The Socio-demographic and Psychiatric Profiles of Clients in the Centre for Rehabilitation of Torture Victims – IAN Belgrade

Željko Špiric
Goran Kneževic

(Translated by Anika Krstic)

Abstract

In the period between January 2001 and June 2003, Centre for Rehabilitation of Torture Victims – IAN Belgrade (CRTV IAN) has provided psychological assistance for over 2,500 clients, of which 1,058 have had detailed admission and diagnostic records, as a part of the overall psychological and psychiatric treatment. From the overall number of clients, 621 of them were victims of torture, whereas the remaining 437 were refugees or internally displaced persons who have come to request assistance due to severe psychic problems arising as consequence of war experience. This paper aims at comparing the group of clients with torture experience and the group of war traumatised clients without the experience of torture (but with severe psychological problems) with regard to their general socio-demographic and clinical profile. Both groups had equally poor markers of socio-economic, i.e. material and existential living condition. General psychopathology was much more prominent in the group of clients - torture victims. Posttraumatic stress disorder was the most frequently diagnosed psychiatric disorder. The two groups differed in intensity and distribution of posttraumatic symptoms: the group of torture victims had much more expressed symptoms of hyper-arousal. The group of torture victims had a more expressed general and specific posttraumatic symptomatology and this confirms the assumption about special vulnerability of this group of traumatised people, as well as about the need for a particular multidisciplinary medical, psychological and social approach to this population.

INTRODUCTION

More than some other types of traumatic events caused by natural or technological catastrophes, the interpersonal trauma perturbs deep and early-formed foundations of interpersonal relations of an individual, threatening to deprive him/her for a longer period or permanently from the feelings of safety, attachment and spontaneous sharing of emotions with other people. Interpersonal trauma can have various forms such as criminal assault, rape, and violence during conflicts or political violence. What makes it especially problematic is its aspect of deliberate infliction of suffering. Torture, as a particular form of political violence, is an extreme use of sadistic patterns in interpersonal relations, resulting not only in psychiatric disorders but often producing powerful and long-term negative consequences to the overall psychosocial functioning of the victim. The most frequent consequence of prolonged and/or intensive torture is the posttraumatic stress disorder (PTSD) accompanied with a range of comorbid psychiatric and (psycho)somatic disorders.

Basoglu and associates (1994) have determined that there are three types of stressors related to various aspects of psychopathology in torture survivors: intensity of torture, secondary consequences of captivity on various areas of life and general psychosocial stressors after captivity. Torture victims are considered the most vulnerable social group after the war and therefore require a multidisciplinary approach in psychosocial rehabilitation (Kucukalic et al., 2003).

Poor economic situation characteristic of refugees and the poor psychic and general health characteristic of torture survivors have a mutual adverse effect, locking the victim in a circle from which it is difficult to escape without significant social support. Hondius and associates (2000) have looked into health problems of tortured refugees with regard to violence, demographic factors and current socio-psychological problems during asylum. They have noted that the ongoing social situation also contributes to health problems, together with the experience of violence. Refugees attributed their somatic and psychological problems to disease (48%), torture (29%) and everyday worries related to exile (40%). In the research made by Kucukalic and associates (2003) with torture victims in Bosnia and Herzegovina, it has been stated that their general socio-economic status is significantly worse compared to the pre-war period. Van Ommeren and associates (2002) have established the link between PTSD and somatic discomforts in torture victims among Bhutanese refugees in Nepal.

A number of authors have noticed the relation between the type of torture and subsequent somatic problems of victims. Edston (1999) has shown results obtained on 201 persons from 34 countries during 5 years. The most frequently registered discomfort was the chronic lumbal pain. A link was established between sexual torture and genito-urinary symptoms, between bastinado (falaka - suspension) and neurological symptoms, between electric shock torture and pain in joints and digestive tract. The intensity of torture was in correlation with PTSD. Bouwer and associates (1999) have established that torture by suffocation is associated with panic disorders, mainly with respiratory problems.

Cunningham and associates (1997) have compared the link between 41 medico-psychological symptoms and 33 torture and trauma experiences. They separated 6 patterns, with the first pattern of symptomatology essentially being the PTSP.

Van Ommeren and associates (2001) researched the impact of torture on the distribution of psychiatric disorders among tortured and non-tortured Bhutanese refugees in Nepal. Torture victims more frequently had an actual and lifelong PTSD, permanent somatophorm painful disorder and dissociative disorders (amnesia and conversion) as well as a history of affective disorders and generalised anxiety disorder.

