of the Vietnam war. In a study of more than 1,000 Vietnamese adults living in Australia, 15 years after the war, those who experienced more trauma, evidenced greater mental illness, even though most did not exhibit obvious mental-health problems. While some studies indicate that over time PTSD symptoms diminish, other studies show that PTSD symptoms may actually increase among older adults if they experience trauma-related stimuli.

Torture Treatment Movement

Whilst there have been numerous torture-inflicting happenings throughout the globe, there have been a considerable effort, regardless of the bulk, at the same time to evaluate and ultimately provide torture survivors with a safe heaven where they could feel a bit of solace and balm their wounds, inflicted by none other than their fellow beings.

The Rehabilitation and Research Center for Torture Victims in Denmark was the first such worldwide program to treat survivors of torture. The center was based on the work of Danish physicians in the 1970's who were attached to Amnesty International, and became the international model for the treatment of torture victims. By the beginning of 2004, there are more over 200 torture treatment programs and centers in 71 countries.
Unfortunately, torture presently is being practiced in more than 100 countries. The international movement against torture has succeeded in creating a worldwide awareness about torture, implementing international laws and treaties against torture with the sturdy hope of its eventual elimination.

The international network of torture treatment programs has been created and expanded to meet the increasing number of victims worldwide, both those who are either nationals or refugees. Like RAHAT in Islamabad, treatment programs typically offer a range of assistance to torture victims including psychological and medical treatment, in addition to meeting their legal and other needs. The primary focus of the torture treatment movement has been to assist all sorts of torture victims.

Case Studies
Two case-studies have been presented below:
Case #1. N.N. is a 58-year-old ethnic Chinese female from Vietnam who, with her husband, was successful in business prior to the fall of South Vietnam in 1975. N.N. was jailed by the new government, her husband was forced into hard labor, and her home and belongings were confiscated. While in jail she was beaten, and deprived of food, water, and sleep. Both she and her husband eventually were released, fled the country and made their way to a refugee camp. N.N. began making and selling jewelry, and again experienced financial success. However, she was repeatedly robbed and beaten unconscious on multiple occasions. PTSD symptoms then began to become manifest.

After several years in the refugee camp, N.N. and her husband were resettled in the United States.

In the United States, N.N.'s PTSD symptoms intensified, including sleep disturbances, depression, anxiety, anger outbursts directed towards her husband, and the inability to maintain employment. She cried often and no longer could engage in any activities she once enjoyed. N.N. also had untreated diabetes contributing to a deterioration of her health.

N.N. was referred to the Florida Center for Survivors of Torture where she received a full psychosocial evaluation and was provided medical treatment through a public health clinic. She was referred to a psychiatrist at a mental health center where she received medication, and brief counseling for her anxiety and depression. She also received a range of social supports. As a result of medical treatment, her diabetes was brought under control. She responded positively to psychiatric treatment and staff support, resulting in reduced anxiety and depression to the extent that she could resume employment. Several months after beginning of the treatment she reported that she felt considerably better for the first time in years.

Case #2. G.K. is a 45-year-old woman from Sudan. In the early 1980s she and her family were captured and tortured by rebels as a result of belonging to a different school of thought regarding their religion and the political views. Over a several year period, G.K. and other family members were jailed several times, severely beaten, forced to starve, deprived of medical treatment, and witnessed other family members being tortured. She experienced one miscarriage after being beaten, and a second after being savagely mutilated with a knife forcing the baby to be aborted. Her husband was kidnapped shortly after her final release and murdered. G.K. was finally resettled in the United States in 1999.

Nearly two decades after her torture and significant losses, G.K. continues to experience depression and sleep problems, and has considerable difficulty focusing and managing day-to-day life affairs. She also has a number of physical problems, including pain, stemming from physical injuries she suffered during the course of being tortured. Her 12-year-old son has both behavioral and academic problems.
Through the Florida Center for Survivors of Torture, G.K. has received medical care resulting in pain reduction and improvement of a serious skin problem, basic necessities such as food, and supportive counseling to help her better manage her day-to-day affairs. The program has helped obtain tutoring and special help for her son that has resulted in notable behavior and academic improvement. While G.K. has not yet consented to treatment for her depression, she has established a level of trust with program staff that enables her to openly share information. It is expected that she will soon consent to psychiatric medication and treatment.

Discussion

N.N. and G.K.'s case studies are examples of the body of research, documenting ongoing symptoms of decades-old torture and trauma experienced by civilians, political prisoners and many others. Nearly 25 years after being imprisoned and tortured, N.N. still had classic PTSD symptoms. Within a few months of beginning of the treatment, her symptoms declined so significantly that she could again become employed and verbalize, experiencing satisfaction from life. G.K.'s symptoms continue even after 20 years of being tortured. While she has so far not allowed herself to begin psychiatric treatment, she has established a trusting relationship with her caseworker from the Florida Center for Survivors of Torture, and has taken other positive steps to improve the quality of life for herself and her son.

To the outside world, G.K., like many torture victims, often presents an outward appearance of personal adjustment. Combined with the length of time that has elapsed since the traumatic events, there is a general misperception that individuals who experienced extreme trauma many years ago are not in distress, and thus do not need assistance. Indeed, such individuals rarely, if ever, ask for help. Yet, they suffer in silence and remain oblivious lying in a corner altogether unnoticed.

Implications for Helping and Healing Providers

As noted previously, there is considerable research evidence that major trauma experienced by victims of torture can persist for decades, with a sizeable portion of individuals experiencing chronic PTSD as well as suffering deterioration in both the physical and the mental health.

This has enormous implications for medical and other helping professionals. Physicians and nurses especially need to be cognizant that they may have older patients experiencing either PTSD or other symptoms of extreme trauma, especially from amongst former political prisoners and refugees. It may only take a few questions to determine if a patient has been likely a victim of torture, such as: Were you ever imprisoned by the government or rebels? Did you suffer while in captivity? Have horrible things happened to you or your family, or have you seen things happen to others?

For individuals found to be victims of torture or extreme trauma, a brief functional assessment needs to be conducted. The settings will guide the length of the interview and assessment, which can range from a few general questions to a more in-depth interview. General questions, which are not threatening that probe possible PTSD symptoms may ask about:

- sleep habits
- feeling sad or depressed
- feeling distant emotionally
- worrying or feeling anxious
- avoiding people or places
- having temper or anger outbursts

Other questions could probe feelings of guilt or worthlessness, relationship problems, fatigue and energy level, and suicide thoughts.

Recognizing that some older or aging torture survivors continue to suffer effects of physical torture, physicians and other health professionals should ask about pain, difficulty walking or moving, vision problems, severe headaches, eating and stomach problems, breathing difficulties, heart problems, and epilepsy.

Once PTSD or physical symptoms of torture have been possibly identified, the context will dictate the appropriate treatment. Medication may help with sleep, anxiety, pain or other after effects of torture. Referral for specialized treatment may be appropriate, such as physiotherapy, acupuncture, or stress reduction therapies.

Physicians, nurses and other helping professionals can and should be the front line in identifying those who may be experiencing PTSD, caused by long-ago torture and extreme trauma, and help them obtain the treatment they so desperately need and deserve.

References


1. Burnett, A., & Peel, M. (2001). Asylum seekers and refugees in Britain: The health of survivors of torture and organised violence. British Medical Journal, 322, 606-609.
2. Genefke, I., & Vesti, P. (1998). Diagnosis of governmental torture. In J.M. Jaranson and M.K. Popkin, (Eds.), Caring for Victims of Torture, (pp. 43-59). Washington, DC: American Psychiatric Press.
3. Genefke, I., & Vesti, P. (1998). Diagnosis of governmental torture. In J.M. Jaranson and M.K. Popkin, (Eds.), Caring for Victims of Torture, (pp. 43-59). Washington, DC: American Psychiatric Press.
4. Kessler, R.C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. Journal of Clinical Psychiatry, (61) [suppl 5], 4-12.
5. Kessler, R.C. (2000). Posttraumatic stress disorder: The burden to th individual and to society. Journal of Clinical Psychiatry, (61) [suppl 5], 4-12. See also, Allodi, FA. (1991). Assessment and treatment of torture victims: a critical review. Journal of Nervous and Mental Disease, 179(1), 4-11; Mollica, R.F., Wyshak, G.,& Lavelle, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. American Journal of Psychiatry, 144(12), 1567-1572;
6. de Jong, J.P., Scholte, W.F., Koeter, M.W., & Hart, A.M. (2000). The prevalence of mental health problems in Rwandan and Burundese refugee camps. Acta Psychiatrica Scandinavica, 102(3),171-177.
7. Basoglu, M., Parker, M., Ozmen, E., Tasdemir, O. & Sahin, D. (1994). Factors related to long-term traumatic stress responses in survivors of torture in Turkey. Journal of the American Medical Association, 272(5), 357-363.

8. Yahuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about Posttraumatic Stress Disorder and its original conceptual basis. American Journal of Psychiatry, 152(12),1705-13.
9. Goldstein, G., van Kammen, W., Shelly, C., Miller, D.J., & van Kammen, D.P.(1987). Survivors of imprisonment in the Pacific theater during World War II. American Journal of Psychiatry, 144(9), 210-1213.
10. Kluznik, J.C., Speed, N., VanValkenburg, C., & Magraw, R. (1986). Forty-year follow-up of United States prisoners of war. American Journal of Psychiatry,143(11), 1443-1446.
11. Zeiss, R., Dickman, H.R. (1989). PTSD 40 years later: Incidence and person-situation correlates in former POWs. Journal of Clinical Psychology, 45, 80-87;Engdahl, B. Dikel, T.N., Eberly, R., & Blank, A. (1997). Post traumatic stressdisorder in a community group of former prisoners of war: A normative response to severe trauma. American Journal of Psychiatry, 154(11), 1576-1581.
12. See, for example Eitinger, L. (1961). Pathology of the concentration camp syndrome. Archives of General Psychiatry, 5, 371-379; Bower, H. (1994). The concentration camp syndrome. Austrailian and New Zealand Journal of Psychiatry, 28(3), 391-397; Robinson, S., Rebaudengo-Rosca, P., & Rapaport, M. (1993). Late effects of massive trauma: Holocaust survivors 50 years later.Minerva Psichiatrica, 34(1), 57-63.
13. Boehnien, J.K., & Kinzie, J.D. (Winter 1996). Psychiatric treatment of Southeast Asian refugees. NCP Clinical Quarterly, 6(1), accessed at Http://www.ncptsd.org/publications/cq/v6/n1/boehnlei.html; Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. Lancet, published online at http://image.thelancet.com/extras/01art9374web.pdf, citing: Mollica, R.F., McInnes, K., Pool, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. British Journal of Psychiatry, 173(6), 482-88; Mollica, R.F., McInnes, K., Pham, T., Smith-Fawzi, M.C., Murphy, E., & Lin, L. (1998). The dose-effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. Journal of Nervous and Mental Disease, 186(9), 543-53.
14. Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. Lancet, published online at http://image.thelancet.com/extras/01art9374web.pdf.
15. Port, C.L., Engdahl, B., Frazier, P. (2001). A longitudinal and retrospective study of PTSD among older prisoners of war. American Journal of Psychiatry, 158(9), 1474-1479; Averill, P.M., & Beck, J.G. (2000). Posttraumatic stress disorder in older adults: a conceptual review. Journal of Anxiety Disorders, 14(2), 133-156.
16. International Rehabilitation Council for Torture Victims, accessed online at http://www.irct.org/usr/irct/home.nsf/unid/JREW-5JPJES; United Nations, accessed online at http://www.un.org/events/torture/bkg.htm.

17. International Rehabilitation Council for Torture Victims, accessed online at http://www.irct.org/usr/irct/home.nsf/unid/BKEN-5MDCFF; Amnesty International Report 2003, accessed online at http://web.amnesty.org/report2003/index-eng; Message of the U.N. Secretary General, accessed online at http://www.un.org/events/torture/sg.htm

Advantage of the Disadvantaged in Afghanistan

Shujaat Ali

Abstract

This paper comprises of two parts (i) situational analysis and the long-term impact of violence against the disadvantaged communities, and (ii) strategies for prevention of violence and rehabilitation for the torture survivors.

Afghan women, girls, and boys have suffered enormous abuses, harassment and restrictions for the last many decades. Afghan history stands witness to some miserable turning points during the last century, on the issues of human, legal, and social rights of the society, creating a torturous and frustrating environment particularly for the vulnerable. The dysfunctional governance may create another human disaster, that of, the long-term psychological consequences of the post-war violence and sadism. The warlords, commanders and gunmen are taking advantage of the prevailing apathy and silence. It has been suggested that there should be a greater role for women, media, NGOs & the private sector in the state affairs, to break the ice.

Section (i) Situational Analysis And Long Term Impact Of Violence Against The Disadvantaged Communities

This section discusses the plight of disadvantaged and vulnerable population in Afghanistan and the long-term psychological impact of conflicts and wars on the masses. In the past, thousands of women, girls and children have been raped, abducted or murdered. The war produced many lasting torturous impacts on human health in terms of physical disability, Post-Traumatic Stress Disorders (PTSD), severe depression and anxiety, as well as social dysfunctions and economic instability. There were massive human rights violations in Afghanistan since the commanders and warlords took advantages of the disadvantaged communities.

The major turning point in the Afghan history occurred after the Soviet occupation, followed by a so-called Holy War that resulted in one of the biggest human tragedies. The preceding Taliban regime was unique, as well as, alien and ridiculous for the majority of the Afghans. Taliban succeeded in maintaining law and order in their territory but the cost was huge and immense. The rigidity and narrowness of Talibans in maintaining rule of law was extremely criticized even in Islamic World. They totally eradicated women from the public scene, stripped them off power and confined them to closets. By imposing a colossal and complex set of social and religious standards, Taliban segregated the society into many parts. A human rights group described the Taliban's restriction on women's rights as "one of the most deliberate forms of discrimination against women in recent history."

When Taliban rule ended, many people within and outside of Afghanistan considered its collapse to be "liberation" particularly for Afghan women and girls. There was much hope that Afghan women would soon enjoy increased freedoms and rights, denied to them under the Taliban regime. But the situation could not change overnight, because the rights especially those of Afghan women and girls had been a contentious issue in Afghan politics and society for most of the time, as Afghan women themselves have been sidelined from public discussions and decision-making about their rights and role in society. Women's rights have been used to polarize politics and ideology of the country, thus the reforms directed at women have often led to both social and political instability, and even to revolutions.

Today, women are still marginalized and discriminated in Afghan society and politics, and women also remain sidelined in the central government  only two cabinet ministers are women, one as minister of women's affairs and the other as the head of the Ministry of Health  policy areas in which female employment is less controversial. Women are also underrepresented in international developmental programs; Afghan men dominate the staff of most of such offices  both U.N. and nongovernmental  a problem that existed well before the Taliban.

Women and young girls, for example, do not go out alone but if they do, they have to wear burqas for fear of harassment or violence, regardless of whether they would otherwise choose to wear it or not. In many parts of the country, women are still threatened, beaten or sometimes killed for not wearing burqas. In addition to the terrible physical and psychological deformity caused by these attacks, it also serves to limit the participation of women in society, thus limiting their access to the basic rights of education, work, privacy, and primary healthcare. Women and girls essentially become prisoners in their own homes. Many of them believe that some leaders  former Mujahideen leaders and the Warlords  deliberately oppose rights of women, due to their mindset, that probably would result in a permanent deprivation of their privileges.

There have been excessive reports about soldiers and commanders raping girls, boys, and women in provinces in southeast Afghanistan, in Laghman, Ghazni, Gardez, and in Paghman, although most are never reported. Women, girls, and boys are abducted outside of their homes in broad daylights and sexually assaulted.

The fears of Afghan women today stem not only from ongoing abuses, but also from the memory of abuses committed by current rulers when they were previously in power.
In Afghanistan like many other countries, reporting and vocalizing sexual violence is a challenge, in part because of women's subordinate status, family concern with "honor" and "dishonor," cultural taboos, and because of women's and girls' own reluctance to share details of the traumatic assault.

Sexual violence leads to severe mental sufferings such as anxiety, depression, irritability, emotional liability, cognitive memory, attention problems, personality changes, behavioral disturbances, and somato-psychic symptoms such as lack of energy, insomnia, and nightmares.

Whole of the scenario leads to a psychological and physical disasters. Brundtland (1999) suggests that in order to address the mental health needs of such a population, specific management ability and approaches are required. The task becomes even more complex as health infrastructure is already damaged. The impact of increased mortality and morbidity further necessitates decay of human and financial efforts. Aggravated poverty also plays its part and endangers survival, maintains dependency, retards reconstruction, hinders reconciliation, and impedes peace and development.

Recognition of the mental health requirements of traumatized population has been emerging but remains poorly addressed, since the allocation of resources does not match. Despite the scientific evidence to the fact that conflict has a devastating impact on the health, it is not given priority by many a decision makers.

Post-Traumatic Stress Disorder (PTSD) is one of the most dominant psychological symptoms, consisting of extreme irritability, social withdrawal, avoidance of situation that can resemble elements of torture situation, nightmares and frightening flashbacks of the traumatic situations. Other important factors of long-term PTSD are the decrease in the quality of social support that a woman receives in her post-captivity environment, her recline in religious faith, and political involvement. PTSD is not the only disorder that may occur following sexual assault; there is an increased risk of major depressive disorders, increased rate of suicidal attempts, anxiety disorders, and substance abuse. A decreased frequency of sexual relations is the most often reported change after rape.

Arcel10 comments that, research on psychological trauma documents threat against life and body in a generally violent context with verbal humiliation and degradation results in persistent mental harm. The terms "coercion and arbitrary" liberty deprivation refer to all forms of isolation, arbitrary custody, and strict control of women movements, prohibiting them from attending school or work.

According to medical and psychology, sexual abuse is considered as a very important life-stress event that leads to many other stresses. Torture exposes people to the risk of psychiatric symptoms and social problems. The traumatic experience of torture, i.e;

prolonged, repeated, man-made, unpredicted, and inflicted with malevolent intent, causes the most serious psychiatric dysfunctions.

Section (ii) Prevention of Violence and Rehabilitation of the Torture Victims

UN Declaration (1993) on the Elimination of Violence against Women (DEVW) defines gender-based violence as:

"Any act of gender-based violence that results in, or likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."

Prevention and Rehabilitation of the torture victims in Afghanistan may be initiated at two levels:

- Governance and Institutional Level
- Psychological Level

It is very difficult for a country to develop a systematic governing system in a very short span of time. The combination of fear, renewed restrictions on freedom of movement, and sexual violence will have a significant impact on the reconstruction of the war-torn country. If women and girls are marginalized, efforts of reconstruction will necessarily be hampered; however, some interim measures may be taken to assure the psychological and physical security of the disadvantaged communities.

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment protects individuals from cruel, inhuman, and degrading treatment; ensures the right to integrity; and requires the state to protect these rights without discrimination of any kind. Under the Afghan Constitution:

"State has the duty to respect and protect the liberty and dignity of the individual Imposing punishment incompatible with human dignity is not permissible."

As far as the disadvantaged communities are concerned, Afghanistan in practice has not observed any rule of law for; however, the newly developed constitution by the Loya Jirga has assured the freedom of women but there probably is no implementing agency that may ensure laws related to women freedom will be implemented. In order to improve governance and rule of law:

- The police system should be systematic with some significant powers to investigate cases of sexual violence.
- Research and documentation facilities should be enhanced to record and report torture against women and children.
- Long-term medical, social and psychological after effects of torture must be publicized by the concerned authorities.
- Judicial System may be established in order to provide easy access to justice to the torture victims and the advocacy organizations

- International law should provide all individuals, male and female, with the rights to freedom of expression, association, movement, equality, work, education, privacy, sexual autonomy, and bodily integrity, including freedom from cruel, inhuman, or degrading treatment.