Current epidemiological clinical surveys have shown a high frequency of comorbid psychiatric disorders in patients with posttraumatic stress disorder. One of the reasons cited for such high comorbidity was the significant symptomatology overlap of PTSD with a range of psychiatric disorders, especially with depressive and anxiety disorder or psychoactive substance abuse (Kulka et al., 1988). Epidemiological survey on comorbidity in USA has shown that 88,3% of men and 79% of women with PTSD have at least one psychiatric disorder (Kessler et al., 1995). Wenzel and associates (2000) have established that tortured patients with PTSD suffer from dysthymia on 49% of cases in women and 21% of cases in men, as well as from the major depressive disorder in 23% of women and 21% of men. In veterans from wars in former Yugoslavia who were diagnosed with PTSD, the comorbidity was established with some of depressive disorders in 41% of cases, in 14,3% with some of anxiety disorders and with alcohol abuse in 28,6% of cases (Špiric et al., 2002).

With regard to the development of PTSD in torture victims, contemporary research is mainly focused on finding answers to three questions: does the traumatic experience of torture contribute more to the occurrence of PTSD than other traumatic experiences, which kind of PTSD symptoms is most prominent in torture victims and what kind or type of torture carries the most risk for the development of PTSD. In contemporary scientific literature dealing with relations between torture and PTSD there are various, sometimes conflicting results related to the role of intensity or specificity of stressors in the development of PTSD.

Momartin and associates (2003) have determined with Bosnian refugees that a life threatening event is the type pf trauma that better anticipates PTSD than trauma related to human rights violations (captivity in concentration camps, torture). Authors of this work have assumed that human rights violations represent a much more general threat to the outcome of psychosocial adaptation of the traumatised person in the areas of functioning that span beyond border limiting the concept of PTSD. Silove and associates (2002) have found in 107 Tamil refugees in Australia that torture is the one of five factors isolated by analysis of main components that most prominently anticipates PTSD symptoms. The authors have concluded that this finding confirms the viewpoint that torture is the most traumatic individual event even when all other war related traumatic event are taken into consideration.

While researching risk factors and prevalence of PTSD among survivors in war situations and mass violence in Algeria, Cambodia, Ethiopia and Gaza, de Jong and

associates (2001) have established that the prevalence of PTSD amounts to 37.4% in Algeria, to 28.4% in Cambodia, 15.8% in Ethiopia and 17.8% in Gaza (de Jong et al., 2001). In all four samples "conflict related trauma" was present as a predictor of PTSD. Followed "torture" in 3 countries, with exception of Cambodia. Less important risk factors were "current and previous psychiatric disorder", "poor living conditions in camp", etc. The authors have shown that various risk factors in various countries play different roles and pointed out the significance of contextual differences in studies of traumatic stress and human rights violations.

With regard to the specific clinical picture of the posttraumatic stress disorder, Mollica and associates (1998) have found that in ex-detainees the severity of torture experience was related to the cluster of hyper-arousal. Henigsberg and associates (2001) conducted a survey on the relation between trauma and PTSD symptom clusters with Bosnian refugees in Croatia divided into 4 sub-groups: veterans, ex-detainees with torture experience, rape victims and refugees. They have found significant sub-group differences in clusters of avoidance and clusters of hyper-arousal, while there were no differences in the cluster of intrusion. Rape victims had more prominent avoidance symptoms, while ex-detainees and veterans had more pronounced symptoms of hyper-arousal. Otherwise both rape victims and ex-detainees had more numerous symptoms than other groups. Strestha and associates (1998) have found that in 15 out of 17 PTSD symptoms torture victims had higher scores than those who had not been tortured.

With regard to particularly difficult experience of trauma related to torture and captivity, we have assumed that among clients-refugees assisted in the *Centre for Rehabilitation of Torture Victims – IAN Belgrade (CRTV IAN)* torture victims would have significantly higher psychic problems and more frequently diagnosed psychiatric disorders, especially the posttraumatic stress disorder. We have also assumed that due to particularly difficult problems in social adaptation these clients would be in a more precarious socio-economic situation and other unfavourable socio-demographic characteristics.

METHOD

CLIENTS

In the period between January 2001 and September 2003, CRTV IAN has provided psychological and psychiatric assistance to over 2,500 clients. During triage done by psychologists-counsellors, 1,245 clients were referred to psychiatric examination due to "serious psychic problems". Other clients were referred to counselling or have received psychological assistance during mobile team interventions.