Developing and implementing a social rehabilitation agenda for the torture victims is a gigantic task for a country like Afghanistan. Medical, psychological rehabilitation, social and institutional development plans are difficult to implement in Afghanistan because of lower level of human resources, lack of expertise, and qualification and a massive pressure from different ethnic groups and warlords. To mitigate the challenge, various policy measures may be taken by involving multiple strategic partners:

- Enhancing private sector role in social infrastructure development.
- Developing, planning and managing the Female Organizations (FOs) both at urban and rural levels. Participation of donors and human rights organization can play a pivotal role in developing the Fos.
- Women and Children Crisis Centers should be developed in the hospitals for treatment and rehabilitation of the torture cases.
- Women should be empowered through participation, consultation and representation in various social, constitutional, legal and political policy making institutions.
- Regional planning and development issues along with gender and child development issues must be addressed at the grass-root levels.
- Concrete measures to be taken to reorganize the Afghan Human Rights Commission (AHRC) so that it can more effectively investigate human rights violations related to women and children.
- Proper monitoring, evaluation and impact assessment system may be devised to monitor the torture related cases.
- The reformist government should encourage the Ministry of Women's Affairs to step up its efforts in promoting women rights.
- The international agencies should maximize their efforts to facilitate Afghan women and girls speaking and advocating on their own behalf.

Given the magnitude of the problem and the lack of resources, individual psychiatric care has a limited impact. Community-based psychosocial care must become an integral part of emergency response and of the trauma victims. This will help prevent psychiatric morbidity and accelerate the improvement of the psychosocial functioning of people. Efficiency may also be enhanced when the concerned community is involved. Arcel10 presents rehabilitation and treatment strategy for victims of sexual harassment as under:

- Reduce their anxiety.
- Alter their perceived threat related to he traumatic memories of violence.
- Help them feel safe, encourage self-worth and reassure about the future.
- Reduce their guilt, shame and self-blame.
- Help them restore their social and career adjustment.

Family and Couple Therapy can prevent breakdown of communication in couples and family. Victims feel increasingly dependent on their partners and the family members, and can be chronically fearful and anxious, which is stressful to their relationships.

According to Wein (1999), the problem of torture is horrifyingly global, but the accumulated knowledge in this field of mental health treatment of torture survivors is remarkably small. Not many of us do this work. There are not a lot number of books and papers describing what we do. There are no large of tools to use as interventions. The theories and models that have been applied are relatively narrow. Those of us, who do the work as professionals, have an obligation to be helpful. And those who are working as scholars have an obligation to deepen the understanding.

In the field of treatment of torture survivors, the need to respond with clinical programs and interventions has thus far been out ahead of the researchers' capacity to conduct treatment studies. Wein introduced the treatment programs for the survivor groups. The care provided was consistent with the body of clinical literature that addresses treatment for torture survivors. The types of interventions, which were clinical and psychiatric in essence, were mainly targeted at individuals, organized around the aim of symptom reduction, imparted in mental health settings and granted by highly trained health professionals.

Wein suggested the project Coffee and Family Education and Support (CAFES) that provides multiple family discussion groups aimed at:

- Helping families to be able to draw upon their strengths and resources to cope together under the stresses of survival and exile, and providing them the basic information that will make it easier for them to obtain appropriate care and services.
- Helping families to overcome isolation by creating a "supportive social context" where families can interact, learn and teach one another. By linking the family with other families and with organizations the group tried to expand the families' social network and to create linkages between community and service networks.
- Focusing on the family's strengths and resources, and offering a model of living, which is applicable to other survivor groups.

Conclusions

Medical and psychological rehabilitation system of the torture victims may be initiated with low cost investment and greater participation of the relief institutions. A sound mechanism may be developed and implemented by maximizing the consultative role of various health sector institutions and professionals.

The Afghan disadvantaged communities are facing a complex situation. We can learn some realities from various Human Rights organizations reports, that there is one commonality; the Afghan People mistrust any regime now. This, as well as the victims suffering long-term impacts of violence, torture and human rights violations, makes the situation extremely difficult to work through.

Any model or system for rehabilitation may take a lot of time to provide a positive outcome, especially in the regions having no rule of law. The reformist government has to show willpower and commitment to the people of its country by implementing a rehabilitation system in the country.

The strong international presence can facilitate and influence changes and the present status of women by providing (i) relevant training, knowledge and expertise to the Afghan Ministry of Health, Women Affairs and various organizations working in Afghanistan in the areas of rehabilitation and health, and (ii) arranging proper security for the relief workers.

The existing international laws and Afghan Laws, protecting health, sexual and reproductive rights, and those prohibiting torture and sexual violence against women, should be consistent with international standards. Commanders and warlords should be instructed strictly to observe and maintain the international codes of ethics.

· The forces and police under various commanders must be gender-sensitized. Capacity-building programs about the long-term psychological impacts of torture, and knowledge of social and political consequences of torture should be provided to various law-enforcing agencies and the communities as well.

Civil Society Organizations (CSOs) should be provided maximum participation and facilitation by the government for speedy implementation of legal, political, constitutional and social reforms in the country.

Forced medical examinations of women's chastity by unauthorized persons should be legally banned. Sexually abused victims must be medically examined only by female doctors/nurses.

Female organizations, independent media and various civil society organizations should be involved in the investigation and welfare of sexual torture and abduction cases.

Breaking the state of silence among communities about the taboo of “rape” the role of free media and independent judiciary will provide greater advantages to the disadvantaged communities.

References

1. Killing you is a very easy thing for us : Human Rights Abuses in Southeast Afghanistan; Human Rights Watch, Vol. 15, No. 5 ( c) -- July, 2003
2. We Want to Live as Humans: Repressions of women and Girls in Western Afghanistan; Human Rights Watch, Vol. 14, No. 11 (c) December, 2002
3. All our hopes are crushed: Violence and Repression in Western Afghanistan Human Rights Watch, Vol. 14, No. 7 (c) November, 2002
4. Coursen-Neff. Z and Sifton. J (2003) Falling Back the Taliban Ways with Women International Herald Tribune
5. Warlords Implicated in New Abuses New York July 29, 2003
6. Stevan W (1999) Torture Mental Health: Questions, Exhortations, Works Project on Genocide, psychiatry and Witnessing, University of Illinois at Chicago.
7. Coursen-Neff, Z (2003) Afghanistan's Women Still Need Our Help Washington Post.
8. Afghanistan: Women Still Not "Liberated" Police Abuse, Forced Chastity Tests, and Taliban-Era Restrictions in Heart New York, December 17, 2002
9. Brundtland, G. H.(1999) Mental health of refugees, internally displaced persons and other populations affected by conflict., Acta Psychiatrica Scandinavica
10. Arcel. L. T (2002) Torture, Cruel and Degrading Treatment of Women Copenhagen, IRCT, Vol 12, No. 1

Mice and Men
Consequences of Sodomy of Boys

Tehmeed Razvi

Sodomy can be likened to torture because of the in-depth damage and trauma it inflicts. Surely any kind of sexual exploitation of children is one of the gravest infringements of the rights of an innocent defenseless child that can possibly be endured.
"We shrink, for very shame, from treating the subject of boys. Fear ye the Merciful, O peoples of the world! Commit not that which is forbidden you in Our Holy Tablet, and be not of those who rove distractedly the wilderness of their desire." (Verse 107)

Taken from the Book of Aqdas this quote plainly condemns the specific practice of engaging in sexual acts with boys. Although sodomy may also be practiced on girls, this article is dealing primarily with the issue of sodomization of boys, as well as male homosexuality, not as a point of condemnation, but as a consequence of sodomy, this will be explained later in this article.

Sodomy refers to anal sex with a person, usually of the same sex, but is not necessarily a practice unique to homosexuals. When it is in conjunction with a child, it brings into question the concerning issue of child sexual abuse. A detailed definition given by the World Health Organization in 1999 stated:

> Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:
> The inducement or coercion of a child to engage in any unlawful activity
> The exploitative use of a child in prostitution or other unlawful sexual practices
> The exploitative use of children in pornographic performances and materials

The word sodomy is a derivative of the name "Sodom." The messenger Lut, resided in the city of Sodom that was located in the area of the Dead Sea. These people, as the Quran tells us, practiced a perversion unknown to the world, namely sodomy. Where sodomy has derived from is debatable, certainly in Hebrew society during the time of Moses it was in existence, as Torah mentioned the episode of Sodom (Genesis 18:19).

Historically, homosexuality was not only confined to common masses, even legendary and many prominent figures practiced it. Persian poetry amply supports the fact that homosexuality was widespread in the Orient. It has also been mentioned, that there were

three centers where eunuchs carried out this 'unnatural business', one of which was, Afghanistan. Homosexuality existed before the pre-Christian era, especially amongst the Greeks and Romans. Saint Paul in the Bible, mentions the issue of effeminacy, which can be associated with homosexuality, it does not deal directly with sodomy. However, it still condemns men's relationships with men, which can be interpreted to include sexual acts with boys as follows:
"If a man also lie with mankind, as he lieth with a woman, both of them have committed an abomination: they shall surely be put to death; their blood [shall be] upon them" (Levictus, 20:13, Holy Bible)

Despite the messages of morality and religious bindings, sodomy continues to exist as a grave and widespread problem in throughout. Being evasive, defensive or else choosing to point the finger at the Western world for encouraging homosexuality (by legalization) the thought of the crime seems to provide a softer landing in our minds. Where Muslims could be at the forefront today in achieving honor, respect and dignity, ironically some are too busy practicing what should have been fought against. Ethnic culture and illiteracy seems to control and distort religion to suit individual needs and so a diminishing of the responsibility to protect children, that is necessary to stop the abuse of children.

For most people in Pakistan, it is generally still a very taboo issue, which makes it an even more mammoth task to deal with. The fact that much CSA (child sexual abuse) occurs within families, often ones that appear outwardly 'normal and happy' makes it harder to manage and provide support to victims as there is a limited acknowledgment of its existence. So long as it lurks in the shadows it is easy for the society to ignore it, but certainly it is not that easy for a garroted child to root it out of the mind's fertile ground.

Afghanistan, by some, is referred to as the homosexual capital of South Asia. Kandahar's Pakhtuns have been notorious for their homosexuality for centuries, particularly their fondness for naive and fair skinned young boys. In Pakistan too, where the feudal/tribal systems prevail, this is still a right, acclaimed by the powerful and rich, to abuse the rights of children. According to many, sodomy is not necessarily a ruinous experience for the child, but it can be ruinous to a man's reputation if he does not avail this perverse service for himself.
Prison cells also generate CSA, where many a boys become victims of sodomy. Cells that are often overcrowded, the mixing of adult and child detainees, well-behaved prisoners with given responsibility of 'supervising' the prisoners, leave young boys vulnerable to abuse. For those who report the incidents there is a lack of effective complaints procedures and an inadequate judicial system that does not protect their rights.

Various institutions sometimes become breeding grounds for CSA. In certain cases, children are sent to institutions for the religious education. The poor children are then at the clemency of the ecclesiastic class. The natural urge of sex, latent in man may be suppressed for some time, but cannot be strangled permanently. So, such children become the victims of the unnatural acts of their benefactors. Orphaned, runaway and impoverished children similarly take to the streets in search of safe havens, usually

ending up as child laborers or involved in sexual crimes in return for money or employment. Inevitably, failure to find adequate employment, due to illiteracy and hence, access to marriage, also cause of unnatural sexual behaviors.

In the long term, the effects of sodomy on boy's lives can be complicated and catastrophic. Rogers and Terry (1984) stated that:

“All boys who had been victims of homosexual abuse exhibited confusion and consternation regarding their sexual identity.”

Due to this confusion in sexual identity caused by being sodomized, it seems that some will inevitably become homosexuals and further perhaps some of these will then sodomize boys. A child's perception of right and wrong conduct can become altered, as well as their perception of themselves. Sadistic abuse can lead to further psychological and sometimes very psychotic behaviors. Boys often go onto using substance abuse as an outlet to the contained feelings, lighting fires to get rid of their burning rage and pain, losing their childhood along the way. Children, who suffer incest from fathers, often have a dichotomist view and feeling towards them. They see their father as having two faces, the good one and the bad one, leading them to confusion as to which is the real one and may be adopted in future. Inevitably, CSA victims develop various problems with sex as they become adults, leading to loss of libido, impotence, feeling sexual towards lots of people, or becoming addicted to sex, resulting in prostitution.

In the short term, signs of having been abused may be exhibited in behaviors, physical or psychological patterns. Children's behavior will depict something not 'normal,' including fear of the darkness, separation, being alone with a particular person, insomnia, nightmares, nervous tics, clamminess, temper tantrums, withdrawn behavior, fluctuation in eating habits as well as bedwetting, sexual aggression towards others, explicit sexual language and alike. Some or all of these may be commonplace indicating the presence of sexual abuse.
Psychologically, children feel guilty, ashamed, confused, helpless and powerless, hurt and betrayed, sad, scared, depressed, and angry experiencing mental anesthesia. Depression is a major health problem in Pakistan. Society's silencing of the subject of CSA; medical health, marital problems, unemployment due to childhood sexual abuse are just some of the contributory factors towards the affluent issue of depression.

Physically, signs may be quite obvious in younger children as a parent is likely to be aware of the child's toileting habits and changes his/her clothes. Bruising, particularly of the thighs and genital area, bite marks and flinching may be apparent. Multiple problems faced by the sexually abused child include feeling itchy, presence of sores around genitalia, having urine infections and experiencing pain whilst walking or sitting. A small child who has been penetrated anally may experience a lot of rectal bleeding and have a larger size of stools/feaces. It is sometimes difficult to make a medical diagnosis as, for example, anal dilation may be abnormal, but is not necessarily due to CSA, it may also be due to pinworms. Advanced technology is necessary to accurately detect sexual abuse causing minimal discomfort to the victim following an incident.

Unprotected sex is common amongst truck drivers, leading to HIV, Aids and other sexually transmitted diseases. Boys are often taken under truck drivers' wings as a means of acquiring cheap labor. This often leads to using them for sexual pleasures too and so, passing on wrecking diseases, affecting both the health and future of the child.
So what is it that drives men to this heinous and repulsive crime? It is important to understand the psyche of an abuser, in order to be aware of potential dangers to children.

Pedophilia; having sexual urges and fantasies relative to children is just one reason. According to Glasser (1998), there are two types of pedophiles:

a) The invariant pedophile that has always been interested in children in a sexual manner. The person has no interest in other adults and is rigid in personality, with limited range of interests and activities, and does not feel shame or guilt over his pedophilia. Invariant pedophiles, having a fixed or obsessive way of thinking, feel isolated and alienated in a world that does not understand them. They usually have low self-esteem, poor self-image, lack confidence and may escape from admitting that the abuse was their fault.

b) The pseudoneurotic pedophile that outwardly appears abnormal is indistinguishable from others. Internally, he is pedophilic, having occasional sexual urges and fantasies related to children for which he feels ashamed. Urges may manifest at times of tension in his adult relationships. The abuser is usually in a position of ultimate power, has superior capability and knowledge to psychologically manipulate the victim.

The pseudoneurotic often has feelings of detachment, lacks empathy, and acts his desires and fantasies out. The ultimate goal of the abuser is to satisfy his urge and desires. The pseudoneurotic abuser is usually a familial offender; incestuous abuse is usually their most common form of sexual abuse. Allegations against relatives prove to be a major obstacle in disclosing the abuse as well, and this in turn gives further liberty to the abuser to continue abusing.

Habitual, fixated abusers are artistic in the manner they exploit children. Offender's method of acquiring a victim for his gratification may initially be, by gaining the child's trust and confidence to begin the process, then perhaps, desensitizing the child to touch and fondling, bribing, threatening, tricking or forcing the child to engage in the sexual act and keeping the abuse secret.

Because of this, children who have runaway from home, need money, have low self esteem, are at an age where they are interested in their bodies or sexuality are depredated upon by abusers. Victims have to be attractive to the abusers engaged in sodomy. Generally, young boys who are fair and feminine are chosen to get them engaged in sexual acts.

It is important to understand why sodomy has become so absorbed in Pakistani society in order to find the exit to this menace. Introduction of rigid Islamic segregation of men and

women in the early 1980s by the military rulers of the country, lead to sexual apartheid in schools, attacking of girls wearing western clothing, not having their heads covered with 'chaddar', female events and programmes that exposed women's legs were not shown on television, contributing further to repression of men's sexuality. Children again became easy targets for the outlet of sexual frustrations.

Medieval practices of child rearing, practiced widely today include, teaching strict obedience to all parental commands, fearing them immensely, using physical punishments, being taught not to laugh "excessively," reinforce the notion that giving in to any of their own needs or desires is horribly sinful. From childhood then, children have been taught to kill a part of themselves and, many, with their hearts filled with hatred for others who enjoy freedom, bring terror into homes. When their trust is shaken and their rights violated, they will also go to extremes to violate others' rights, and will find it very difficult to trust anyone. In case of sibling incest, most sodomized boys will sodomize or maintain incestuous relations with a younger sibling to project their anger and gain control and power that they lacked during their own abuse.

On the one hand there is dying and killing for Allah against 'evils' of the West, yet on the other hand, the practical example shows that those fighting in the name of Allah are themselves often found carousing in sins of sodomy, and others. Whereby girls are punished or outcast if they have been raped; boys, even though similarly extorted, are made to live and enjoy a happy life. This of course spurs the desire of maintaining the illicit relations, because they are never made to believe that the act was, in any terms, an unethical one.
However, the Qur'an (24:2) stipulates 100 lashes for this offence but, Prophet Muhammad stoned a number of men and women (Sahih Muslim Chapters 623, 680, 682 and Hadith Malik 493:1520) and so this punishment is Islamic Shariah Law, which is practiced to this day in certain parts of the country, hence, making federal laws ineffectual.
“And as for the two of you who are guilty thereof, punish them both. And if they repent and improve, then let them be, Lo! Allah is Relenting, Merciful” (Holy Qur’an (4:16))

This statement refers to homosexuality, for which even God may forgive if the crime is not committed again. But can one forgive a perpetrator for abusing a child in such a sordid and torrential manner? The law and mankind on the one hand do not show mercy when distributing such torturous punishments yet on the other, selectively remain ignorant and tolerant of such happenings.

Modern studies and theories regarding homosexuality convey a blurred conception that biological disturbances are responsible for misdirected lust. Just as other criminal acts of immorality cannot be condoned because of biological, psychological, environmental factors, so too, these factors cannot be expositional in favor of, diminished blame for the act of homosexuality. Neither reasoning nor punishment of the perpetrator is comforting to the victim  the boy who is not mighty, so cannot protect himself, and self-fearing, like a mouse.

According to Cullberg (1975), how the child responds to the trauma depends on four factors; the triggering situation, significance of the occurrence, the particular point in his or her life or development the abuse took place, and social circumstances such as those associated with family situation. However, what kind of attachment the child has with the abuser and what kind of support he/she receives from the non-abusive parent if he discloses is also relative to the coping ability.

Children do not always disclose the abuse, which for onlookers can be frustrating and confusing. This may be because:

They are scared that they will be punished for telling ‘lies’
They are embarrassed and feel ashamed to share the experience
They do not know where to seek help from
They are unaware that what has happened to them was an 'abuse’
They must keep the abuse secret due to pressure from family members/society
They believe the abuse was their fault
They have been led to believe by the abuser that nobody will believe them
They think what happened to them was to inspire a homosexual side in them
They think their ego will be damaged if they complain of being hurt by someone

But it is not just the victim who cannot disclose. Mothers, as witnesses or knowledgeable of the abuse taking place may not utter the incident because she:

Is unable to accept the incident so tries to minimize it
Has been abused as a child herself
Hopes it will stop
Fears stigma and social isolation
Fears being disbelieved
Does not understand the seriousness of 'abuse’
Is afraid of perpetrator
Thinks she can stop abuser
Does not know what to do

Whether disclosed or not, children's innocence is castrated with effects, outlasting the term of the event leaving them broken and bewildered, not knowing what has happened to their bodies quite often, why, and how they can possibly deal with the problems they then face.