Until June 2003, there were 1,058 clients with full records on file and registered in the computer database. Most of the clients referred to psychiatric examination were torture victims (621). Another 437 clients were refugees or internally displaced persons who could not be qualified as torture victims but have nevertheless approached the centre because of

serious psychic problems caused by other war and post-war stressors; some of them were also family members of torture victims.[1]

Therefore CRTV staff has also provided psychological and psychiatric assistance to individuals who were not torture victims in the strict sense of the word as defined in the UN Convention Against Torture.[2] Even when the experience through which the client had been through could not have been classified as torture in the strict sense of the word, it is certain that all clients who have been provided with assistance in CRTV fall into the category of people "with serious psychic problems" and that their discomfort was related to traumatic war events or police brutality.

Client registration and documentation

Documentation about clients has been kept in accordance with the standardised procedure. All clients who have approached CRTV were registered through the "Client lists". For the clients who were assessed during triage as having serious psychic problems for which psychiatric assistance was necessary an appropriate documentation was formed, consisting of the Socio-demographic data list, completed by the psychiatrist during and after the interview with the client, as well as of a battery of psychological and psychiatric tests given and applied by psychologists. The precondition for application of these tests was the signed informed consent of the client. All data collected in writing were entered in the electronic database.

In the course of our work we have been unable to collect all planned information about clients and to complete all planned tests, due to the following reasons:

- Inability of client to provide appropriate information (illiteracy, old age, nature of disability or illness)
- Open refusal of clients to give their informed consent to the application of testing material or refusal to reveal any other information about themselves apart from the basic ones
- Passive resistance to testing (despite the signed informed consent) characterised by superficial, incomplete and incorrect filling in the data, which were subsequently assessed as invalid documents

1 With the view of simplifying the terminology used in this text, we shall refer to the group of torture survivors as "the tortured" in contrast to the other group refered to as "non tortured".

2 UN Convention Against Torture, Article 1 (1984): Torture is "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person 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. "

- Inability to apply the complete battery of tests in situation of time limit in contact with clients, such as the situation of mobile CRTV team visit to collective centres, when the priority was to provide immediate assistance to clients
- Refusal of the offered psychological and psychiatric assistance by clients who have selectively requested and obtained legal and/or medical aid

Incomplete information has led to a quite varied database. While the basic demographic data were registered for the vast majority of clients, some more specific demographic data as well as all clinical, psychological and psychiatric data could be registered only for about one third of all clients.

Sample, framework and selection

Out of 1,058 registered clients, 621 of them are torture victims. The remaining 437 were mainly refugees or internally displaced persons who have approached the Centre for assistance in their serious psychic problems related to war experience, or family members of torture victims.

The majority of clients torture victims already had appropriate documentation related to captivity (ICRC certificate or the certificate of the Federal Commission for Exchange of Prisoners attached to the Ministry of Defence of FR Yugoslavia) and many of them were already members of the "Association of Former Camp Detainees from War in 1991", located in Belgrade. We have attached to this article a list of camps/prisons where our clients have been tortured. This list relates to 367 clients (a part of the overall number).

CLINICAL ASSESSMENT

Clinical assessment was conducted during medical examinations and encompassed a psychiatric clinical interview and application of psychological and psychiatric tests led by a psychologist. For the purpose of this paper we have used the data obtained though the application of following tests:

1) **Client list,** questionnaire that is filled in during first and each following contact with the client. A total of 865 clients have filled in this questionnaire (519 torture survivors and 346 persons without torture experience). The questionnaire contains the following sections:
   a) General demographic data,
   b) Registering problems for which the client is seeking help, with a list of experienced stressful events (violence, war and exile, civilian casualties, health, family and emotional problems, as well as problems in communicating with other people),

c) Psychological assessment of the client by therapist and registering psychopathological phenomena shown by the client during the interview, and

d) Type of intervention applied by therapist

2) **List of basic socio-demographic data** in the form of semi-structured psychiatric interview designed for working with clients in CRTV. So far 353 clients have filled in this list (256 torture survivors and 97 people without torture experience). The list is composed of the following parts:

a) General demographic data (gender, age, marital status, education level)

b) Data related to current and pre-war social status (current and pre-war residence, vocation and type of employment, family situation, social circumstances, social welfare or humanitarian aid)

c) Data related to exile

d) Data related to war (stressful experiences such as wounding, captivity, loss of close persons and loss of property)

e) Description of current and previous health (somatic and psychic) problems and discomforts

f) Data related to psychomotoric and psychosocial development in childhood and youth

g) Data related to heredity of psychiatric disorders

h) Detailed information related to the torture experience

3) **Structured Clinical Psychiatric Interview** (SCID-I; First, Gibbon, Spitzer & Williams, 1996) was used to establish psychiatric morbidity. Interviews were held with 301 clients (220 torture survivors and 80 persons who did not have the experience of torture).

4) **Clinician Administered PTSD Scale** (CAPS; Blake et al., 1990) was used to diagnose posttraumatic stress disorder and assess the prominence of posttraumatic symptoms and clusters of this disorder. The scale was applied on 288 clients (213 torture survivors and 75 persons who did not have the experience of torture).

5) **Impact of Event Scale** (IES; Horowitz, Wilner & Alvarez, 1979) was also used to assess posttraumatic symptoms. The scale was applied with 826 clients (494 torture survivors and 332 persons who did not have the experience of torture).

6) **Symptom Check List Scale - revised version** (SCL-90-R; Derogatis, 1983) was used to assess the general psychopathological symptoms. The scale was filled in by 865 clients (519 torture survivors and 346 persons who did not have the experience of torture).

Psychiatric diagnosis was established on the basis of the clinical assessment made by the psychiatrist, upon psychiatric examination, in accordance with Tenth International Classification of Disorders by World Health Organisation (ICD-10).

STATISTICAL ANALYSIS

When processing the data collected, we have used standard descriptive and analytical statistical methods: establishing mean value and standard deviation, Student's t-test and chi-square test.

RESULTS

GENERAL DEMOGRAPHIC CHARACTERISTICS

Gender structure was different in relation to experience of captivity and torture. There were significantly more men in the overall number of clients, mainly due to their considerable dominance in the group of torture victims (Table 1).

Table 1. Gender structure

	Tortured		Non-tortured		Total	
	n	%	n	%	n	%
Male	528	85.0	258	59.0	786	74.3
Female	93	15.0	179	41.0	272	25.7
Total	621		437		1058	

Pearson's chi-square: $?^2 = 90.68$, $p < 0.01$

Average age of CRTV clients was 45.69 ± 13.29 years of age (span from 14 to 81), with an average 10.72 ± 3.70 years of schooling. Clients with torture experience were significantly older.

Table 2. Age of CRTV clients (n = 784)

	Tortured n = 472	Non-tortured n = 312	t-test
Age	48.25 ± 12.28	41.82 ± 13.83	t = 6.82*

Values are given as: mean value ± standard deviation; $p < 0.01$

Two groups have differed significantly with regard to marital status. (Table 3)

Table 3. Marital status

	Tortured n=519		Non-tortured n=344	
	Number	Percent	Number	Percent
Separated	41	7.90	40	11.59
Single	70	13.49	72	20.87
Married	367	70.71	189	54.78
Widowed	17	3.28	27	7.83
Divorced	24	4.62	16	4.64

Pearson's chi-square: $?^2 = 26.5$, $p < 0.01$

With regard to years of schooling there was no significant difference between tortured and non-tortured individuals (Table 4) but the groups differed in the level of attained education by clients (Table 5).

Table 4. Years of schooling

	Tortured N=260	Non-tortured N=172	t-test
Years of schooling	10.45 ± 3.29	11.13 ± 4.26	t = -1.87, p = n.s.

Table 5. Level of attained education

	Tortured N=519		Non-tortured N=346	
	n	%	n	%
No education	58	11.18	66	19.08
Incomplete primary school	14	2.70	5	1.45
Primary school	117	22.54	51	14.74
Secondary school	260	50.10	186	53.76
Student	0	0	7	2.02
Advanced school	26	5.01	13	3.76
High school / university	44	8.48	18	5.20

Pearson's chi-square: $?^2 = 31.9$, $p < 0.01$

Employment structure of CRTV clients given in Table 6 shows a highly unfavourable existential situation of all CRTV clients. We have established no difference between the two groups with regard to employment structure, but there is an obvious difference in the status of employment of both group members in two time points, before and after the war.