Therefore, early identification of sexual abuse victims is crucial to the reduction of suffering of innocent children and to achieve healthy psychological development for adult functioning. It is interesting to note that both mother and son may not be aware of the seriousness of abuse. Because of the gender segregation in schools, an ommittance of sex education in the curriculum, many do not understand that sodomy is a form of sexual abuse. It is a violation of the child's rights and exploitation of their bodies. Not taking the matter seriously is corroding childhoods and society who have to deal with the resulting problems.

So what is it that stops medical professionals, teachers and others who may bear witness to the act or are involved in the welfare of the victim in dealing with the issue of CSA? It is human nature to have personal feelings, but these must not stand in the way of treating the victim. Others dealing with CSA victims may be so intrigued with sexual details that they begin to fulfill their own fantasies by probing the victim for explicit details that one may not be ready or willing to disclose. An inability to immediately bring the victim to a point of recovery can also make the doctor or therapist feel incompetent and frustrated. The abused victim may remind the professional of his own abuse during childhood, hindering the ability to help. Our own prejudice is often the knot that serves as the stumbling block towards expungement of traditional CSA practices. There is an urgent need to break traditional taboos that prevent people from talking about the issue of CSA, even though, ironically, entertaining prostitutes or watching pornographic videos may be a comfortable matter for discussion.

In order for a sodomized victim to be helped adequately, it is essential that professionals such as therapists, child welfare workers, doctors and police dealing with the victims, receive specialist training. The trauma of the sexually abused child is vexatious and real; the person, the child confides in, is an important player in the process of recovery from CSA. Professionals must remember that a sexually abused child is a victim and not the perpetrator. From adults, such victims need:

Calm response
Support and reassurance that the incident was not their fault
Believe, affirm and acknowledge
To be sensitive and patient
Enable and empower to overcome trauma
Private and child-friendly atmosphere where a child can talk comfortably
Teach children to help themselves

Children can be helped to self-recover by partaking in groups that help CSA victims to recover. These groups can serve as a forum to educate children about CSA issues including prevention and protection from abuse. Taking part in youth activities can provide a distraction and alleviate feelings of isolation. Group therapy can provide an opportunity to safely disclose the traumatic event and aid in the recovery process. Drama, play and art therapy are all extremely effective means of helping in the recovery process for sexually abused children. This can also give them the opportunity to empower and make children able to recover.

But there needs to be a system to combat the root cause of sodomy. Having a system at least offers some help and relief to victims; however, limited this may be. Sexual abuse will not disappear by ignoring it, instead, under the current climate, it may only thrive. In Pakistan, there are a handful of NGO's that are dealing specifically with the subject of CSA. The governments and law enforcing agencies also have a responsibility to join hands with parents, professionals, and non-governmental organizations to eradicate such vice from society. Some measures that need to be taken are:

The government must find a long term solution to poverty
There must be proper police procedures for reporting and investigating CSA
Child discriminatory laws should be abolished
The acts that Pakistan has ratified to protect children should be enforced by the law
There should be close monitoring of professional bodies to avoid exploitation of children in their care
Laws to stop prostitution, trafficking, (counteracting tribal laws) must be enforced
Protection must be given to victims and their families if they disclose CSA
Perpetrators must be punished for their crime, not the victims
Resources should be provided for professionals to receive specialist training to handle CSA cases
There should be more routine health screening for STDs
Schools should provide child-friendly information on CSA and STDs
There should be a major national awareness-raising campaign on CSA
Parents and teachers must be educated to prevent, recognize and deal with CSA
Have proper child protection procedures to deal with CSA cases effectively

The issue of CSA can be ignored, but the abnormal and inappropriate desire for having sex with a child cannot be justified or dispelled. Each and every person must take at least a morsel of responsibility to make the jigsaw of a CSA free society complete. The children that were affected yesterday are the adults of today and these are the parents and professionals with the responsibility to ensure that the cycle of abuse does not continue. The need be that there must be objectivity in discerning decisions and the discharge of duties:

"O you who believe! Stand out firmly for justice, as witnesses to Allah; even though it be against yourselves, or your parents, or your kin, be he rich or poor, Allah is a better Protector to both (than you). So follow not the lusts (of your hearts), lest you may avoid justice, and if you distort your witness or refuse to give it, verily, Allah is Ever Well-Acquainted with what you do" (Holy Qur'an (4:135)).

Religion is a complete way of life, teaching morals and values, no matter what faith is followed. Humanity needs to be universal essentially for all the mankind. We must ponder upon the duties on us, as human beings, to stop the sinning of sodomy upon sinless boys.

References:


1. Book of Aqdas
2. Glasser, M. (1988). Psychodynamic Aspects of Pedophilia. Assoc. for psychoanalytical psychotherapy, National Health Service, London
3. Holy Bible
4. Holy Quran
5. Nyman, A. & Svensson, B. (1997). Boys sexual abuse and treatment. Jessica Kingsley Publishers, London
6. Rogers, C. & Terry, T. (1984). Clinical Intervention with boy victims of sexual abuse. Van Nostrand Reinhold. New York

# Genocide in the Name of God:
# How Can We Heal the Wounds?

Ruth Barnett

Genocide is a term that has been coined only recently, in the 20th century. It is a crime against humanity (another recent term) that has been perpetrated by us, the human race, repeatedly since the dawn of recorded history. Time and again our ancestors perpetrated this crime and claimed they did it 'in the name of God.'

Whether or not perpetrators believe their genocide is ordered or sanctioned by God, it is the agreed-upon fact that this heinous act always leaves deep wounds in the survivors and their descendants; the wounds that do not simply heal 'with time'. It is true that these deep wounds can be banished from the collective consciousness and deleted from the history that has been passed down in the prevailing culture. But they remain and are transmitted at a deeper unconscious level. Genocides have been not only repeatedly perpetrated but REPEATEDLY forgotten. The emphasis is on 'repetition'. As the philosopher Santayana said, “Those who cannot remember the past are doomed to repeat it.”

I would add that literature and art to some extent become the cultural containers of not only what is selected but also of what is repressed. Angelika Rapoport, in a paper at the IW Museum said, “What people repress, literature and art reveals and records.” Perhaps Wilominski's “Fragments” is a part of this.

Instead of being mourned and memorialised, past genocides have necessarily festered in the psyche of the individuals and groups caught up in the genocidal drama. As angry boils beneath the surface, suppurating psychic wounds have been transmitted in the unconscious culture of communities and nations. Although we may not realize it, we are all profoundly affected today by this accumulation of un-mourned loss and unhealed wounds. We know only too well that the whole of Jewry identifies with the massive loss, incurred by the holocaust. Non-Jewish families too suffered losses and disruption in World War II that has not been fully acknowledged and mourned. Many soldiers returning from the war never talked of the horrors they experienced. The Kinder who came to England on the Kindertransport (KT) suffered the trauma of being uprooted. A whole generation of evacuees were also uprooted. Beyond this, lies the transmitted trauma of past genocides that were not mourned and memorialised. Could this have something to do with the rising proportion of people, suffering clinical depression?

We need a twofold approach: to promote healing and to take steps to prevent further genocides developing so that there is space and time for healing. The healing process cannot begin until the wounds are acknowledged. Denial of genocide is like telling persons with shrapnel buried in their flesh that they are imagining it and the pain will go away if they only stop making a fuss. While we hide behind ignorance, indifference, and denial, further genocides are inevitable.

I will begin by considering a few short quotes from the Holy Scriptures, which are the foundation of religions Judaism and its daughter religion, Christianity.

1. "The sword and the book came down from Heaven wrapped together, and God said: If you do what is written in this book, you will be saved from the sword; if not, you will be slain by it." (Deuteronomy Rabbah 4.2)

2. "When the Lord thy God shall bring thee into the land whither thou goest to possess it, and hath cast out many nations before thee, the Hittites, and the Girashites, and the Amorites, and the Canaanites, and the Perizzites, and the Hivites, and the Jebusites, seven nations greater and mightier than thou; and when the Lord thy God shall deliver them before thee; though shalt smite them, and utterly destroy them." (Deut. 7:7)

These are the words of a very harsh and punitive God, saying, "Do as I command or else I'll have you killed." Supposedly, the Hittites, Girashites, Amorites, Canaanites, Perizites, Hivites and Jebusites annoyed God with disobedience and so the Israelites were ordered to kill them. As the story is told from the Israelites point of view, presumably they believed God told them to do it. But why has this story been kept in the bible all this time? Is this what we believe today? I suggest that the bible has been kept with all its stories intact because they can be interpreted in different ways to meet the needs of different people at different times.

I suggest that we can interpret these two quotes as the words of a God that was made in the image of the people, by the people of that time. The first quote embodies a useful way of disciplining unruly nomadic people by putting the fear of God into them. In the second quote, the Israelites wanted the land they perceived as 'flowing with milk and honey.' What better way to get their soldiers to go and grab it than to convince them that God had ordered them to murder the inhabitants and take the land? By projecting their own lustful desires for land and power into God, the Israelites avoided taking responsibility. Perhaps the story is still there in the Torah as a memorial to the murdered peoples of Canaan.

3. "The sword enters the world because of justice delayed and justice denied." (M. Avot 5:8)

This seems to me a somewhat more advanced idea than the first two quotes. If you negotiate quickly and justly it won't come to using the sword. In other words jaw-jaw not war-war. But there is still the problem of lustful desire for more and more money, land, and power, and that leads to wars still today.

4. "…and they will beat their swords into ploughshares, and their spears into pruning-hooks; nation will not lift up sword against nation, and never again train for war." (Isiah 2:2)

The swords never did get beaten into ploughshares; instead they have grown into 'weapons of mass destruction.' We have put men on the Moon but we still can't live in peace on Earth. We have invented the technology for instant communication between all parts of the globe, but we still can't relate harmoniously with our immediate neighbours.

5. "We encounter God in the face of a stranger… God creates difference; therefore it is in one-who-is-different that we meet God." Rabbi Sacks, "The Dignity of Difference" Continuum 2002.

Difference is something that our human minds find problematic. A certain amount of difference is stimulating and exciting. Advertising firms know this and bombard us with 'new' products and tell us we must try them because they are 'different'; different implying better.

Individually and collectively there is a limit to how much difference we can tolerate. Too much difference starts to feel threatening, dangerous and bad. An individual feels scared in a strange environment or among people very different to oneself and one may withdraw or become defensively aggressive. At a universal level, a group or community feels threatened by a growing number of people who are different. Aggression towards the group perceived as 'too different' is based on deep irrational fears. An example is a person who once said to me, "These illegal immigrants are all crooks taking away our jobs and sponging on benefits that we have to pay for in taxes." He was quite oblivious of his generalisation that all immigrants were illegal and all working as well as taking benefits was illegitimate too. He was so driven by irrational fear that his thinking got bogged down. Maybe he had also found a scapegoat into whom to project his own desires to cheat.

The Waiting Room

I sometimes think of our planet Earth as a waiting room. We are all together in this gigantic 'waiting room' waiting for our time to move on into death. It is a beautiful waiting room, big enough for us all and fitted out with every possible comfort and potential source of pleasure and satisfaction. But what do we do with it while we are waiting? Instead of sharing and helping each other to enjoy the amenities while we are waiting, we are consumed with greed for more than our share and lust for power. We compete to humiliate each other and make wars that slaughter or traumatise each other. From a Garden of Eden we have made the waiting room into Hell on Earth.

I often get bogged down with depressing feelings that there is nothing we can do about all this the wars and the massive trauma they cause that it will simply go on and on. War and genocide inflict such deep wounds, so much pain and humiliation, so many uprooted and dispossessed refugees. So much suffering and thirst for revenge. There is no time or space to begin the process of mourning and healing before we are into the next round of war and slaughter. What can I possibly do that would make even an atom of difference?

And then something happens. I hear someone's inspiring story- a lecture, a workshop, a book. My faith in dialogue is restored. So I offer you my view that the only way forward, towards both healing and prevention of genocide, is through education  getting people talking, listening, introspecting and sharing. I do this when I go into schools and talk with teachers and children in their holocaust education projects. It is also what I do as a therapist  getting my patients talking and listening to their inner self. As a teacher for 19 years before I became a fulltime psychotherapist, I prefer an educational way of understanding psychotherapy to the medical model.

Dialogue

Here, I would like to have a pause and pay respects to three of the earlier lecturers in this series that have given me ideas to enhance my own. Teresa Howard's seminar two weeks ago clarified that a dialogue is more complex than mere talking. It means a group of people contributing to the emergence of a resolution as an alternative approach to the more familiar adversarial either/or situation we are more used to. George Bush's formula is “Either you are for us or against us” when clearly masses of people do not agree to take sides. Zelda Alexander, in her beautiful seminar on Martin Buber enlarged on this: two people communicating in the 'I-Thou' mode are in dialogue while two people in an 'I-It' encounter, are really in parallel monologues. We can apply this to groups that 'take sides' each 'side' in a monologue that cannot communicate with or even hear the other. The frustration of adversarial monologues leads to violence, revenge and counter-violence that can escalate to war and genocide.

Could the conflict in Israel, the Canaan of the original genocide, be resolved by a group dialogue? Not impossible. Many projects have already started with interested people from a variety of origins getting into dialogue. My own view is that this needs the support of education projects; getting children used to communicating through dialogue  circle time is one useful method, live-witnesses addressing groups is another. Most essential is tackling the gaps in history and culture where genocides have been denied, erased or distorted by revisionists.
I don't want this paper to go into history or politics but I would like to recommend a book published this year in English and paperback: “The Banality of Indifference: Zionism and the Armenian Genocide” by Yair Auron. The conclusion that can be drawn from the book may be that the tragically widespread indifference to the Armenian Genocide undermined the courageous few, who initiated dialogue during and after World War I. If they had been supported in their project for a triple alliance of Jews-Armenians-Arabs, we might have a very different picture of the Middle East today. Another book I would recommend is “The forty Days of Musa Dagh”  an account of the Armenian holocaust brought to life through fiction by a German Jew, Franz Werfel. This fine novel was avidly read when it first came out in 1933, especially in the Jewish ghettos. It was banned by Turkey and burnt by Hitler and few people know of it now.

This brings me to the third lecturer in this series that influenced my thinking for this paper. Bob Young in his paper propelled a discussion of the banality of indifference, the triteness of evil, and what qualities make for developing good principles that are not

given up even in life-threatening situations. The idea that impressed me was to do everything with character. People who choose the role of rescuer or protester in the drama of genocide tend to have a depth and complexity of character that is absent in the banality of evildoers and indifferent bystanders. Hannah Arendt puts forward the idea of evil being banal and the character of evildoers being shallow.

Genocide and Trauma

It must be clear what does the term 'genocide' and 'trauma' mean. Genocide is an attempt to wipe out a whole people  an attempt by a powerful well-armed group to decimate a vulnerable group that has neither the means nor the intention of harming the aggressors. The perpetrators are usually fundamentalist fanatics planning their genocide in the name of a distorted form of religion or ideology that has developed anti-morality elements. Their victims carry the bit of morality that has to be wiped out so that the perpetrators' ideology or religion can flourish. The Armenians were regarded by the Turks as 'infidels and traitors.' The Jews were labelled 'vermin' that had to be purged to purify Arian blood. The Aborigines were considered as sub-humans by the British colonists, not deserving a place in the human society. The Africans were considered by slave-traders as on a par with wild beasts, to be captured and put to work.

The perpetrators' murderous plan unfolds by a process of stages. It starts with vilification and persecution of the chosen scapegoat group and progresses through dehumanising and demoralising them with restrictions and pogroms. When these are not countered by neighbouring nations, the perpetrators continue with impunity to planned mass-murders. The final stage of genocide is the establishment by the perpetrators of denial that if there ever was a genocide involved: “It was just war!” or “The victims started it and had it coming to them” or “The victim group had secret plans to take over the world” or “They were vermin that had to be got rid of.”

Trauma

Trauma is a vast and complex topic. It would need a series of seminars to explore the psychological mechanisms involved.  There are many ways of attempting to define what is trauma. I can only suggest some books that explore and clarify the psychic processes in the experience of trauma. Books such as “Trauma and Recovery” by Judith Lewis-Herman, and “Understanding Trauma” by Caroline Garland, or “War of Nerves: Soldiers and Psychiatrists” by Ben Shephard.

For the purpose of this paper I am defining trauma as 'a break in the continuity of being'. Genocide violently disrupts the continuity of being of a whole people at a collective level. Every individual caught up in the genocide (including perpetrators, bystanders and rescuers as well as the victim group) is traumatised. Their ordinary lives are disrupted by the outbreak of the concocted drama. Trauma is a Greek word meaning a 'wound'. In medicine, a trauma is a wound that has broken the skin. Freud described 'psychic trauma' as a rupture of the 'psychic skin' or 'protective shield,' that holds the psyche together, caused by an external agent or by flooding of anxiety from inside or by interaction. The idea of our psychic skin not holding us together is terrifying; it conjures up mental

images of fragmenting, literally falling apart, disintegrating, time 'out of joint', being annihilated, snuffed out and no longer existing. It is often impossible to tell whether such 'existential angst' causes trauma or in itself is caused by it. For continuous mental functioning, it is vital that we have strong enough defences to protect us from being in this feeling for very long. We need to make meaning out of our experience otherwise we can't continue to exist psychically. If we can't make meaning of our experience, we have to shut it off to prevent it from destroying us. The muschelmaener in the concentration camps are an example of people whose psychic functioning was destroyed although their physical bodies were still alive.

Personal Encounter With Trauma

You may have difficulty, like I do sometimes, in holding unwelcome images in mind and thinking about them long enough. But I believe strongly that knowing about and understanding trauma and genocide has to be faced and experienced. Putting what is unwelcome, unbearable, and unthinkable into words is both therapeutic and vital for our own mental health and that of our patients, our profession as well as our society. I would go so far as to say the future of civilisation as we know, depends on this.

To pick up the clues to buried and repressed psychic trauma in our patients, let alone enable them to work with it in treatment, we need to have experienced the encounter with trauma ourselves. It is generally accepted that we can't take our patients where we have not dared going ourselves. By this I mean not only confronting our personal trauma but the trauma suffered and/or perpetrated by our ancestors. There are massive problems involved in this. We cannot help being affected by the myths in our culture that subtly invite us to collude with stereotypes and denial. This 'not knowing' is a subtle form of revisionism that we are involved in, without being aware of it. One such myth is:

“ Although there were many wars and insurrections, the holocaust was the only real genocide of the 20th century.” We can, therefore, beat our breasts chanting “Never again” and feel better without disturbing the deeper issues that the myth masks.

In fact, there was a genocide of the Herera people in Africa in the first decade of the century, a major genocide of the Armenians in 1914/15 and about 45 genocides worldwide since 1945.

Our individual struggle with owning how we are affected by genocidal trauma may be further complicated by these myths carried in the psyche of the community of which we are a part. The failure to deal with one genocide, has a bearing on subsequent genocidal behaviour. The failure of a community, to acknowledge, mourn, and work through the massive trauma of genocide to a reparative resolution, leaves not only individual survivors with unprocessed trauma encapsulated in their psyche but also denied elements of trauma in the psyche of the community. Later, I shall illustrate this with some elements of the infamous 'slave trade' and the genocide of Australian Aborigines as well as the holocaust that have been transmitted in our national psyche because they have not yet

been fully acknowledged and worked through. First I will focus on our struggle with trauma as individuals.