Table 6. Employment of CRTV clients, before the war and in current exile

	Employment before the war in percent[†]		Employment in current exile in percent[‡]	
	T (n=256)	NT (n=97)	T (n=519)	NT (n=346)
Unfit for work	*	*	20,4	24,3
Unemployed	11,7	26,8	17,0	21,7
Employed	76,2	60,8	0	0
Black labour market	0	0	62,6	54,0
Pupil / student	4,7	2,1	*	*
Pensioner	2,0	5,2	*	*
Other	5,5	5,2	*	*

[†] Data used from Client's List, [‡] Data used from Client's List sociodemographic data section, * no data available, T = tortured, NT = non-tortured

Both tortured and non-tortured clients most often sought psychological assistance. Significantly higher number of torture victims requested medical help, while non-tortured clients opted for legal aid. Legal aid most often required by non-tortured clients was related mainly to issues of return to community of origin and restitution of property (Table 7).

Table 7. Type of assistance requested by CRTV clients

	Tortured n=519		Non-tortured n=346		?^{2}	p <
Type of assistance	n	%	n	%		
Information	265	51.1	183	52.9	0.28	n.s.
Psychological assistance	366	70.5	224	64.7	3.19	n.s.
Medical aid	119	22.9	44	12.7	10.09	0.01
Legal aid	99	19.1	98	28.3	14.16	0.01
Material assistance	49	9.4	17	4.9	6.04	0.05
Protection from violence	2	0.4	1	0.3	0.06	n.s.

Most frequent lifetime stressors of our clients (excluding captivity) were of material and existential nature and related mainly to loss of property and current social status (Table 8).

Table 8. Most frequent life problems and lifelong stressful events

	Tortured n=519		Non-tortured n=346		$?^2$	p <
List of problems and events	n	%	n	%		
Captivity	519	100.0	0	0		
Loss of property	361	69.6	239	69.1	0.02	n.s.
Material problems	281	54.1	207	59.8	2.72	n.s.
Existential problems	236	45.5	168	48.6	0.79	n.s.
War plight	171	32.9	84	24.3	7.51	0.01
Participation in war	244	47.0	127	36.7	9.00	0.01
Loss of close person in war	101	19.5	86	24.9	3.56	n.s.
State organised violence	87	16.8	20	5.8	23.10	0.01
Chronic somatic disease	107	20.6	47	13.6	7.02	0.01
Chronic psychiatric disorder	92	17.7	15	4.2	34.34	0.01
Physical injuries	76	14.6	8	2.3	30.00	0.01
Disability / invalidism	71	13.7	52	15.0	0.31	n.s.

Most of our clients, over 70 % of them, had their pre war residence in Croatia (Table 9). The difference between the two groups is due to the higher percentage of torture victims from Bosnia-Herzegovina and a higher percentage of non-tortured from Serbia and Montenegro, including Kosovo.

Table 9. Permanent place of residence

	Tortured n=256		Non-tortured n=97	
Pre-war residence	n	%	n	%
Republic of Croatia	196	76.56	68	70.10
Republika Srpska (RS)	5	1.95	1	1.03
Bosnia and Herzegovina (excl. RS)	38	14.84	8	8.25
Kosovo	7	3.73	11	11.34
Serbia and Montenegro (excl. Kosovo)	10	3.91	9	9.28

Pearson's chi-square: $?^2 = 17.08$, $p < 0.01$

ADAPTATION TO REFUGEE STATUS AND NEW LIVING ENVIRONMENT

CRTV clients have demonstrated a highly negative attitude towards return in their community of origin (Table 10). Almost half of the clients expressed their plans to immigrate to third country (Table 11). Although a number of clients had unpleasant experiences as refugees (Table 13) about 50% of clients nevertheless feel accepted in their new environment (Table 12, Table 14).

Table 10. Attitude toward return

	Tortured (n=256)		Non-tortured (n=97)	
Plans to go back to the place of origin:	n	%	n	%
No, regardless of conditions	219	85,5	74	76,3
Not for the time being	19	7,4	11	11,3
Not sure	12	4,7	3	3,1
When right conditions are created	6	2,3	9	9,3
Yes, have initiated procedure	0	0	0	0

Pearson's chi-square: $?^2 = 10.38$, $p < 0.05$

Table 11. Attitude toward migrating to third country

	Tortured (n=256		Non-tortured n=97)	
Plans to emigrate from the country:	n	%	n	%
No	143	55,9	61	62,9
Yes, but has not worked on it	37	14,5	13	13,4
Yes, emigration procedure under way	76	29,7	23	23,7

Pearson's chi-square: $?^2 = 1.55$, p = n.s.

Table 12. Feeling of being accepted by local population

	Tortured (n=256)		Non-tortured (n=97)	
Feels accepted:	n	%	n	%
Not at all	27	10,5	21	21,6
Partly	34	13,3	18	18,6
Yes and no	57	22,3	21	21,6
Mainly yes	115	44,9	25	25,8
Completely accepted	23	9,0	12	12,4

Pearson's chi-square: $?^2 = 15.04$, $p < 0.01$

Table 13. Unpleasant experiences related to exile

	Tortured (n=256)		Non-tortured (n=97)	
Did the person have unpleasant experiences as a refugee:	n	%	n	%
Not al all	83	32,4	31	32,0
Somewhat	86	33,6	35	36,1
Yes and no	50	19,5	18	18,6
Mainly yes	31	12,1	9	9,3
Experienced unpleasant things	6	2,3	4	4,1

Pearson's chi-square: $?^2 = 3.46$, p = n.s.

Table 14. Experience in establishing relations of friendship with local population

	Tortured (n=256)		Non-tortured (n=97)	
Have made friends among local population:	n	%	n	%
Not at all	25	9,8	18	18,6
Some	41	16,0	17	17,5
Yes and no	39	15,2	15	15,5
Mainly yes	123	48,0	34	35,1
Completely accepted	28	10,9	13	13,4

Pearson's chi-square: $?^2 = 7.60$, p = n.s.

WAR AND CAPTIVITY

Up to 44,2% of clients had war related physical injuries. Significantly higher is the percentage of torture victims: 51,6% compared to 21,6% of non-tortured CRTV clients (Table 15).

Table 15. Physical trauma during war

	Tortured (n=256)		Non-tortured (n=97)	
	n	%	n	%
Yes	132	51,6	21	21,6
No	124	48,4	76	78,4

Pearson's chi-square: $?^2 = 25.63$, $p < 0.01$

Data on duration of captivity were obtained for 240 torture victims. Table 16 shows the distribution by time span, from which it can be seen that approximately one quarter of torture victims have spent up to 10 days in captivity, almost half of them remained captive for one month, three quarters of torture victims spent less than three months in captivity, while 95% of them remained in captivity for less than a year. Average duration of captivity for 239 torture victims was 122,07 ± 351,35 days.

Table 16. Time spent in captivity by CRTV clients, torture victims

Duration of captivity	Number of prisoners (n=240)	Percent	Cumulative percentage
Up to 10 days	58	24,2	24,2
11 – 30 days	51	21,3	45,4
1 – 2 months	35	14,6	60,0
2 – 3 months	44	18,3	78,3
3 – 6 months	32	13,3	91,7
From 6 months to 1 year	6	2,5	94,2
1 – 2 years	6	2,5	96,7
2 – 3 years	1	0,4	97,1
3 – 4 years	1	0,4	97,5
4 – 5 years	3	1,3	98,8
5 – 6 years	1	0,4	99,2
Over 6 years	2	0,8	100,0

A more detailed explanation of types of torture experienced by CRTV clients is given elsewhere in this monograph.

MORBIDITY

Average duration of health problems upon arrival to CRTV was (N = 226) 65.24 ± 42.69 months for clients torture victims, significantly longer than with non-tortured ones (N = 85) 53.88 ± 49.26 months ($t = 2.0$, $df = 309$, $p < 0.05$). Clients - torture victims had significantly more chronic health problems and more often had requested psychiatric assistance before coming to the CRTV (Tables 17, 18, 19).

Table 17. Duration of health problems in CRTV clients

	Tortured (n=226)		Non-tortured (n=85)	
	n	%	n	%
No problems	29	12.8	14	16.5
1 - 12 months	20	8.8	14	16.5
1 – 2 years	8	3.5	7	8.2
2 – 4 years	23	10.2	8	9.4
Over 4 years	146	64.6	42	49.4

Table 18. Previous psychiatric treatment before coming to CRTV

	Tortured (n=256)		Non-tortured (n=97)	
	n	%	n	%
Yes	77	30,1	18	15,96
No	179	69,9	79	84,04

Pearson's chi-square: $?^2 = 3.91$, $p < 0.05$

Table 19. Psychiatric diagnosis prior to treatment in CRTV

	Tortured (n=256)		Non-tortured (n=97)	
	n	%	n	%
PTSD	54	21,09	4	4,26
Depressive disorders	10	3,90	5	5,32
PTSD + Depressive disorder	10	3,90	0	0
Anxiety disorders	6	2,35	6	6,38
No diagnosis	176	68,76	79	84,04

Table 20 shows that most clients requested assistance primarily due to psychic discomforts and problems.