Many genocides continue today in the last stage of denial. While we persist with this denial, healing cannot begin. Each manifestation of denial re-opens the wounds and re-traumatises the descendants of the survivors The descendants experience the denial as a denigration of their roots within themselves accompanied by feelings of powerlessness, helplessness, and doubts about their right to be. As one-fourth generation survivor said to me, “My ancestors are denied existence and if they have never existed, who am I?”

Hamid

A man I shall call Hamid (not his real name) was referred to me by his solicitor for psychotherapy. Hamid was not allowed to work while he was applying for asylum. As he had no means to earn money the court was to pay for his therapy. Hamid had been assessed by a psychiatrist who found him uncooperative and argumentative, and diagnosed him as paranoid and violent, recommending psychotherapy to help him taking responsibility of the act of violence, he had committed. The court banned him from seeing his children until he had complied with the psychiatrist's recommendations. Hamid was anxious to co-operate with anything in order to see his children and restore his family.
I saw Hamid six times. Alternately, he was over-polite and pleading and then he flipped over to being aggressively uncooperative. He did not want psychotherapy, did not agree that he needed it and did not think it could help him. He had not seen his children for over two years; he missed them terribly and, most of all, he needed to pour out his story to someone who would listen and believe him. Back in his country of origin his family had been persecuted for their unwillingness to convert to the 'right' religion. His parents and many of his large extended family had been murdered. Just before he, his wife and children were due to leave the country, Hamid was arrested and tortured brutally. He held out long enough for his family to get away to the safety of Britain. His story became incoherent about his time and treatment under inhumane conditions in prison and how he escaped or was he released. When he finally reached London, he found his wife wanted a divorce. She and their children were living with a 'cousin' who was her solicitor as well as her lover. This is something extremely shaming according to Hamid's cultural norms. Without much of a command of English and in a state of confusion he had signed the papers, his wife's lover demanded him to sign, before he could see his children. In fact, the document was an admission that he had been violent to his family. On the basis of this paper, the court had deprived Hamid of all contact with his family and ordered a psychiatric assessment. For a period of two years the court had repeatedly adjourned Hamid's case for reasons, he did not understand. (Nor was his solicitor able to enlighten me).

The psychiatric report mentioned nothing about Hamid's trauma, before the family left their original home, or the compounding trauma he experienced on reaching England. Hamid was able to defend himself to some extent against the trauma of torture through the belief that he was protecting his family. Uprooted and disoriented by being in a

strange country with an unfamiliar language, he was too vulnerable to cope up with the traumatic shame he suffered in losing the family, he had been protecting. Officious authorities questioning him, not believing his story and discounting his experiences added to his trauma. Not surprisingly, he succumbed to fragmentation of his identity and lost his hold on reality. I was left experiencing some of his helpless despair, as I was unable to help him even to see his children. I could only hope that my listening to him and drafting a report with him for the court may have given him some atom of hope.

Severing the last tenuous connection to a person's roots is a very severe trauma. Persecution forced Hamid to flee his country and sever his roots there. He could hold himself together at a psychic level through this and the torture preceding it as his family represented his roots and continuity of being. When his family too cut him off, he lost his last root. This was a massive wound that breached his psychic skin. The people, who might have helped him in holding his battered-self together did not understand, could not communicate with him, disbelieved him, and discounted his experience. Probably, without realising what they were doing, they added to his already severely traumatised state. Small wonder that his outward behaviour seemed aggressive, unco-operative and paranoid.

## Understanding Trauma

The effects of trauma are ubiquitous. Yet trauma is seldom a topic in the curriculum of training courses and there are many books about therapy that do not have the word 'trauma' in their index. The reason for this is not hard to surmise. The word 'trauma' tends to trigger unpleasant associations and we have defences against such things. Not only trainees, trainers too shy away from trauma as a topic to be studied in itself. Talking and thinking about trauma can be traumatising like the government health warning on cigarettes, it can be bad for our health. However, I believe that avoiding knowing about trauma can be even MORE damaging to our mental health.

We may think we understand genocide from following the news in the media. We may think we know trauma from the seminars in our training and the books and papers we read; but there may be deeper layers that remain untouched and limit our ability to listen and engage with the true knowledge of trauma and genocide.

## My Own Experience as an Illustration

I will illustrate this from my own experience of discovering that I had locked away unthinkables in the cellar of my mind that I had kept myself apparently ignorant of for almost fifty years. During nine years of psychotherapy, from which I benefited greatly, the doors to this particular hoard had remained sealed. Why had my therapists not picked up clues to the existence of this hoard? Was it me or my therapists who was not ready to open, what might have become a Pandora box? Looking back, I was certainly not ready myself.

I was not ready until 13 years ago when, in June 1989, Bertha Leverton organised a two-day conference for everyone who came to England as a child without parents in the late

1930s. She called it the 50th Reunion of Kindertransport, because most of the children came to England on special trains in the nine months between Kristallnacht (Nov.1938) and the outbreak of World War II (Sept 1st 1939). It was shocking awakening for me! Until then, I had not even taken the word Kindertransport into my vocabulary. I had no idea that any other children, apart from my brother and me, had been sent to England for safety. But 10,000? That was incredible! There they were, about 1000 of them in the Harrow Leisure Centre, chatting at tables and listening to people from the stage. The stories they were telling were amazing, some horrendous and all unbearably moving. It was mainly a joyful event, a celebration of survival. We were no longer victims of Hitler's evil racism but survivors of his 'Final Solution' for the Jews. But of course memories were tangibly there, of relatives who had been murdered. Cherished photos of them were shown around and we said prayers for them. This made it a therapeutic and healing event.

My experience of this Reunion was an epiphany. It was as if scales dropped from my eyes and ears. I had been a psychotherapist for nine years and a marriage counsellor for four years before that. Suddenly, my patients started telling me about what they or their parents had gone through as a result of the policies of Hitler's Third Reich. One client revealed to me that he had been caught up in the war between Pakistan and India as a child. This was entirely a new material, as it was with several of my clients. Was that due to the world outside my consulting room beginning to talk about the atrocities and horrors of World War II? Lately there had been a lot of documentaries on TV, articles in the papers, and films on the theme. Or was it that my eyes and ears had been 'closed' for fifty years to anything I feared unconsciously might not trigger memories and feelings that could overwhelm me, that I wasn't ready to face?

From the time of the Reunion, I saw things differently. I realised I had been avoiding knowing things I must have heard and seen. Had my therapy patients unconsciously sensed that certain things were not to be talked about things I would not hear or would not want to hear? Perhaps they sensed a change in me in 1989 and dared talking about formerly 'unthinkable' things. For their sake, but perhaps even more for myself, I made up for lost time by exploring every avenue to discover missing details of my life story. Of course this plunged me into the horrific backdrop of the world war, in which I grew up and which I had been avoiding knowing about ever since the war ended. I had positively avoided films about war etc.

We each have our individual defence systems that may, effectively block us from getting to know all our deeply buried and sealed-off personal trauma. One of these defences we may use, is to become a therapist and address the trauma out there in the patient and thereby avoid knowing it in ourselves. Even years of personal therapy may not reach our deepest trauma if we are not ready to find the key. However, in my opinion, a 'good-enough' therapy gives us a sound foundation and resources. Then, later, we can draw on this to do further work on our own or in a different setting when we become ready.

Cumulative Trauma

Trauma often has a cumulative effect when there has not been safe time and space to deal with one wound before the next trauma impinges. The 'undigested' elements of trauma may remain in our psyche like 'foreign bodies' blocking our normal functioning directly or by taking up psychic space and psychic energy if they are kept repressed and denied or encapsulated locked away in a corner of our mind. People caught up in major disasters like war and genocide are likely to suffer repeated trauma, without time in between to deal with the effects. The cumulative effects of this are obvious. This also applies to the cumulative effects of physical and sexual abuse on young children. Cumulative trauma may not be outwardly manifest or immediately apparent.

I will illustrate this with an example from my own work. Heidi, aged 34, came to see me for therapy because she was starting a therapy-training course that required her to have personal therapy. She was pleased because this course requirement gave her a valid reason to have therapy. I asked her what would not be a valid reason. She replied that she would feel too self-indulgent if she wasn't doing it eventually to help others. Her life story was one of repeated moves in early childhood, to different countries and homes where she was cared for, by different relatives and foster-parents, at different times. All these had been happy homes and she experienced her caretakers as kind and helpful. This was her role model to be kind and helpful to others. Her presenting problem was that she had had a series of boyfriends and wanted to understand why none of these relationships had developed. She had a boyfriend currently and was two months pregnant. She was not sure if she loved the man enough to have his baby as she would then be dependent on him.

Heidi was sensible, serious and always cheerful. She engaged with me easily and well but it felt superficial. Was she going to allow a therapeutic baby to be conceived by us? Would this make her scared of being dependent and precipitate her into aborting the therapy by stopping abruptly? We survived the first break at Christmas. She seemed to gain confidence and decided to continue her pregnancy. We survived the Easter break and all was going well. She had her baby in May and she was able to keep up sessions by bringing the baby a little girl who slept peacefully throughout each session. I wondered about the baby representing her grateful compliant baby self. I would have liked to focus more on preparing for the longer summer break but she was in what Winnicott termed “maternal preoccupation.” She was identified with, perhaps fused with the baby. She was confident that all was well, that I had helped her a lot etc.

Towards the end of the break, she wrote to me that she saw no point continuing her therapy or her training as her boyfriend had left her and she needed all her energy coping with her baby who had become colicky and distressed. Several attempts on my part to get her to meet with me, even if only once more, failed. I felt dismissed, rubbished and attacked and wondered if she had made her boyfriend feel the same and perhaps that was why he left her. I didn't give up and finally in November, after a gap of over three months, she came, bringing Lucy who was now 6 months old a bouncing bonny child who smiled at me and went peacefully to sleep. Heidi was amazed the child had been so miserable and particularly difficult to get to sleep the last few months. I suggested that perhaps Lucy had been expressing Heidi's distress at being abandoned by me in August

and, now that they were here, Lucy could leave Heidi to express it herself. Heidi broke down in tears. I suggested she needed to show me her distress with tears, before we could put into words what she had actually been feeling. I noticed that she had developed quite extensive eczema on her hands. She accepted my suggestion that we should meet again and she decided to continue.

First we discovered how much it had meant to her that I persisted in getting her back. She was then able to insisted in getting her boyfriend back. Gradually she then became ready to look at all the times as a small child she had stifled her distress and maintained a cheerful compliant front. She first lost her mother soon after she was born as her mother went to hospital and a granny looked after her. When her mother was well enough to take her back, she had been passed on to the other granny. Soon after that, she lost her mother again at just over two, when a brother was born. She was looked after by her father while mother was in hospital but mother soon became ill again. The beloved granny looked after the new baby and she was taken in by an auntie and an uncle who had three children of their own. When Heidi went home at age three, her baby brother was established there before her. Then Heidi became ill at age four and spent several months in hospital. The nurses were kind and helpful and Heidi was compliant. At five Heidi appeared to adjust to school easily  her teacher was kind and helpful  but she had eczema for several years.

It took a lot of work before we began to understand the emotional effect of each loss and how Heidi did not have any means of dealing with the trauma of one before the next one impinged on her. The 'helpfulness' of her caretakers had been experienced by Heidi as containing a potent message that she should not make a fuss, that she had no reason to be distressed, and that expressing distress was self-indulgent. It also became clear that Heidi was affected by her parents' experiences (as well as her own) of persecution in their home country, the splitting up of the family, and their experiences as refugees in Britain. The prevailing family defence against trauma was to focus on being grateful that they had all severally survived and helpful to others so that their own neediness could be denied by projecting it into those 'others'.

Transmission of Trauma  the Second Generation

There have been many studies of the psychological effects on people who grew up as the children of holocaust survivors and also some studies of how the children of perpetrators were affected. Peter Zivrovsky wrote “Schudig Geboren” (Born Guilty) containing material from interviews with children of convinced Nazis. Several children of holocaust survivors have written their own story. Anne Karpf “The War After” is one notable example. Up until a decade ago, children of holocaust survivors did not recognise themselves as having been affected by living in the shadow of their parents suffering. They wanted to spare their parents further pain and make up to them for what they had suffered. This often prevented these second generation children leading a normal life. They did not feel entitled to ordinary feelings of emotional pain and strain because nothing could measure up to what their parents had suffered. “You don't know what suffering is! And, please God, may you never find out” is something Ilan, the adored

youngest son of a father, who survived as a child in a concentration camp, remembers his father saying many times.

Another patient, Harry, reported his parents could not bring themselves to tell him about their Holocaust experience. Harry knew they wanted to protect him from the horror they had experienced, as that is what they told him. He didn't ask questions because he wanted to spare them further pain of remembering. In therapy he discovered that he was also protecting himself of hearing unbearable things and his parents were also protecting themselves from re-living painful memories. When therapy helped him to pluck up enough courage to ask questions, he found his parents quite relieved for him to take the initiative. He discovered he had been named after his mother's little brother Hansi who had been murdered in an extermination camp. Consequently he had not been able to be himself as he had to live the life of this lost uncle as well as his own. (Dina Wardi describes this phenomenon in detail in her book "Memorial Candles".)

Dinora Pines, a psychoanalyst and survivor herself, wrote of her work with children of survivors in a paper "The Impact of the Holocaust on the Second Generation."

"By living through their children, the parents hoped to re-establish a family life that had been destroyed, and vicariously live through them parts of the life cycle that they themselves had been deprived of. Naturally, many of these children are over-valued and over-protected by their parents, whether the secret of the Holocaust is revealed or not. Many children are expected to live in a state of perpetual happiness in order to make their parents happy."

From all that has been written in the therapy literature, it is clear to me that many survivors were too intensively traumatised by their holocaust experiences to begin the process of acknowledging and mourning the massive loss and wounding of themselves, their families, and communities. Inevitably then, the trauma has been transmitted in some form to their children. This second generation then gets a second chance to begin or carry forward the work of knowing, bearing and mourning otherwise the task may be transmitted to further generations.

Transmission of Trauma in the Psyche of Communities and Nations

Transmission of trauma on a massive scale has undoubtedly taken place through failure to address previous genocides. Hitler is recorded as having said to his generals in a speech on the eve of his invasion of Poland, to incite them to genocide, "Who now remembers the Armenians?" The Armenian genocide is largely denied today, still disavowed by the Turkish government and missing from most histories of World War I. This failure contributed the impunity seized on by later perpetrators. The governments of several countries, including the European parliament, have now acknowledged that the murder of over a million Armenians by Ottoman Turkey was genocide. Yet every time a lecture, seminar or conference on the Armenian genocide is publicized, Turkish ambassadors or their representatives interfere to get it cancelled or subvert it. Several films have been stopped from reaching us.

The governments of Britain, Israel, Germany and the USA collude with Turkey by withholding acknowledgment that it was genocide for their own reasons of self-interest and 'realpolitik'. This hypocrisy, as well as the persistence of denial, adds to the trauma that is being transmitted unconsciously. This is particularly topical now with the growing movement to bring Turkey into the European Community. Are we going to accept Turkey into the EU without owning her past as well as reforming the rights of her citizens? Knowledge and evidence of the Armenian Genocide are available for those, ready to know. The Imperial War Museum (I strongly object to that name) has a new and permanent exhibition of crimes against humanity (and a showing of the film Ararat on Aug 3rd ) and there is an organisation CRAG (Council for the Recognition of the Armenian Genocide) that will supply literature.

Going further back, we are now about ten generations on from the final end of black slavery by white Europeans and Americans. The massive trauma of several centuries of this brutal injustice does not 'disappear' in ten generations. A black American psychoanalyst, Joel Kovel, in his book "White Racism", details the psychic interaction between the slaves and enslavers, and the legacy it created.
Barbara Fletchman Smith, a black psychotherapist, in her book "Mental Slavery" discusses quoting some clinical examples of how transmitted trauma from their ancestral history of slavery, has affected the black clients with whom she has been working.

On the other side of our global waiting room, but still very much part of 'us' there is the currently still maintained denial of the genocide of the Australian Aborigines. John Pilger describes this eloquently and horrifically in his recent book "The New Rulers of the World." He calls the Aborigines 'the first nation' because in the Kimberley region in the remote north of Western Australia, these people have been there for 40,000 years a great deal longer than the white colonists.

He quotes Martin Taylor, 1997 "Bludgers in Grass Castles: Native Title and the Unpaid debts of the Pastoral industry" Resistance Books, Sydney.

".. sections of the Queensland pastoral industry participated in the genocide of the Aboriginal people. By 1920, the indigenous people had been reduced from at least 120,000 to 20,000; this involved at least 10,000 direct killings …… Brutalised Aborigines from the South were imported to form the Queensland Native Police, which was used as a death squad against Aborigines. Disease also ravaged the population."

(Does this not echo the co-opting of brutalised Lithuanians and Jewish Capos to do the Nazis' dirty work of terror and murder?)

Pilger describes how the remaining Aborigines today are imprisoned in ghettos in the outback, under punitive government control, with much less public money spent on them than the lavish amenities for the white communities, while blaming them as regressed, uncivilised and 'wasted on grog'. They are hidden from view, especially from visitors like medical inspection services, Human Rights inspectors, assessing Australia for the

Olympic games bid. To further cover up a few Aborigines are trained up to demonstrate their ancient dances and play the didgeridoo for tourists.

(In case we start feeling judgemental and 'holier than thou', is this very different to what we are doing today with our asylum seekers here in Britain?)

There is a myth that millions of dollars (the missing millions) have been spent on Aboriginal welfare and wasted by them. Why? Asks Pilger, and then adds, “Its part of the Australian psyche at some level. By believing that money has been spent and wasted, people move to the conclusion that conforms with what is in the back of their minds; that the real reason is innate or genetic. More important, it allows white Australians to say that it isn't their fault, it's the fault of Aboriginal people. A whole language of denigration backs this up they don't look after their kids, they don't wash etc and allows the majority population to distance itself from the truth that our first nation continues to be denied essential citizenship rights: basic services, housing, a decent access to education, a hope for the future.”

Then there is the terrifying saga of the 'stolen generation' told in the novel “Rabbit-proof Fence” a systematic policy of the Australian government in 1933, of abducting Aboriginal children of mixed race to be raised in white communities in ignorance of their parentage to 'breed out the colour.' (I believe this was repeated in the late 40s to 'give Aborigine children a decent upbringing'). The white communities were and still are kept largely ignorant of what was going on. Denial and indifference play a huge part. The novel is currently unobtainable and the film did not stay very long.

I wonder where the Australians may have gotten this white supremacy/racist idea from? Could it have come from Hitler? Or might it go further back and be something to do with the deportation of socially unwanted children from Britain to Australia that Alan Gill writes about so eloquently in his book “Orphans of the Empire”?

I quote the opening paragraph of his book:

“According to the history books transportation to Australia ended in 1868. Actually, it ended only recently. From the eighteenth century to the late 1960s, thousands of children were shipped from Britain to distant parts of the Empire; about one in three came to Australia.”

A final quote from Pilger: “In my experience, a guilt about what has been done to and taken from the native people is deep within the Australian psyche. ….. it is often those with a powerful attachment to the land itself who are most aware that the land is not 'theirs' and that the indigenous people have a unique relationship with it.” I understood the full meaning of this in retrospect when I read Gill's book in 1999 when he stayed with us at the time of the KT reunion. In 1985, I visited one of the families who had fostered me during World War II, as they had emigrated to Tasmania. I met a lot of Australians in Tasmania and Sydney. Something puzzled me about the way they needed to apologise for their ancestors being 'criminals' deported from the UK. Their deported ancestors would

not be considered criminals now  why did they carry guilt for them? I now see this as a psychic displacement. The so-called criminal ancestors were brutalised in Port Arthur prison (a place as bad as the concentration camps). Those who survived their sentences and their guards were the original white settlers who perpetrated genocide on the Aborigines  a crime against humanity that is still going on. While it is denied it can't be owned  so the guilt is displaced onto crimes that are not crimes.

This is a strong stuff and hard to stomach. What unconscious elements of trauma are there, perhaps deeply buried, in our British psyche? Can we hear, know about, and own the part, our own British forebears played in these denied, and therefore unmourned crimes to humanity? Can we take up the task of mourning and working through them so that the trauma is not passed on to further generations? It reminds us of the struggle of post-war-born generations of Germans with the effects on the German psyche of two world wars.  The Germans and the Australians are in 'the waiting room' with us. The Germans are our neighbours in Europe. The current Australians are the offspring of our own ancestors, many of whom Britain deported there as criminals. Only a few survived the horrendous cruelty and brutalisation of places like Port Arthur Prison in Tasmania.

Perhaps the most difficult part of our personal encounter with trauma is not only to know about the depths of depravity, violence, and suffering human beings inflict on each other. We need to go further to recognise our own part in the human story. That we too have the capacity to perpetrate atrocities is undeniable. That we have murderous fantasies, that we may or may not be conscious of, may be hard to accept. It is the fantasies that we can't acknowledge that are likely to cause us problems. When we can allow ourselves to be conscious of violent fantasies we are in a position to choose to keep them in the realm of fantasy. It is when we can't own our fantasies that we are in danger of acting on them.
Our psychic need for a denigrated 'other' into whom we can project our disowned unmanageable feelings and shortcomings is at best latent. Insecurity activates it and collectively we find a scapegoat, more vulnerable and insecure than ourselves  to make us feel better and more deserving. A tragic illustration of this is the 'pecking order' among holocaust survivors, which is created by themselves, comparing how many years you were in a camp or the intensity of cruelty and deprivation you suffered  a sort of competition for who suffered most and is therefore the most needy or deserving. It is not possible to compare suffering. Intense feelings of powerlessness and vulnerability are hard to bear. The compulsion can become very strong to find a scapegoat to look down on and thereby elevate ourselves.

Only when we have dared to wade into this mire of ultimate inhumanity, dared to stand and face the murderer and the cowardly bystander as well as the rescuer and helper in ourselves, can we reach, in my opinion, the core of our own humanity. Then we may become ready and open to receive our clients' unconscious clues to their unthinkable trauma and be able to hear the cries of the traumatised child disguised in the narrative of the material our clients bring us.

In my opinion, Western society has developed an ethos of too much individualism.

What should be kept in check  greed and personal gratification, power over others, and reigns; and what should reign  compassion.

I have hope that through dialogue  (define) we can reverse this current self-centred egotism.

I want to finish with a poem in the special service for the Day of Atonement that moves me each year when we read it in the synagogue:  Gate of Repentance p 268:

"How long shall the curse of Cain
Continue to haunt the human race?
How long shall Abel's blood, the innocent blood
Cruelly shed in countless wars,
Plead all unheeded that men are brothers,
And every man the keeper of every other?
Cannot the race whose mind and will have set men's feet upon the moon
Do equal wonders on its native soil?"

Some Useful Books for Educational Purpose


1. Aberbach, David, 1989, "Surviving Trauma: loss, literature and  psychoanalysis", Yale Univ .Press.
2. Auron, Yair, 2003 "The Banality of Indifference: Zionism and the Armenian Genocide" Transaction Publishers, USA and UK (paperback edition)
3. Barker, Patricia  - Trilogy of novels
4. Bar-On, Dan,1999, "The Indescribable and the Undiscussable: reconstructing Human Discourse after Trauma", CEU Press.
5. Bentovim, Arnon, 1992, "Trauma Organised Systems", Karnac Books.
6. Dalal, Farhad, 2002, "Race, Colour and the Processes of Racialisation", Brunner-Routledge.
7. Darke, Dorothy, 1995  "The Leaves Have Lost Their Trees"
8. Dermen Sira, "Psychoanalytic Perspectives on Traumatised Children: the Armenia Experience" in "The Legacy of Winnicott" ed. By Brett Kahr 2002 Karnac.
9. Fletchman-Smith, Barbara, 2000, "Mental Slavery", Rebus Press.
10. Freud, Signund, 1919, "Introduction to Psych-Analysis and War Neurosis", VolVXII Std. Ed. Hogarth.
11. Garland, Caroline,1998, "Understanding Trauma", Tavistock Clinic series.
12. Gill, Alan,1997, "Orphans of the Empire", Millenium Books, Random House, NSW Australia.
13. Karpf, Anne, 1996, "The War After: living with the Holocaust", Heinemann.
14. Kovel, Joel, 1988 (third Edition)"White Racism", Free Association Books.
15. Lago, Colin, 1996, ""Race, Culture and Counselling", Open Univ. Press.
16. Lewis-Herman, Judith, 1992 "Trauma and Recovery" Basic Books.
17. Leys, Ruth, 2000, "Trauma: a geneology", Chicago Univ. Press.

18. Mischerlich, Alexander and Margarete, 1967, “Die Unfaeigkeit zu Trauen” (The Inability to Mourn) Piper Verlag Gmbh Munich (15th reprint 1998)
19. Pilger, John, 2002, “The New Rulers of the World” Verso, London & New York.
20. Rapoport, Angelika 2003 “Working Through Trauma in 'Reality' and the Imaginary: a Psychoanalytic Approach” paper given at the imperial War Museum conference, not yet published.
21. Rosenbaum, Alan (edit.) 1996, “Is the Holocaust Unique?: perspectives on comparative genocide”, Westview Press.
22. Shay, Jonathan, 1994, “Achilles in Vietnam: combat trauma and the undoing of character”, Touchstone.
23. Shephard, Ben, 2000, “War of Nerves:Soldiers & Psychiatrists”, Jonathat Cape.
24. Sinason, Valerie, 1998, “Memory in Dispute”, Karnac Books.
25. Weale, Adrian, 2001, “Science and the Swastika”, Channel 4 books/Macmillan.
26. Werfel, Franz, 1933 (original in German) “The Forty Days of Musa Dagh”, Carol &
Graf 3rd edition paperback 2002.
27. Wiesenthal, Simon, 1998 (reprint in paperback) “The Sunflower:on the possibilities and limits of forgiveness”, Schocken Books.
28. Whiteman, Dorit, 1993, “The Uprooted: a Hitler Legacy”, Insight Books.
29. Virag,Terez, 2000, “Children of Social Trauma”, (translated) Jessica Kingsley.
30. Zivrovsky, Peter, 1987 “Schulig Geboren”(Born Guilty) Kiepenheuer& Witsch.

# Psychological Consequences of Political Imprisonment

Julia Muller

Abstract

We investigated the psychological consequences of political imprisonment in a series of studies with former East German political prisoners. First, we present facts on the conditions of imprisonment and detention during the communist dictatorship in East Germany between 1949-1989. Second, we present and discuss the data on our studies: High PTSD rates were found. Individuals with and without PTSD not only differed in psychological processes (mental defeat, alienation) but also showed differences in interpersonal variables (need for disclosure, recognition as victim/survivor) as well as in their life span developmental sequelae and personal growth.

## The communist dictatorship in East Germany 1949 - 1989: Studies on the psychological consequences of political imprisonment

One of the great tragedies of the 20th Century was the communist rule system, from 1917-1991. The historians Courtoise and colleagues (1997) estimated that approximately one million humans died forcibly in Eastern Europe (excluding the Soviet Union). However, the European public remains largely unaware of these facts.

Furthermore, the communist regimes not only took lives allegedly in the context of their mission to form a fair world but also locked up millions of people in punishment camps, prisons, and labor camps, where various methods of torture were used. Another element of the communist regimes' despotism, the enormous secret services, e.g. “state security” (“Stasi”), did destructive work. Due to their well thought-out systems, some communist regimes used less overt terror but more sublime forms of betrayal and fear to terrorize people.

The following article deals with the situation of the German Democratic Republic (GDR). In particular, we focused on the former political prisoners, whose sensitivities and psychological states were examined in a series of studies in the late 1990's.25,26,27,29

## Historical Background: Political Detention in the GDR

Already in 1944, German communists were planning to establish a communist dictatorship in entire Germany. Under Soviet guidance they proposed to adopt the Soviet political system and prevent a German orientation to the west. However, with their crew power, the Soviets had reserved the monopoly of force for themselves, and they surrendered this only gradually to the German communist authorities after 1949.35

Soon after it's foundation in 1949, political power in the GDR shifted to the Communist party, at that time allied closely with the Soviet leadership under Stalin. The Communist

Party not only launched several campaigns to crush the resistance of political opponents, resulting in many politically-motivated imprisonments, but also used violence to defend the totalitarian regime. Additionally to individuals, who criticized the totalitarian regime consciously or were politically active against it, also those who got into conflicts with the authorities unintentionally or had differing political conviction were persecuted. Between 1949 and 1989 estimated 150,000 to 200,000 individuals were imprisoned for political reasons. Forty-three thousand of these died in detention.34

The terror in the GDR was regarded as "relatively lenient", compared to other Eastern European countries.3. This relates to the fact that the Soviets limited the overt terror in East Germany from the beginning, since they did not want the terror to dominate the outside picture of the GDR in West Germany. For this reason, no mass shootings or large show trials, such as those in Poland and Bulgaria, took place. Bartosek (1997) adds, that large-scale violence was unnecessary in East Germany, because the preceding Nazi regime had already induced fear and anxiety.

Several phases of arrest conditions can be distinguished during the communist GDR-regime.43 Extreme conditions dominated the Stalinist period (1949-1953). Mortality rates increased from starvation and infectious diseases. Particularly, Social Democrats, oppositional communists, arbitrarily denunciated persons, church representatives, Christian oppositionals and Jehovah's witnesses were arrested. Often the punishment added up to lifelong imprisonment. Paradoxically and tragically many of these victims had already been arrested by the Nazis .35

Prisons were overcrowded and labor was forced during the reign of the first communist party leader Ulbricht (1953 to 1971). Arrests and long-term prison sentences increased after a laborer uprising was thwarted with the help of the army in 1953. In 1961, a wall was built between East and West Germany and around West Berlin to prevent people from leaving East Germany. Individuals who planned to leave East Germany or opposed official state policy, were repressed by the state authorities, particularly by agents of the increasingly powerful Stasi. Thenceforward, the Stasi had their own prisons, where approximately 80% of the political prisoners were held until trial. After the erection of the wall, more than 50,000 individuals were imprisoned for extended periods.

Rebuilding of the prisons improved the conditions in the period of the second communist party leader, Honecker (1972 to 1989). Additionally, new penal laws caused a shift from open physical violence to psychological torture (i.e. particular forms of examination, threats, isolation) (Amnesty International, 1989). In this period, 40-50% of the political prisoners were individuals who had unsuccessfully attempted to leave the GDR ("Republikflüchtlinge"), 15-20% were prosecuted, in public, after they had pleaded for an application to leave the GDR ("Ausreiseantrag"). Another 10-20% of the prisoners were arrested due to unpopular statements as "hostile agitation against the GDR" ("stattsfeindliche Hetze"), state slander, or "public vilification" ("oeffentliche Herabwuerdigung"). Additionally 1-5% were prosecuted for establishing news and contacts with enemy institutions as West Germany:

Arrests in GDR refugees usually took place in flagrante delicto, i.e. in the frontier segments during the attempt to escape. The frontier military personnel regularly used firearms, either actively (shots directly at the person or close to the side) or passively (i.e. arrests at gunpoint). More than 500 people were killed while attempting to escape, an unknown number were seriously injured.

In other cases imprisonment was unforeseeable and surprising. Arrests often took place at home early in the morning or in the workplace. The policemen, or Stasi, were authorized to use their weapons, even if the person they were arresting, as mostly, did not possess any weapons. Holding the haunted at gunpoint was typically accompanied by the threat to use the weapons in case of an attempt to escape.

As documented in many autobiographies18,21 the examinations were characterized by intimidation, dishonor, and threat. Furthermore, threat to life, physical condition, or the family, were used. Much psychological pressure was used, including examinations during the night, sleep deprivation, isolation cells, and darkroom confinement. These methods are defined as torture by the UN (1987). To cite the historian K. D. Müller (1997) in the GDR basic human rights were violated “to a higher degree than it is usual in every prison system” (p. 126).

We aimed to investigate imprisonment and maltreatment conditions and to analyze their connection with the symptoms of posttraumatic stress disorder (PTSD).

## Political Imprisonment and Posttraumatic Stress Disorder

Political imprisonment can bee seen as traumatic, long-lasting stress situation under repressive circumstances, or as sequence of traumatic experiences which can lead to psychological consequences such as PTSD. According to the DSM-IV11 a particularly severe and long-lasting disorder is plausible if the trauma is man-made, as political imprisonment.

A non-clinical group of 146 former political prisoners was recruited through advertisements in newspapers and in newsletters of former political prisoners' organizations. All of the participants (124 men, 22 women) had been legally exculpated after 1990. The mean age at our investigation was 54 years (range 27-82 years). On average the participants were imprisoned for 38 months and had been released 24 years ago. The control group, 75 former non-persecuted East German citizens, had the same age range and gender ratio.

## Participants

The first sample consisted from 146 former political prisoners. They were recruited through advertisements in newspapers and in newsletters of former political prisoners' organizations. All of the participants (124 men) had been legally exculpated after 1990. The mean age at our investigation was 54 years (range 27-82 years). On average the participants were imprisoned for 38 months and had been released 24 years ago. The

control group, 75 former non-persecuted East German citizens, had the same age range and gender ratio.

The second sample consisted of 178 former political prisoners. The same methods as in the first sample were used for recruiting. 74% of the participants (n = 132) were male, with an average age of 55.1 years (SD = 9.3; Range = 34 - 81). 72% (n = 128) of the participants were married or were in a secure relationship, a quarter (26%; n = 44) were separated or divorced and 4% (n = 7) were widowed. 24 % (n = 42) had completed junior high school, 30% (n = 52) the first public examination in secondary school, 7% (n = 13) had graduated from high school and 38% (n = 67) had completed university education. This sample was representative of the East German population in terms of education (Statistisches Amt der DDR, 1989).

Measures

Among others, the following instruments were used to assess the first sample:

Diagnostic Interview for Psychological Symptoms (DIPS; Margraf, Ehlers, & Schneider, 1994). This interview is an extended German version of the Anxiety Disorders Interview Schedule - Revised (ADIS-R; DiNardo & Barlow, 1988). It includes anxiety, mood, somatoform, and eating disorders, as well as screenings for alcohol and drug dependency, and schizophrenia. Interviews were conducted by trained interviewers (psychologists). The interview allows for the assessment of those 17 symptom criteria of PTSD that define the disorder according to DSM standards. In accordance with their allocation to criteria B, C, and D of the DSM-III-R (APA, 1987) the number of existing symptoms was added up, resulting in sum values of intrusion (DSM-I; range 0-4), avoidance (DSM-A; range 0-7), and hyperarousal (DSM-H; range 0-6).

Impact of Event Scale - Revised (IES-R; Maercker & Schützwohl, 1998; orig. Weiss & Marmar, 1996). The IES-R was designed to assess the frequency of posttraumatic stress reactions. It comprises 22 items and produces subscales of intrusion (IES-I, range 0-35), avoidance (IES-A, range 0-40), and hyperarousal (IES-H, range 0-35). The validation of the German version showed internal consisteny coefficients between  = .75 and  = .90.

Mental defeat was assessed by rating interviews according to the Rating manual for the constructs mental defeat, overall feeling of alienation, control strategies, permanent change, and political commitment (Ehlers & Boos, 1996).

Among others, the second sample was assessed with the help of following questionnaires:

PTSD symptoms. The Impact of Event Scale - Revised Version (IES-R; Maercker & Schützwohl, 1998; orig. Weiss & Marmar, 1996, s. Above).

Trauma exposure. Conventional items assessed the degree and duration of the traumatic injury.26 The 4 items “degree of physical violence,” “use of weapons,” “severity of

injury," "subsequent need of medical assistance" constituted a Trauma Exposure Index with an Cronbach's alpha á = .78.

Posttraumatic cognitions. The Post-traumatic Cognitions Inventory (PTCI; (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) assesses typical posttraumatic changes in the victim's thoughts and beliefs. The 33-items constitute the 3 sub scores Negative Cognitions about Self (e.g., "My life has been destroyed by the trauma"), Negative Cognitions about the World (e.g., "The world is a dangerous place"), Self-blame (e.g., "Someone else would not have gotten into this situation"), and a total score. The scales showed excellent internal consistency and good test-retest reliability and discriminated between groups of individuals with and without PTSD. The formulations of the items fit to different kinds of trauma.

Disclosure of the traumatic experiences. The Disclosure of Trauma Questionnaire (DTQ; (Müller, Beauducel, Raschka, & Maercker, 2000) measures aspects of a person's intention to disclose traumatic events on a 5-point scale. The 34-item self-report contribute to three subscales. The first scale (13 items) assesses how participants describe themselves as not wishing to tell others about the trauma (Reluctance to Talk, e.g., "I find it difficult to talk to people about the incident"). The second scale (11 items) measures how persons try to express themselves about the traumatic experiences (Urge to Talk, e.g., "I feel compelled to talk about my experiences again and again"). These two subscales are independent of one another (r = .14). The third scale (10 items) assesses how participants describe their affective state during talks about the trauma (Emotional Reactions during Disclosure, e.g., "Describing the event makes me feel very sad"). The latter scale is moderately positive correlated with the first two scales (r = .49 and r = .41, respectively). In previous research the DTQ scales showed good reliability and validity (Cronbach's alpha: á = .82 - .88, retest-reliability: rtt = .76 - .89.33

Social Acknowledgment: The Social Acknowledgment as Victim Questionnaire29 is a 16-item self-report scale. On a 5-point scale it measures perceived recognition or acknowledgment of being victim or survivor of a traumatic event and how affected persons feel supported by their family, friends, acquaintances, and local authorities. The three SAQ-scales assess a) perceived positive reactions including experienced sympathy for what happened (Recognition as Victim/Survivor , 6 items, e.g., "Many people offered their help in the first few days after the incident") b) perceived refusal or lack of understanding (General Disapproval, 5 items, e.g., "Somehow I am no longer a normal member of society since the incident") c) families' underestimation of the experiences (Family Disapproval, 5 items , e.g., "My experiences are underestimated in my family"). The first and second scales are correlated moderately negative (r = -.38). The third scale is positively correlated with general disapproval (r = .42) and moderately negative with recognition as victim/survivor (r = -.49). The reliability and validity of the SAQ are satisfying with á = .79 - .86 and rtt. = .70 - .79 (Maercker, & Müller, in press).

The sample's traumatic prison conditions were differentiated regarding the remand prison time that most prisoners had to spend in Stasi prisons and the following punitive prison ,(see Table 1).