Table 20. Type of health problems for which the clients requested assistance in CRTV IAN

	Tortured (n=256)		Non-tortured (n=97)	
	n	%	n	%
Only somatic problems	28	10,94	16	16,50
Only psychic problems	124	48,44	54	55,67
Psychic + somatic problems	77	30,08	16	16,50
No health problems	27	10,54	11	11,39

The structured diagnostic interview for DSM-IV (SCID-I) was conducted with CRTV clients. About 60% of clients had more than one psychiatric diagnosis (Table 21).

Table 21. Psychiatric morbidity in CRTV clients (based on SCID-I)

Number of psychiatric diagnoses	Tortured (n=220)		Non-tortured (n=81)	
	n	%	n	%
No psychiatric diagnosis	19	8,6	11	13,6
One psychiatric diagnosis	72	32,7	22	27,2
Two or more psychiatric diagnoses	129	58,7	48	59,2

Table 22. Psychiatric diagnoses established on the basis of SCID-I

	T (n=220)	NT (n=81)	$?^2$	p <
No psychiatric diagnosis	19	11		
Isolated PTSD (current or healed)	39	11		
PTSD + one or more psychiatric disorders	140	46		
Current major depressive episode	42	22		
Previous major depressive episode	52	20		
Current manic episode	2	0		
Previous manic episode	1	0		
Current hypomanic episode	1	1		
Previous hypomanic episode	2	6	9.69	0.01
Dysthymic disorder	44	12		
Psychotic and combined symptoms	0	4	11.04	0.01
Bipolar disorder	2	3		
Major depressive disorder	31	13		
Alcohol abuse disorder	26	6		.
Alcohol dependency	10	1		
Non-alcoholic substance abuse	1	1		
Non-alcoholic substance dependency	1	0		
Panic disorder	13	11	4.78	0.05
Panic disorder with agoraphobia	12	5		
Agoraphobia without panic disorder	5	4		
Social phobia	5	5		
Specific phobia	16	12	4.05	0.05
Generalised anxiety disorder	13	3		
Obsessive-compulsive disorder	8	4		
Anxiety disorder NOS	2	2		
Somatisation disorder	8	2		
Pain disorder	10	4		
Non-differentiated somatophorm disorder	2	1		

	T (n=220)	NT (n=81)	$?^2$	p <
Hypochondriasis	6	2		
Dysmorphophobic disorder	1	1		
Eating disorder	9	4		
Adjustment disorder	1	3		

Chi-square values are given only for statistically relevant differences between groups, T = tortured, NT = non-tortured

Table 23. Psychiatric diagnoses for CRTV clients established on the basis of SCID-I, by groups of diagnoses (only current diagnoses)

	Tortured (n=220)		Non-tortured (n=81)	
	n	%	n	%
PTSD	136	61,8	48	59,3
Depressive disorders	79	36,7	32	40,5
Anxiety disorders	52	24,2	27	34,2
Somatophorm disorders	24	11,2	8	10,1
Alcohol abuse / dependency	29	13,5	6	7,6
Other disorders	13	6,0	8	10,1