Frequency of reported maltreatment in GDR-confinement in 146 persons.

| Maltreatment category | In remand prison (%) | In subsequent punitive prison (%) |
|---|---|---|
| Solitary Confinement | 66 | 29 |
| Darkroom confinement | 17 | 11 |
| Special confinement („arrest“) | 13 | 28 |
| Physical maltreatment | 57 | 42 |
| Verbal abuse or threats | 63 | 42 |
| Witnessing torture or violent deaths | 32 | 48 |
| Explicit life threats | 32 | 27 |

Table 1

Regarding the historical eras of imprisonment between 1949-1989, we found an interesting pattern of relationship between objective and subjective stress characteristics. While the number of maltreatment forms during remand prison varied, PTSD prevalence did not differ between the three historical eras. Therefore, it can be assumed that the subjective distress prisoners suffered did not differ between historical periods. This led to continued studies examining the consequences of the initial psychological strains concerning the later effects.26

Approximately 60% of the sample developed PTSD after the political detention (“life-time diagnosis”). Even years or decades later this disorder still occurs acutely in approximately 30% (“acute diagnosis”). These findings are consistent with other results in former East German political prisoners6 as well as with findings in other victims of political persecution and imprisonment.4,41

Also other psychological disorders are common among former GDR political prisoners.6 The most frequent other disorder in our 1997 study was a specific phobia, particularly the claustrophobic subtype (22%). Claustrophobic subjects reported intensive fears and avoidance behavior, relating, for example, to dressing cubicles, and a desire to keep windows and doors open even during cold seasons. Additionally, somatoform disorder, major depression, substance abuse, social phobia and agoraphobia were elevated in the sample. Anxiety disorders, substance abuse, and somatoform disorders were significantly more frequent in the prisoner group than in the control group. Whereas no significant group differences existed regarding depressive disorders. Additionally, the prisoner group showed high comorbidity rates within these disorders.30

Inquiries into the Psychological Processes of PTSD

Previous theoretical and empirical work suggests that how people process and interpret their traumatic experience and it's consequences influences the development or maintenance of PTSD.12 In the following, two theoretical concepts of particular interest for PTSD in political prisoners, are described:

Mental Defeat is the perceived loss of autonomy, the state of mentally giving up all efforts to retain one's identity as a human being with a will of one's own. It's the perceived threat to one's psychological integrity, i.e. to percept oneself as an autonomous individuum. Reports on Mental Defeat frequently include the feeling that one is no human being any longer (e.g. “I am an object”, “I was destroyed as a human being”), ceasing to care about oneself (e.g. “I don't really care whether I die or not”), or having a complete breakdown of all inner resistance to the perpetrator (e.g. “I let everything happen to me from outside”).

Mental defeat seems to be relevant in political prisoners because torture aims to break the will of the tortured person. It is important to note that mental defeat is not identical with actions of defeat. For example, many prisoners in our study conceded defeat and signed false confessions. This was rarely experienced as mental defeat but rather described as a decision made with the intention to terminate the interrogations. Similarly, some prisoners asked their torturers to kill them, went on hunger strike, or tried to commit suicide as an act of resistance rather than mental defeat.
As further important aspect of interpersonal violence potentially central to PTSD, traumatized people show an overall feeling of alienation from people without similar experiences. This inability to relate to others has already been demonstrated in other groups of victims. Individuals with chronic PTSD often report trauma-caused permanent personality changes (alienation from oneself) or deletion of their former lives (alienation from one's life goals).

Sample was divided in three groups: participants with chronic PTSD, participants with recovered PTSD (those who had experienced PTSD after release from prison but had recovered), and participants who had never had PTSD. In contrast to participants without PTSD, those with chronic or remitted PTSD were more likely to perceive mental defeat and an overall feeling of alienation from other people. Chronic PTSD was also related to perceived negative and permanent change in their personalities or life aspirations .12

Life Span Developmental Sequelae of Traumatization Through Political Imprisonment

Additional focus was on developmental-psychological detention consequences: Consequences of different ages at imprisonment on PTSD prevalence and severity, and psychosocial complications after detention due to PTSD.

Even victims themselves show a relation between their age at traumatization and severity of trauma sequelae.25

A woman aged 17 who was imprisoned for supporting her lover who distributed leaflets, reports:

“And then I was sentenced to 10 months in jail. I was 17 years old. And that was kind of, well you can imagine, when you experience something like that at such a young age; you know, my first really bad experience in life. I guess that really got to me. First, because I was really pretty green until then and sort of got pulled out of a perfect idyll. You know, I

grew up in a village. Everything was normal at home. I had a really normal home, you know, always harmony. And then suddenly something like that happens to me. You see I'd never had any bad experiences before or anything really negative. And that was the first one and so damn hard and really bad from the start. Well, that was basically the worst about it all."

A 20-year-old man who was imprisoned for writing poems with oppositional content, reports:

"I was put into solitary confinement without anything, behind thick walls at just 20 years of age. And then all that began. That was the shock of my life ...I had no strategy. First talking about the first couple of weeks here the first weeks were paralyzing. That's what it was for me anyway; I couldn't even think straight. You have to imagine, I was just 20. Hey, that's no excuse, but it gives you an idea. That I never imagined would ever happen to me. You know I imagined I could escape (the country), manage to get across the border with all my poems. Get them published. You see I did have plans, just in case I got lucky; not in case things got out of hand. You see, I never thought, what do I do if I get jailed? I never wasted a thought on that idea. I was in an absolutely positive frame of mind. And then it occurred to me ... life, it's all over for me, cut, over, buried alive ... It was in effect the forming experience of my life "

Only some psychological studies have focused on age-related impact on the risk for PTSD-development. Earlier studies focused on age-related effects on quantitative differences within the symptomatology of general stress reactions (i.e. reports of depressive symptoms, anxieties, and physical complaints).

We tried to explain theoretically age-specific PTSD vulnerabilities on the basis of bio-psychosocial changes across life span.25 We focused on the PTSD symptom clusters (intrusion, avoidance, and hyperarousal) and assumed biological vulnerabilities, constituting the basis from which altered cognitive processes result in the realm of information processing which are accompanied by changes of self-image and relevant coping abilities.

Our life span psychological model summarized theoretical approaches and empirical findings, concerning the relationship between age of traumatization and symptomatology as follows:

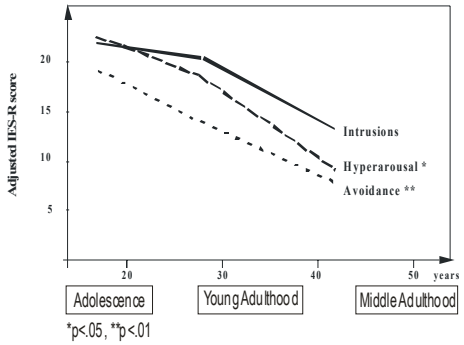
Consequent to a need for psychological differentiation (maturation) and a reduced repertoire of available coping abilities, poor preconditions exist for post-trauma adaptation during adolescence. This might be due to a state of psychological and physiological instability in adolescence.31 But elderly also show greater vulnerability to traumatization than young and middle-aged adults. The aging process is based on biological changes that lead to reduced cognitive inhibition of stimulation and unstable

arousal via reduction of frontality.

Due to a limited traumatization age range in our sample (17-55 years), only the increased vulnerability to traumatization during adolescence could be examined. As hypothesized, a main effect was found for trauma age groups: Individuals, traumatized during adolescence, showed the highest values, followed by those detained during young and middle adulthood (see Figure 1). These differences were significant for avoidance and hyperarousal but not for intrusions.[24]

The fact that no age trend could be found concerning the intrusion symptoms of former political prisoners could result from the more ubiquitous nature of intrusive memories,

*Means of the three IES-R subscales in three trauma age groups*
*(adjusted for current age and sex)*




*p<.05, **p<.01

*Figure 1*

whose symptoms aren't as specific as avoiding thoughts and feelings or hyperarousal states.

Further, we investigated psychosocial complications after traumatization by imprisonment. Various studies have indicated that traumatic experiences could cause aspects of psychosocial dysfunction, like unemployment and marital/family problems.[7,15,32]

Besides unemployment rates (current and lifetime) and marital problems (divorce rates current and lifetime), we examined educational development following traumatization, and career direction. Traumatized and non-traumatized differed significantly in these variables: Compared to the controls, the former prisoners showed lower educational qualifications, had average career directions of "zero", as well as higher divorce rates.

*Indicators of lifetime psychosocial development: Comparison between traumatized former prisoners and comparison groups.*

| | Former Prisoners | Comparison persons | Significance of group differences |
|---|---|---|---|
| Highest educational level (1-5) | 2.53 1.44[a] | 3.47 1.64[a] | p< .001 |
| Career direction (-1 - +1) | 0.00 0.82[a] | 0.31 0.73[a] | p< .01 |
| Unemployment, current | 22.5% | 16.0% | Non-significant |
| Unemployment, ever | 14.7% | 29.3% | Non-significant |
| Divorce, current[b] | 24.3% | 14.7% | Non-significant |
| Divorce, ever[c] | 34.3% | 22.1% | p< .01 |

[a]Mean Standard deviation, [b]extended over 3 months, [c] one or more.

*Table 2*

Unemployment rates did not differ significantly between the groups. This unexpected finding may be due to a regionally and historically specific external bias: High unemployment rates in East Germany following German reunification, affected members of all educational backgrounds and personal situations. Individuals who had emigrated to the West did not differ significantly from those who had remained in East Germany regarding educational qualifications, unemployment, or divorce rates. The former did; however, achieve higher values in career direction than did the East Germans. These results confirm findings in other trauma victim groups[7,14,32] even if the specific historical circumstances of the man-made traumatization by political persecution is taken into account.

We further confirmed the theoretically driven assumption that a present PTSD diagnosis, as opposed to having experienced a trauma(s) per se, was related significantly to indicators of negative psychosocial functioning (educational qualification, career direction, and divorce rate). This result underlines the importance of disorder-related complications, namely PTSD. It should be noted that psychosocial changes following trauma are predominantly determined by the severity of the posttraumatic stress disorder.

**A Different Outcome of Imprisonment Experience: Posttraumatic Personal Growth**

From historic point of view, it was surely useful to place PTSD into the center of research on consequences of persecution and genocide. At the very least, it directed the public attention towards the psychological needs of this group and enabled knowledge from other groups of victims, like victims of disaster and criminality, to be used.

There are, nevertheless, further psychological processes relevant to the group of former political prisoners, which play a role in their daily lives. In this respect the psychological processes of personal growth is worth examining.

Personal growth through coping with trauma is a subjective balancing of positive psychological consequences of stress or trauma. Tedeschi and Calhoun (1995) found three areas of possible positive changes: changes regarding the self perception, changes regarding the relationship with others and changes in the philosophy of life.

To clarify this definition we present a participant's answer, addressing the question “Did you also gain something positive from the detention time?”:

“The positive was that you learned to live ... a little more consciously. If you experience what you lose in being locked up, you learn to find it valuable, how beautiful it is outside; how beautiful life is, if you can or can't do things as you like. You see the sun, you see the nature, the quite simple things in life ... You learn to see life more consciously and that is what I have maintained since then.”
“I learned something here ....like how humans behave under difficult conditions ... I think the experiences make it easier to me to deal with other people. I sometimes say to myself also, if you have so much experience with physical and psychological force, you have a quite different life somehow. Also, my experiences that there are even people who have a similar attitude, who can argue mentally, were good experiences (...) I also believe, I learned somewhat more tolerance...”

Although personal growth after traumatization has already been described variously in literary and autobiographical publicationsa it has received little attention in the field of psychology. The first case reports and theoretical conceptions of personal growth were published in connection with surviving the KZ detention and getting over life-threatening physical illnesses.8,17,23 In the 1980s positive statuses following severe or traumatic life events were investigated in detail.20,22

Positive modifications were reported in three clear-cut categories: changed life philosophy, improved knowledge of human nature, and increased self-confidence.24. The most frequent assertions were made regarding changes in life philosophy. This included a more intense perception of the “small things” in life, a higher appreciation of the natural environment, as well as reports that later life problems had become relative after the detention and that the former prisoners subsequently experienced a higher degree of calmness in daily life.

Overall, 72% of the interviewed gave one or more examples demonstrating that they gained something positive from their term of imprisonment applying to their later lives. About 41% mentioned positive changes in one, 19% in two, 8% in three and 3% in all four content categories (including one residual category).

On the other hand, 28% stated not to have gained anything positive from their term of detention. This was expressed with different types of response: e.g. direct denial ("it was lost years"), refusal of the question ("I don't understand the question, there hasn't been anything good"), emphasizing the lack of relevance to the present-day situation (“the detention does not carry weight at all... it is crossed off somehow") as well as irrelevant or avoiding statements that failed to address the question's psychological content (e.g. "I was compensated, that is the positive thing about it").

Compared to the control group, the ex-prisoner group scored higher in the Stress-related Growth Subcales.37 This result verified the assumption that experiencing traumatic stress is associated with the perception of positively evaluated changes in the self.

Beyond that, experiencing the trauma of being imprisoned seems to be accompanied in particular with positive modifications in life philosophy and self-assurance. Due to the experience, former political prisoners feel more independent in their judgments, more persistent in pursuing their targets and receptive to new ideas. Similar changes have been reported in studies on disaster survivors20 and war participants.1

Despite these findings one has to assume that subjectively perceived personal growth does not exclude psychopathology. The two psychological processes have no systematic relation to each other, which means that personal growth does not exclude, for example, PTSD, fear or depressive disorders.

Further Outcomes of the Imprisonment Experience: Anger, Need for Disclosure, and Recognition as Victim/Survivor

Trauma victims often report persistent anger or need for disclosure of traumatic experiences and recognition as victims or survivors. Therefore, our studies also included interpersonal aspects.

Anger is a salient symptom of traumatized victims and a major concomitant sign of PTSD. It has been described as a psychological factor that maintains PTSD symptoms13 as well as an essential factor in the etiology of comorbid disturbances and interpersonal difficulties.

Compared to German standardization values of psychological anger assessment, traumatized participants reported a higher anger level.39 Additionally, victims with PTSD showed significantly higher anger scores than non-PTSD victims. The groups did not differ regarding the extent to which feelings of anger were expressed outwardly and the extent to which the victims controlled their feelings of anger. The findings indicated that many years after the trauma, the ongoing tendency of former political prisoners to feel anger might directly result from their experience of posttraumatic intrusions. Further statistical analysis indicated that perceived social support might lessen feelings of anger: Traumatized people who feel emotionally supported and socially integrated seem to experience less anger.

When regarding PTSD consecuting disturbed normal processes of recovery, interpersonal and socio-cognitive aspects are assumed to play an important role in processing traumatic experiences. PTSD can be seen to be maintained by specific disturbances in communication, such as, non-disclosure and a lack of social acknowledgement as a victim.

Studies investigating disclosure indicate recovery-supporting effects of disclosing stressful experiences and damaging effects of suppression of emotional

conversations.16,38 In a recent study with a newly recruited sample of former political prisoners28,33 a questionnaire was constructed, consisting of three subscales: reluctance to talk, urge to talk, and emotional reactions while disclosing.
In this new investigation of 178 former political prisoners (74% male, mean age = 55 years), we found significant associations between closure or emotional reactions and PTSD symptoms. However, we did not find expected negative correlations between the urge to talk, emotional content and PTSD symptoms. A possible explanation could be seen parallel to the usual findings concerning social support: While present social support does not influence PTSD symptomatology positively, lacking support may have negative effects on recovery.36 According to this, disclosing an emotional content is not stress reducing per se, but the not disclosing reproduces stress. Disclosure of the examined political prisoners' traumatic experiences was not supported by the GDR regime, nor is it facilitated in present (the latter because of the "short-lived societal memory").

"Acknowledgment as a victim/survivor", includes others' positive reactions, which respect victims' unique position and validate their attempts to cope with the situation. We examined whether this concept is a potentially recovery-promoting factor differing form general social support. Johnson et al (1997) developed a related conceptualization, the "homecoming reception of war veterans."

Trauma victims without PTSD reported significant more acknowledgment as victims than the PTSD group. Victims with PTSD, on the other hand, reported feelings of rejection or a tendency to enhance negative reactions of others. They also expressed a lack of appropriate respect and acknowledgment from their families.

## Conclusions

Scientific knowledge on mental problems following man-made violence has increased greatly during the last years. It is well known, that torment not only exists during torture or other psychological maltreatment but also persists the following years or decades. Nevertheless, even after working for more than a decade with victims of political persecution, important questions still remain unanswered: Does traumatization affect somatic morbidity and mortality rates? What are the relative contributions of traumatic experiences and torture to successful/unsuccessful life stories? How do escape into exile and refugee status interacts with trauma aftermath? Research has to give attention to these questions, regarding the fact of torture in more than 90 countries worldwide2 and the serious health implications of politically motivated persecution.

## References

1. Aldwin, C. M., Levenson, M. R., & Spiro, A. (1994). Vulnerability and Resilience to combat exposure: Can Stress have life-long effects? Psychology and Aging, 9, 34-44.
2. Amnesty International (1989). German Democratic Republic - Sweeping Laws - Secret justice. London: amnesty international publication.
3. Amnesty International (2000). ai-Jahresbericht 2000. Frankfurt: Fischer.

4. Bartosek, K. (1997). Mittel- und Südosteuropa. In J. L. Margolin (Ed.), Das Schwarzbuch des Kommunismus. Paris: Laffont.
5. Basoglu, M., Paker, M., Paker, O., Ozmen, E., Marks, I., Incesu, C., et al. (1994). Psychological effects of torture: a comparison of tortured with nontortured political activists in Turkey. Am J Psychiatry, 151(1), 76-81.
6. Bauer, M., Priebe, S., Haring, B., & Adamczak, K. (1993). Long-term mental sequelae of political imprisonment in East Germany. J Nerv Ment Dis,181(4), 257-262.
7. Bryant, R. A., & Harvey, A. G. (1995). Posttraumatic stress in volunteer fire-fighters: Predictors of distress. Journal of Nervous and Mental Disease 183(267-271).
8. Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.
9. Courtoise, S., Wertha, N., Panné, J., Paczkowski, A., Bartosek, K., & Margolin, J.1997). Das Schwarzbuch des Kommunismus. Paris: Laffont.
10. Dennis, D., Eslam, J., & Priebe, S. (1997). Psychische Störungen nach politischer Inhaftierung in der sowjetischen Besatzungszone und der ehemaligen DDR. Fortschritte der Neurologie und Psychiatrie, 65, 524-530.
11. Diagnostic and Statistical Manual of Mental Disorders, 4th edition, American Psychiatric Association.
12. Ehlers, A., Maercker, A., & Boos, A. (2000). Posttraumatic stress disorder following political imprisonment: the role of mental defeat, alienation, and perceived permanent change. J Abnorm Psychol, 109(1), 45-55.
13. Ehlers, A., Mayou, R. A., & Bryant, B. (1998). Psychological predictors of chronic posttraumatic stress disorder after motor vehicle accidents. J Abnorm Psychol, 107(3), 508-519.
14. Elder, G. H., Pavalko, E. K., & Clipp, E. C. (1993). Working with archival data: Studying lives. Newbury Park: Sage.
15. Elder, G. H., Shanaham, M. J., & Clipp, E. C. (1994). When war comes to men's lives: Life- course patterns in family, work and health. Psychology and Aging, 9, 5-16.
16. Esterling, B. A., L'Abate, L., Murray, E. J., & Pennebaker, J. W. (1999) Empirical foundations for writing in prevention and psychotherapy: mental and physical health outcomes. Clin Psychol Rev, 19(1), 79-96.
17. Frankl, V. (1946/1984). Ein Psychologe erlebt das Konzentrationslager. München: Kösel.
18. Fuchs, J. (1979). Vernehmungsprotokolle. Reinbek: Rowohlt.
19. Johnson, D. R., Lubin, H., Rosenheck, R., Fontana, A., Southwick, S., & Charney, D. (1997). The impact of the homecoming reception on the development of posttraumatic stress disorder. The West HavenHomecoming Stress Scale (WHHSS). J Trauma Stress, 10(2), 259-277.
20. Joseph, S., Williams, A., & Yule, W. (1993). Changes in outlook following disaster: The preliminary development of a measure to assess positive and negative responses. Journal of Traumatic Stress, 6, 271-280.
21. Kempowski, W. (1969). Im Block. Ein Haftbericht. München: Knauer.
22. Lehman, D. R., Davis, C. G., DeLongis, A., Wortman, C. B., Bluck, S., Mandel, D. R., et al. (1993). Positive and negative life-changes following

Bereavement and their relations to adjustment. Journal of Social and Clinical Psychology(12), 90-112.
23. Lipowski, Z. (1970). Physical illness, the individual and the coping process Psychiatry in Medicine, 1, 91-102.
24. Maercker, A. (1998). Posttraumatische Belastungsstörungen: Psychologie der Extrembelastungsfolgen bei Opfern politischer Gewalt. Lengerich: Pabst.
25. Maercker, A. (1999). Lifespan psychological aspects of trauma and PTSD: Symptoms and psychosocial impairments. In Z. Solomon (Ed.), Posttraumatic stress disorder: A lifespan developmental perspective (pp. 7-42). Seattle: Hogrefe & Huber.
26. Maercker, A., Beauducel, A., & Schutzwohl, M. (2000). Trauma severity and initial reactions as precipitating factors for posttraumatic stress symptoms and chronic dissociation in former political prisoners. J Trauma Stress, 13(4), 651-660.
27. Maercker, A., Fehm, L., & Raschka, J. (2000). Psychische Folgestörungen nach politischer Haft in der DDR: Verhaftungsgeschehen, Lebensgefahr und Misshandlungen als Risikofaktor chronischer Beschwerden. Zeitschrift für Klinische Psychologie und Psychotherapie, 48, 172-184.
28. Maercker, A., & Müller, J. (2003). Factors of recovery from PTSD: Social-cognitive, and interpersonal factors.Unpublished manuscript, University of Zurich, Department of Psychology.
29. Maercker, A., & Müller, J. (in press). Societal acknowledgement as a victim or survivor: A scale to measure a recovery factor of PTSD. Journal of Traumatic Stress.
30. Maercker, A., & Schützwohl, M. (1997). Psychological long-term effects of political imprisonment: A group comparison study. Social Psychiatry and Psychiatric Epidemiology, 32, 434-442.
31. Marcia, J. E. (1980). Identity in adolescence. In J. Adelson (Ed.), Handbook of adolescence. New York: Wiley.
32. McCarren, M., Janes, G. R., Goldberg, J., Eisen, S. A., True, W. R., & Henderson, W. G. (1995). A twin study of the association of post-traumatic stress disorder and combat exposure with long-term socio-economic status in Vietnam veterans. Journal of Traumatic Stress, 8, 111-124.
33. Müller, J., Beauducel, A., Raschka, J., & Maercker, A. (2000) Kommunikationsverhalten nach politischer Haft in der DDR. Entwicklung eines Fragebogens zum Offenlegen der Traumaerfahrungen. Zeitschrift für Politische Psychologie, 4, 413-427.
34. Müller, K. D. (1997). Haftbedingungen politischer Häftlinge in der DDR (Imprisonment conditions for political prisoners in the GDR). In A. Stephan (Ed.), Die Vergangenheit lässt unsnicht los. Haftbedingungen politischer Gefangener in der SBZ/DDR und deren gesundheitliche Folgen. Berlin: Berlin Verlag.
35. Neubert, E. (1997). Geschichte der Opposition in der DDR 1949-1989. Berlin Links.
36. Pagel, M. D., Erdly, W. W., & Becker, J. (1987). Social networks: we get by with (and in spite of) a little help from our friends. J Pers Soc Psychol, 53(4), 793-804.
37. Park, C. L., Cohen, L. H., & Murch, R. L. (1996). Assessment and prediction of stress- related growth. Journal of Personality, 64(1), 71-105.

38. Pennebaker, J. W., & Francis, M. E. (1996). Cognitive, emotional, and language processes in disclosure. Cognition and Emotion, 10(6), 601-626.
39. Schützwohl, M., & Maercker, A. (2000). Anger in former East German political prisoners: relationship to posttraumatic stress reactions and social support. J Nerv Ment Dis, 188(8), 483-489.
40. Tedeschi, R. G., & Calhoun, L. G. (1995). Trauma and Transformation London: Sage.
41. Turner, S. W., & Gost-Unworth, C. (1993). Psychological sequelae of torture. In J. P. Wilson & B. Raphael (Eds.), In: International handbook of traumatic stress. New York: Plenum.
42. UN. (1987). Anti torture convention. In C. Devine, C. Hansen, R. Wilde, D. Bronkhorst & H. Poole (Eds.), Human rights: The essential reference. Phoenix: Oryx.
43. Werkentin, F. (1995). Politische Strafjustiz in der Ära Ulbricht (Political justice in the Ulbricht era). Berlin: Links.

# Gender and Other Predictors of Anxiety and Depression in a Sample of People Visiting Primary Care Clinics in an area of political conflict: Gaza Strip.

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Abstract

Objective: This was a quasi-experimental survey that looked at gender difference of mental disorders and the prevalence of mental health problems of the people visiting primary health care clinics in the Gaza Strip. A survey of 661 randomly selected primary health care patients was completed using the HSCL-25. About 73% of the patients visiting primary care clinics in the Gaza Strip had mental disorders. The prevalence of the mental health problems among females was higher (76.8%) than males (67%), living in refugee camps, was predictive of both anxiety and depression. In case of depression, the difference can be traced amongst those living in the camps, termed as refugees vs. those who are citizens. Similarly the literacy level and the marital status leave impact on the mental health of people. Low educational level is a predictor of anxiety and not being married is linked to depression. About 6% of the variance of anxiety can be accounted for in regression by sex, place of residence and education with gender being the most robust predictor. Only about 2.9% of depression can be accounted for sex marital status and education. Again gender is the most important predictor. The results are discussed in the context of Palestinian culture and the ongoing geopolitical conflict.

## Introduction

Mental disorders, constitute one of the most challenging health problems for primary healthcare professionals, in both developed and developing countries (1, 2). Several epidemiological studies have shown tangible differences in the prevalence rates of mental illness in primary healthcare clinics. Some studies attribute the variations to the difference in the survey tools used; others cite differences in actual morbidity in the population studied (3,4,5, 6). Furthermore, patients screened as psychiatric cases in primary healthcare clinics have been shown to be more often females, unmarried, unemployed, and elderly (7, 8, 9).

Palestinian women often experience especially high stress in Gaza. The frequent absence of men in the Palestinian households, burden women with dual responsibilities of both their productive family roles and the responsibilities as bread earners. Sociopolitical hardships occupy a unique position among the common stressors in the lives of Palestinian women. Not only does the typical Palestinian female live in crowded substandard conditions, she is at the same time exposed to a constant strain as a result of Palestinian/Israeli conflict, either in vivo or in the press and on TV. The vulnerability of Palestinian women, leading to mental health problems, is high because women often have to pass through stressful and negative life experiences. A study carried out by GCMHP, Research Department showed that 63% of Palestinian women in Gaza were exposed to

traumatic life events (10). Khamis Vivian (11) in her study of psychological distress and wellbeing among Palestinian women, found a significant effect for family roles on the psychological distress and wellbeing, where the study indicated that mothers had higher scores of distress than daughters. Also married and widowed women had higher scores of psychological distress and wellbeing than others, while home-workers had higher scores than students.

The present study aims at investigating the prevalence of mental disorders in the Gaza Strip and its correlation with the gender difference. In addition, the study aims to investigate the prevalence of mental disorders among Palestinian refugees' women, who live in camps, compared to those living in different areas in the Gaza Strip.

Hypotheses

1. Refugees living in the concentration camps will have greater mental disorders than non-refugee patients, and more than those living in different parts of the Gaza Strip.
2. The prevalence of mental disorders would be higher in female patients, than males.

Research Questions

1. What is the overall level of psychiatric symptoms in a population of Gaza Strip residents visiting an outpatient clinic compared with a normative sample?
2. In addition to gender, what demographic variables are predictive of psychiatric symptoms? 3. Are there differences among gender on specific depressive or anxiety symptoms?

Population and Method

Primary health care (PHC) services are mainly offered through two health sectors in the Gaza Strip: the Public Health Services are available in the Gaza Strip both to refugee and non-refugee residents covered by health insurance; and The United Nations Relief and Work Agency (UNRWA) offering free primary healthcare only to registered refugees.

In order to study up to the grass root level, 10 primary healthcare clinics in the Gaza Strip were randomly selected from the five regions that form the Strip (Southern, Gaza City, Khan Younis, Rafah, and Middle Region). Five of these clinics belong to UNRWA health services and 5 clinics to the public sector. Participation was entirely voluntary and was requested through direct contact, where the purpose of the study was explained.
The sample was drawn from among the patients coming to the primary healthcare centers to be seen by the physicians. All patients aged between 16-55 years were included in the study; while those who came for referral, vaccination, insurance or driving license examinations, prenatal care, and medical reports were excluded from the study. Similarly people coming to the healthcares for emergency treatments were also excluded from the study. Every second patient in each clinic was approached and invited to participate in the study. After the medical consultation by the GP, the selected patients were asked to fill in 25 items of HSCL in addition to different socio-demographic factors.

Of the total of 670 patients eligible for inclusion criteria, 661 patients agreed to participate in the study. Of 661 patients who completed the HSCL-25 questionnaire, 112 (17%) patients were excluded for not responding to all items in the questionnaire, leaving 549 responses for analysis.

## The Instrument

The Hopkins Symptom Checklist-25 (HSCL-25) was used as the screening instrument to detect neurotic psychiatric symptom (12). It has been used in several versions of different lengths (16-90 items) and in a wide range of primary healthcare settings (13). The HSCL-25 has been shown to be satisfactorily valid and reliable as a measure of mental health symptoms, able to differentiate between normal and neurotic patients (14). Translated versions of the HSCL-25 have been widely used to screen mental disorders, in particular, anxiety and depression experienced during the preceding week (15). It is suitable for psychiatric assessment in primary healthcare settings and it shows high correlation with clinically-assessed depression (16,17).

In this study SCL-25 was used where patients record their own estimates of symptom severity, present during the past week, on a 4-point scale ranging from 1 “not at all” to 4, “extremely”. Responses are summed and divided by the number of the answers. The patient was considered a psychiatric case if the mean rating score was well over 1.75 (18,19). The patients were also asked for information about demographic background such as age, sex, marital and civil status, living places and educational levels.

In order to minimize misunderstanding of the SCL-25 questionnaire, a back translation technique was used. The questionnaire was translated into Arabic and then retranslated, by some other person, back to English. The back-translated questionnaire was compared to the original one in order to iron out any discrepancies in terminology and phrasing. The questionnaires were discussed with 5 local experts to see the relevancy of the questionnaire items to the Arab culture. The only difficulty in applying the questionnaire was that the patients felt embarrassed to answer the item about sex. A pilot testing was carried out, the alpha Cronbach indicated that reliability correlation coefficient is 0.77.
The HSCL-25 is suitable for psychiatric assessment in primary healthcare settings and this assessment tool generally shows high correlation with clinically assessed depression. Lavik et al (17) did a validation study comparing the results of HCSL-25 with the Global Assessment of Function (GAF) and the Global Rating on the BPRS in a refugee population in Norway (the majority were from the Middle East). They reported that the HCSL-25 predicted mental health problems in the multicultural subject population.

## Data Analysis

The basic design was a quasi-experimental correlation study. Of interest was the difference between the psychiatric symptomatology of males and females in the study and what demographic factors might also be associated with these symptoms. The analysis strategy consisted of ANOVA or T-tests, in which the mean value of the

symptom was compared across gender and the level of demographic variable. Each variable, in which statistical significance was found, became an independent variable to use in a linear regression, in which the value of the Depression and Anxiety scales respectively, were regressed on the IVs. Partial correlations were run to ascertain the importance and uniqueness of each IV in predicting the symptom.

Item-by-item responses to the HSCL-25 were analyzed descriptively using cross tabulations. For each of the twenty-five questions, extreme responses to each question ("not at all" or "extremely") were selected and cross-tabulated by gender. Standardized residuals were used to compare the gender-based extent of disproportionality regarding the endorsement of extreme responses to the 25 questions of the instrument.

The Results

Table (1) breaks down the sample, by patient characteristics, across residential categories. Females predominated in the sample. There were 314 female respondents (57.2%) compared with 235 males (42.8%). The vast majority claimed refugee status (378, 69.1%) although less than half actually lived in a refugee camp at the time of the survey (232, 42.3%). About a quarter lived in villages and in cities and a smaller number (43, 7.8%) in new residential areas. As expected, the large majority of those designating themselves refugees, lived in camps. Although there are more women in the sample, but men and women appear to be fairly evenly distributed across places of residence. Surprisingly, unemployment did not seem to be concentrated in camps, office workers

and laborers belonged to camps, villages, or cities.

Level of education was mixed. Over 96% had some formal education, but only 210 (38.3%) had finished secondary school or had more than a secondary education. Educational level seemed to be independent of the place of residence. There was a disproportion found among people who were non-educated, those with secondary education, and some with higher education. All the three types were disproportionally represented in the camps. The sample consisted of the largely unemployed (111, 20.2%) and the listed housewives (222, 40.4%).

About one-fifth sample consisted of office workers and one-tenth students. The mean age of the sample was 30.29 (SD 10.34).

| | Total N. % | Camp N. % | Village N. % | City N. % | New areas N. % |
|---|---|---|---|---|---|
| **Civic status** | | | | | |
| Native | 31.2 | 8.8 | 46.2 | 41.5 | 3.5 |
| Refugees | 377 68.8 | 5 | 52 13.8 | 71 18.8 | 37 9.8 |
| | | 7.6 | | | |
| **Gender** | | | | | |
| Male | | 4 | 50 21.4 | 61 26.1 | 23 9.8 |
| Female | 42.7 | 2.7 | 81 25.8 | 81 25.8 | 20 6.4 |
| | 314 57.3 | 132 42.0 | | | |
| **Age** | | | | | |
| 16-24 | | 4 | | | |
| 25-34 | 37.5 | 9.0 | 21.1 | 19.1 | 10.8 |
| 35+ | 26.8 | 41.1 | 17.1 | 34.9 | 6.8 |
| | 194 35.7 | 71 36.6 | 61 31.4 | 51 26.3 | 11 5.7 |
| **Marital Status** | | | | | |
| Married | | | | | |
| Single | 64.6 | 38.7 | 26.3 | 28 | 7.1 |
| Prev. Marriage. | 31.6 | 49.1 | 20.8 | 20.2 | 9.8 |
| | 21 3.8 | 10 47.6 | 2 9.5 | 8 38.1 | 1 4.8 |
| **Occupation** | | | | | |
| Housewife-Unemployed | 221 40.5 | 4 | | | |
| Laborers | 2 | 1.2 | 25.8 | 29.0 | 4.1 |
| Office work | 0.3 | 4 | | | |
| Student | | 9.5 | 15.3 | 24.3 | 10.8 |
| | 11.4 | 24 38.7 | | | |
| | 92 16.8 | 4 | 32.3 | 22.6 | 6.5 |
| | 60 11.0 | 5.7 | | | |
| | | 19 31.7 | 25.0 | 19.6 | 9.8 |
| | | | 14 23.3 | 19 31.7 | 8 13.3 |
| **Education** | | | | | |
| No school | | | | | |
| Primary | 6.8 | 43.2 | 29.7 | 4.3 | 2.7 |
| Preparatory | | | | | |
| Secondary and higher | 20.6 | 32.7 | 26.5 | 34.5 | 6.2 |
| | | | 44 23.9 | | |
| | 34.3 | 44.1 | 45 21.4 | 24.5 | 7.6 |
| | 210 38.3 | 86 45.1 | | 48 22.9 | 10.0 |

***Table (1):-*** *Socio-demographic characteristics of patients in each residential area.*

The sub-scales of the HSCL-25 had adequate reliability on this sample. The Depression and Anxiety scales showed a Chronbach alpha of .7875 and .7560, respectively. Mean scores for the sample on the two scales were 20.85 (SD 6.46) for Anxiety, and 31.030 (SD 8.30) for Depression. Both scales evidenced normal distributions as indicated by skewness and kurtosis statistics close to zero.

Hypothesis (1): Refugees who live in the refugee camps will have greater mental disorders than original resident patients, and more than those who live in other parts of the Strip.

Camp residents showed the highest mean anxiety level of the four residential groups (21.63, f = 2.85, p = .036, Camp and Village dwellers significantly different on post-hoc test using Tukey-B). When non-camp residents are lumped together into a single group, the camp residents still exhibited a greater anxiety level (21.63 vs. 20.30, f = 5.86, p = .018). Those merely identifying themselves as refugees, regardless of place of residence show no significance than those identifying themselves as refugees, for either anxiety or depression. Although camp dwellers were more depressed than the other three types of residence (Table 2) differences were non-significant. However, when the other three groups were lumped together into one, a significant difference did emerge (t = xx, p = .004). Although camp dwellers show the highest level of depression of the four groups, the difference is not significant. However, when the non-camp groups are merged into one, a significant difference does emerge (f = 7.54, p = .006)

| Variable | Category | Anxiety Subscale | | Depress. Subscale | | Hopkins Total | |
|---|---|---|---|---|---|---|---|
| | | Mean | Sig. | Mean | Sig. | Mean | Sig. |
| Gender | Male | 19.42 | <.0005 | 30.01 | .012 | 49.44 | <.0005 |
| | Female | 21.92 | | 31.80 | | 53.73 | |
| Marital Status | Marrid | 21.01 | Ns | 30.59 | .017 | 51.60 | Ns |
| | Not Mar. | 20.57 | | 31.85 | | 52.42 | |
| Occupation | House wife | 22.65 | <.0005 | 32.01 | <.002 | 54.65 | <.0001 |
| | Unemployed | 19.97 | | 31.05 | | 51.02 | |
| | Laborer | 19.05 | | 28.43 | | 47.48 | |
| | Office Worker | 20.13 | | 32.26 | | 52.39 | |
| | Student | 18.87 | | 28.48 | | 47.25 | |
| Education | <Secondary | 21.51 | .036 | 31.55 | Ns | 53.06 | .008 |
| | Secondary+ | 19.81 | | 30.20 | | 50.01 | |
| Address (4 categories) | Camp | 21.63 | .036 | 32.17 | Ns | 53.80 | .024 |
| | Village | 19.80 | | 29.99 | | 49.79 | |
| | City | 20.97 | | 30.46 | | 51.43 | |
| | New Res. Area | 19.58 | | 30.05 | | 49.62 | |
| Address (2 categories) | Camp | 21.63 | .018 | 32.17 | .005 | 53.79 | .004 |
| | All Other | 20.30 | | 30.21 | | 50.51 | |
| Civic Status | Citizen | 20.66 | Ns | 30.81 | Ns | 51.47 | Ns |
| | Refugee | 20.95 | | 31.14 | | 52.40 | |

***Table (2):-*** *Summary of Hopkins Checklist Totals By Demographic Characteristics, Broken Down by Depression and Anxiety.*

For anxiety, the interaction of residence (camps vs. non-camps) and civic status (refugee vs. non-refugee) is non-significant. The controlling factor for anxiety seems to be where the respondent lives and has nothing to do with the civic status. However, the interaction between these two factors for depression is significant (f = 3.58, p = .014). Refugees who live in the camps are the most depressed (32.32) but surprisingly the self-proclaim refugees not living in the camps are the least depressed (29.55). Citizens, whether camp dwellers or others, fall in between and are similar to each other (citizen camp dwellers, 30.0, vs. citizen non-camp dwellers, 30.89).

Hypothesis (2): The prevalence of mental disorders would be higher in female patients, than males.

Female respondents had a mean anxiety score of 21.92 vs. 19.42 for males (t = -4.57, p = < .0005). Similarly, mean depression score for females was 31.80 vs. 30.01 for males. (t = -2.51, p = .012).

Research Question 1: What is the overall level of psychiatric symptoms compared with a normative sample?

As a whole, the entire sample was quite depressed and anxious, compared with standard clinical norms. Sixty-five percent was above the clinically significant cutoff of 1.75 for the Anxiety subscale, and 69% were above the cutoff for depression. Clinically significant anxiety and depression was over represented in the female part of the sample for both of the symptoms (÷ = 8.76, df 1, p = < .01 for anxiety; ÷ = 6.37, df 1, p > .05 for depression).

Research Question 2: What demographic variables, in addition to gender, are predictive of psychiatric symptoms?

Table 2 displays the results of comparing the total score of the Hopkins Symptoms Checklist and the two subscales, Anxiety and Depression, across selected demographic categories. The four categories of "Address" were merged into two as a comparison of people living in the camps with all other residents was of theoretical interest. Although the category of occupation was statistically significant, it was redundant with the 'gender' category. Every housewife was female, so this occupational category just repeated the significant difference found for gender. As can be seen, marital status was predictive of depression but not anxiety; educational level was predictive of anxiety but not depression. Age was also accounted for in the survey but it showed no association with the Hopkins total score or with either subscale.

The statistically significant demographic variables were used as independent variables in linear regressions predicting anxiety and depression. Neither regression produced a standardized residual greater than 3.42, suggesting no outliers in the analysis. Histograms of standardized residuals appeared roughly normal and normal probability plots of standardized residuals indicated no sign of heteroscadasdicity. Table (3) shows anxiety to be more powerful than depression. It appears that being female, having less than secondary education, and living in the camps is a fairly robust predictor of anxiety, regardless of the civic status. Gender appears to be the most powerful predictor having a unique correlation with anxiety of .180. Demographics could only predict about half the variance in depression compared to anxiety. However, being female, with less than a secondary education, and being unmarried were the important factors that seemed of equal importance as predictors

| Anxiety | | | | | Depression | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | IVs | T | Par. r | | | IVs | T | Par. r |
| R | .245 | Education | .007 | -.115 | R | .170 | Education | .030 | .063 |
| R2 | .060 | Address | .009 | -.112 | R2 | .029 | Address | .009 | -.120 |
| F | .0000 | Sex | .000 | .181 | F | .001 | Sex | .009 | .110 |

***Table (3):-*** *Comparison of Linear Regression Predicting Anxiety and Depression From Demographic Characteristics*

The individual questions on the Hopkins Symptoms Checklist were examined to ascertain gender differences in responding. A cross tabulation of 2x4 was run by gender for each of the 25 questions. Only the extreme responses, either "Not at all" or "Extremely" are displayed in the Table (4) below, alongwith the standardized residual. A high-standardized residual indicates that men or women were disproportionally represented in that cell in proportion to the number of respondents in the cell. Positive numbers indicate overrepresentation while negative numbers signify under representation. In the case of a few questions, responses were overwhelmingly in the "Not at all" category; e.g. 74% of the respondents responded "Not at all" to the question about ending their life, probably due to religious and ideological taboos about suicide. But, most of the questions had adequate responses across all four categories.

As can be seen that the largest standardized residuals occur in the questions dealing with anxiety, and somatic complaints (headache), and with crying. Women over-endorse these categories in every case, and men under-endorse them. The question on crying is probably confounded with cultural prohibitions about the crying of men, especially in the Arab culture. In only three questions were men significantly over represented in the

"Extremely" category: insomnia, worries about the future, and having no interest in things. The latter two may be related to worries about work and the role of breadwinner for the family, in an environment of underemployment and economic uncertainty.

| Question | Standardized Residual | | | |
|---|---|---|---|---|
| | Males | | Females | |
| Hopkins Question | Not at all | Extremely | Not at all | Extremely |
| Suddenly scared for no reason | 1.7 | -2.0 | -1.5 | 1.7 |
| Feeling fearful | 2.6 | 3.2 | -2.2 | 2.8 |
| Faintness, dizziness, weakness | 1.6 | -1.8 | -1.3 | 1.5 |
| Nervousness or shakiness inside | 1.7 | -1.6 | -1.5 | 1.4 |
| Heart pounding or racing | 1.7 | -1.8 | -1.5 | 1.6 |
| Trembling | .4 | -.8 | -.3 | .7 |
| Feeling tense or keyed up | .6 | -.7 | -.6 | .6 |
| Headaches | 2.7 | -2.7 | -2.3 | 2.3 |
| Spells of terror or panic | .9 | -1.3 | -.8 | 1.1 |
| Feeling restless, can't sit still | -.2 | .5 | .1 | -.4 |
| Feeling low in energy, slowed down | 1.2 | -.7 | -1.0 | .6 |
| Blaming self for things | .2 | -1.0 | -.2 | .9 |
| Crying easily | 5.2 | -5.4 | -4.5 | 4.7 |
| Loss of sexual interest or pleasure | 1.6 | -2.0 | -1.4 | 1.8 |
| Poor Appetite | .2 | .1 | -.1 | -.1 |
| Difficulty falling, staying asleep | .8 | 1.3 | -.7 | -1.2 |
| Feeling hopeless about the future | -.9 | 1.1 | .8 | -.4 |
| Feeling blue | -.9 | .5 | .8 | -.4 |
| Feeling lonely | -.3 | -1.7 | .2 | 1.5 |
| Thoughts of ending life | .2 | -.1 | -.2 | .1 |
| Feeling of being trapped or caught | .4 | -.2 | -.3 | .1 |
| Worrying too much about things | .4 | -.7 | -.3 | .6 |
| Feeling no interest in things | -.1 | 1.3 | .1 | -1.2 |
| Feeling everything is an effort | .2 | -.2 | -.1 | .2 |
| Feelings of worthlessness | .4 | -.3 | -.4 | .2 |

***Table (4):-*** *Standardized residuals for males and females for the individualized questions on the Hopkins Symptoms Checklist*

**Discussion**

The study in general confirms a high level of both reported depression and anxiety from patients visiting clinics in the Gaza Strip. Some but not all of the factors found in previous studies were found to contribute to anxiety or depression. Gender, low educational level, being single (for anxiety) and place of residence were all predictive. Unlike prior studies, age was not associated with either anxiety or depression, and this is not surprising, given the current political climate. The majority of Palestinians feel trapped in the Gaza Strip and face an ever-deteriorating economic situation, making it difficult for wage-earners to support their families. Unemployment is high and those who work have no assurance that their work will provide steady income, rather they know that their source of income may cut off at any time by Israeli restrictions. Crowding is common, especially in the camps, and there is limited opportunity for either social or geographic mobility.

Consistent with prior epidemiological studies (20, 21, 22), sex is highly predictive of both anxiety and depression and in fact has the highest unique correlation with both. A cross-cultural study showed that 62% of primary care patients are females; around 50% of them were at the age of 15-24 years. In Jordan, women have a significantly higher prevalence of psychiatric disorders 69% than men 52% (6). The Nordic study (4) showed that 64.2% of the patients visiting primary care centres are females. Overall, the study indicated that there was no significant difference in mental illness prevalence regarding gender. However, there was a tendency of female patients being mentally ill.

A possible explanation could however be that Palestinian women have a unique cultural and environmental situation. They are living in an authoritarian community where men assume power and the authority (23). A study by Research Department of the GCMHP (24) indicated that 25% of women in Gaza have been exposed to domestic abuse at least once in their childhood. During the Intifada women were very active and participated jointly with men in the political struggle against the Israeli occupation. Their role was changed from that of a traditional housewife, only taking care of the children, to a woman who have a role in the struggle and development, taking care of the family members. As indicated by FAFO study, 10% of the females participated in their study, were the housewives (23). This was clear among families, mainly refugees, when the father is arrested, imprisoned or killed in the struggle. This new role raises women's self-esteem and self-confidence. During the Intifada, there was a 'collectivistic style' of relationship between the individuals and the community; the individual puts aside the self-interest and obeys the will of the group norms and values. (23,25). They renounce the losses of their beloved such as sons, husbands, brothers and fathers. When the Intifada subsided and terminated by the Declaration of Peace Principles between Palestinians and Israelis, the high expectations and the hope that people put on the peace process were not brought about. This output opened the wound of beloved losses such as husband, fathers, and any other love object.

The analysis of the survey reveals higher levels of anxiety and depression in women generally, and higher levels of anxiety and depression for the camp dwellers. In the case of the camp dwellers, only those self-proclaiming to be refugees report more depression. Why should being a refugee, have no effect of the different anxiety levels, between the camps and non-camps but be a factor in depression? We believe that the reason is economic. Those, identifying themselves as citizens, living in the camps prior to its creation and probably had established jobs and some measure of economic security as well as family support. These factors may mitigate depression by allowing the residents feel less helpless. As indicated in FAFO study, the refugees in the Gaza Strip camps showed that 70% of refugees live in homes with “average amenities”, 18% have poor infrastructural services, and 12% live “above average” (23). Another explanation may, however, be attributed to the Palestinian culture, which has a role to play in the presentation of mental symptoms. Such a culture indicates a general tendency of individuals to present emotional distress in somatic forms, which allows them to occupy the sick role, avoiding the blame and stigma (26). Therefore, people tend to present their psychological sufferings in the form of physical symptoms, which is considered to be a

factor that contributes to the high frequency of physical symptoms of depression and anxiety among Palestinians (25).

## Conclusion

In Palestine as in many developing countries, the most frequent health indicators used in planning the health services are linked to physical health problems. These indicators are mostly based on the magnitude and distributions of physical health problems such as infant mortality rate. These indicators are essential in planning any health services; however, any comprehensive health service plan has to consider the mental health indicators.

## References


1. World Health Organization (1990) the introduction of a mental health component intoprimary health care WHO Geneva
2. Weiller E., Bisserbe J,. Maier W and Lecrubier Y. (1998) Prevalence and recognition of anxiety syndromes in five European primary health settings: a report from the WHO study on psychological problems in General Health Care British Journal of Psychiatry, 173 (suppl. 34) p.p. 18-23.
3. Robins LN., Helzer JE., Weissman MM et al (1984) Lifetime prevalence of specific psychiatric disorders in three sites Archives of General Psychiatry, 41 pp. 949 958
4. Fink P. Jensen J, Borgquist L, Brevik JI, Dalgard O.S., Sandager I, Engberg M. , Hansson L, Holm M, Joukamaa M, Karlsson H, Lethinen V, Nettelbladt P, Nordstrom G, Stefansson CG, Sorensen L. (1995) Psychiatric morbidity in Primary Public Health Care: a Nordic multicentre investigation Part 1: method and prevalence of psychiatric morbidity Acta Psychiatric Scand, 92 PP 409-418.
5. Portegijs P.J., van der Horst F.G., Proot I.M., Kraan H.F., Gunther N.C., And Knottnerus J.A. (1996) Somatisation in frequent attenders of general practice Soc. Psychiatry Epidem 31 pp. 29-37.
6. Al-Jade H., and Malkawi A. (1997) Prevalence, recognition and management of mental disorders in primary health care in Northern Jordan Acta Psychiatr Scand vol. 96 pp. 31- 35.
7. Froom Jack, Hideyasu Aoyamma, Doron Hermoni, Yoshio Mino and Nora Galambos (1995) Depressive disorders in three primary care populations: United States, Israel, and Japan Family Practice 3, pp. 274-277.
8. Hansson L., L. Borgquist, P. Netelbladt and G. Nordstrom (1994) The course of psychiatric illness in primary care patients: a 1-year follow up Soc Psychiatry Psychiatr Epidemiol, 29 pp. 1-7.
9. Kramer T. and Garralda (1998) Psychiatric disorders in adolescents inprimary care British Journal of Psychiatry, 173 pp. 508-513
10. Qouta S., El Massri M. & Temraz Neda (1999) The prevalence of mental disorders in the Palestinian community in Gaza. GCMHP newsletter, Gaza Palestine,

11. Khamis Vivian (1998) psychological distress and well being among traumatized Palestinian women during the Intifada Soc. Sci. Med, 8. PP.1033-1041
12. Derogatis L., Lipman R., rickels K., Uhlenhuth and Covi L., (1974) The Hopkins Symptoms Checklist (HSCL): A measure of Primary Symptoms Dimensions Psychological Measurement in Psychopharmacology Pharmacopsychiat, 7 pp. 79-110 19.
13. Joukamaa M, V. lehtinen, H. Karlsson and E. Rouhe (1994) SCL-25 and recognition of mental disorders reported by primary health care physicians Acta Psychiatric Scand, 89 pp. 320-323.
14. Goldberg DP (1972) the detection of psychiatric illness by questionnaire Oxford University press London
15. Hesbacher PT., Rieckels K. Morris RJ., Newman H., Rosenfeld H.(1980)Psychiatric illness in family practice J Clin Psychiatr 41 pp/6-10.
16. Feightner JW., Worrall G (1990) Early detection of depression by primary care physicians Can Med Assoc J 142 pp.1215- 1220.
17. Lavik NJ, Laake P, Hauff E and Solberg O. The use of self-reports in psychiatric studies of traumatized refugees: Validation and analysis of HSCL-25. Nord J Psychiatry, 1999, 53(1):17-20.
18. Barrett JE, Barrett JA, Orman T, Gerber P., (1988) the prevalence of psychiatric disorders in a primary care practice Arc Gen Psychiatry, 45 pp. 1100-1109
19. Sandanger I., Moum T., Ingebrigtsen G., Dalgard OS., Sorensen T., Bruusgaard D (1998 Concordance between symptom screening and diagnostic procedure:the Hopkins Symptom Checklist-25 and the composite International Diagnostic Interview I Soc Psychiatr Psychiatr epidemiol. 33: 345-354
20. Robert Peveler, Lesley Kilkenny, and Anne-Louise Kinmonth (1997) Medically unexplained physical symptoms in primary care: a comparison of self-report screening questionnaires and clinical opinion Journal of Psychosomatic Research, 3 PP 245-252
21. Marco Piccinelli and Gregory Simon (1997) Gender and cross-cultural
22. differences in somatic symptoms associated with emotional distress. An international study in primary care Psychological Medicine, 27 pp. 433- 444.
23. Larry G. Kessler, Paul D. Cleary and Jack D. Burke (1985) Psychiatric Disorders in Primary Care: results of a follow up study Arch Gen. Psychiatry 42 June pp. 583-587
24. Marianne Heiberg and Geir Ovensen (1994) Palestinian Society in Gaza, West Bank and Arab Jerusalem: A Survey of Living conditions FAFO-report 151
25. Qouta3 S., El Massri M. & Temraz Neda, (1999) the prevalence of mental disorders in the Palestinian community in Gaza GCMHP Publications Gaza Palestine
26. Dwairy M. (1998) Cross-Cultural Counseling: the Arab-Palestinian Case a worth Press New York
27. Afana A (1996)Community in Crisis Health Action, April-June p 20.

# Reflections on Mass Torture

Dr. P. Deeksha

Keywords: VRCT, Mass torture, Primary victims, secondary Victims, Psychosocial support.

## Introduction

Mass torture is an issue we often come across, but we do not react to the problem. Vasavya Rehabilitation Center for Torture Victims (VRCT), a unit of Vasavya Mahila Mandali, a registered non-governmental organization in southern part of India, reached the people of a remote village in response to a news item appearing in a daily paper. Fact-finding was done by social worker of VRCT, followed by a medical camp and psychosocial support to the people.

## Methodology

- One One interviews
- One Group interviews
- Focus group Discussions
- House visits

## Sample Group

- Primary victims of torture tortured directly by police
- Secondary Victims of Torture family members of the primary victims
- Peoples' representatives
- Media persons

## Sample Village

Pullapadu, a remote village with 1400 population is having harmony and peace without religious/caste conflicts. The village surrounds a lake, which caters to the needs of the villagers. The people were electing the village president unanimously since the past 15 years. Traditionally an able and an educated person was elected as a president. The main occupation of the villagers was agriculture. Health services were not available in the village, and communication with the villagers was a bit too difficult.

## Tools

- Medical case sheets
- Counseling case sheets
- Recording of views and discussions
- Photos & video

## Training

- The team was trained in the following areas:
- The sensitivity of the issue
- Methodologies and tools
- Counseling techniques
- Psychological status of the Survivors
- Physiotherapy methods

Efficacy

- 20 Committed staff
- 2 Trained and experienced doctors
- 1 Physiotherapist
- 6 Nurses who were trained in torture-related work
- 4 Experienced social workers and 4 counselors.
- 2 Photographers

The Incidence

At 6 am, approximately 150 police personnel came in 20 vehicles and surrounded the village without any former notice, and most of the houses were searched. Men, women, and children were maltreated and a pregnant woman also was manhandled by the police. Male police dragged a woman from her house and was abused and beaten by many policemen. An old man, in the middle of pooja, was not given a chance to dress up properly and was dragged and dumped in the police van. Police took 13 men and 1 woman to the police station. The whole village was terror-stricken. There was no support from the government or health services, so the people of the area felt isolated and insecure. They lost faith in the system of law enforcement.

Methods of Torture Used

Maintaining un-natural position half sitting posture, and bending backwards, etc.

- Systematic beating with baton on joints, ankles, knees, and back.
- Falanga beating on the soles of the feet.
- Hair torture pulling of hair.
- Torture with heavy weights on the thighs in half-sitting posture.
- Forced running in between other types of torture.
- Cold water was thrown on the bodies of victims in between the beatings.
- Beating with rifle butts.
- Oral abuse using foul language.
- Threats and insults.
- Kept them incommunicado

Medical Findings
Symptoms

- Body pains
- Palpitations complained by adults and children
- Sweating
- Joint pains
- Back pain
- Extreme fear
- Insecurity
- Migration
- Suicidal tendency

Signs

In case of police torture, the signs are less visible compared with symptoms. In other words we may say that the picture was “less visible and more felt”.
However, following signs were seen amongst the patients:

- Abrasions
- Joint swellings and tenderness
- Swelling of soft tissue
- Fracture of small bones of feet metatarsals and tarsals
- Tenderness of muscles of calf, thighs, back and upper arms
- Acute Post Traumatic Stress Disorder (PTSD) in primary and secondary victims
- Visible insecurity and fear in all villagers
- Non acceptability of unknown people

Follow up Activity

VRCT had followed the recovery of the victims with medical follow up and distributed the splints and bands for ankles and wrists of the victims.

Psychosocial support was provided to overcome the insecurity of the victims. Similarly, advocacy with police and government officials was given priority, which went a long way in providing a sense of security. Report of the incident was disseminated to all concerned departments of Justice.

VRCT intervention gave the villagers strength to file a case against the police with the help of the report made by VRCT. V-Voice, a monthly e-news letter from VRCT disseminated the information both nationally and internationally.

However, threats made by the police on VRCT staff gave further momentum to our fight against torture and a massive campaign. For the sensitization of police was launched.

Lessons Learnt

- To be more careful about the safety of the volunteers in view of the remoteness of the focus area.
- To inform police personnel before intervention in view of the sensitiveness of the issue and to avoid negative interaction with police.

Conclusion

Mass torture reflects the void that is found to exist between the police and community. Community enriched about their rights interacting with unchanged police system results in mass torture. In this transitory period we experience such inhuman and degrading acts by the persons who are to follow the rules of society.

VRCT continued in its endeavor to uphold the human rights preservation through advocacy with police and government. The report was disseminated to police and office bearers of Legislative Assembly of Andhra Pradesh state. The response was not very encouraging initially, but persistent advocacy with police and government proved to be successful.

Note to Contributors

The villagers did not allow any officials, as they were not there for them in the hour of need. The activities of VRCT include sensitization workshops for police on human rights in general and torture in particular, to help avoiding mass torture in future.

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