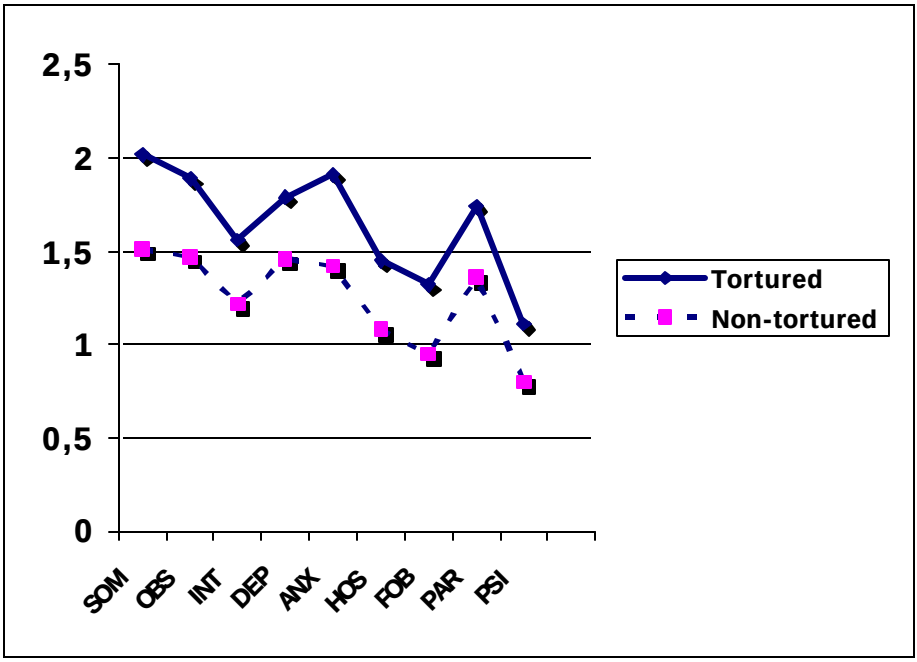
Together with current posttraumatic stress disorder (diagnosed in 60% of clients), the most frequently established diagnosis was one of the depressive disorders (40%), two times less anxiety disorders (26,3%) and rarely the diagnosis of alcohol abuse, somatophorm and other disorders. There is a significant difference in alcohol abuse/dependency, which has been established twice as frequently in torture victims than in non-tortured individuals (Table 23).

GENERAL PSYCHIATRIC SYMPTOMATOLOGY

A total of 865 clients have filled in the SCL-90-R. The test result analysis has shown a persuasive difference in prominence of current psychiatric symptomatology with significantly higher scores in the subgroup of torture victims (Table 24 and Picture1)

Table 24. Difference in mean score value in relation to symptom dimensions on SCL-90-R between torture victims and non-tortured CRTV clients

Scale	Groups	n	M	SD	t	p <
Somatisation	non-tortured	346	1.51	1.02	-7.12	0.01
	tortured	519	2.02	1.04		
Obsessiveness	non-tortured	346	1.47	0.98	-6.23	0.01
	tortured	519	1.89	0.97		
Interpersonal sensitivity	non-tortured	346	1.22	0.92	-5.25	0.01
	tortured	519	1.56	0.97		
Depressiveness	non-tortured	346	1.46	0.93	-5.14	0.01
	tortured	519	1.79	0.94		
Anxiety	non-tortured	346	1.42	1.06	-6.75	0.01
	tortured	519	1.91	1.06		
Hostility	non-tortured	346	1.08	0.91	-5.49	0.01
	tortured	519	1.45	1.02		
Phobic anxiety	non-tortured	346	0.95	0.91	-5.51	0.01
	tortured	519	1.32	1.02		
Paranoid disorder	non-tortured	346	1.36	0.94	-5.46	0.01
	tortured	519	1.74	1.01		
Psychoticism	non-tortured	346	0.80	0.81	-5.32	0.01
	tortured	519	1.11	0.88		



Picture 1. Graphic representation of mean values for 9 psychopathological dimensions derived from SCL-90-R in CRTV clients (scale scope from 0 to 4) for both tested groups. SOM=somatisation, OPS=obsessieveness, INT=interpersonal sensitivity, DEP=depressiveness, ANX=anxiety, HOS=hostility, FOB=phobia, PAR=paranoid disorder, PSI=psychoticism

POSTTRAUMATIC STRESS DISORDER

For 288 CRTV clients we have applied CAPS-DX. While an equal percentage of both torture victims and non-tortured individuals met the criteria for diagnosing current PTSD, among those without current PTSD there was a higher number of individuals with earlier healed PTSD in the group of torture victims than in the group of non-tortured clients (20,2% compared to 12% of non-tortured) (Table 25).

Table 25. PTSD diagnosis for CRTV clients established through CAPS-DX

	Tortured (n=213)		Non-tortured (n= 75)	
	n	%	n	%
Without PTSD	34	16,0	18	24,0
Current PTSD	136	63,8	48	64,0
Previous healed PTSD	43	20,2	9	12,0
Total PTSD	*179*	*84,0*	*57*	*76,0*

Pearson's chi-square: $?^2 = 4.04$, p = n.s.

Table 26. Comorbidity of PTSD and other psychiatric disorders

	Tortured (n=208)				Non-tortured (n=73)			
	+PTSD (n=132)		No PTSD (n=76)		+PTSD (n=47)		No PTSD (n=26)	
	n	%	n	%	n	%	n	%
Depressive disorders	63	47,7	13	17,1	26	55,3	5	19,2
Anxiety disorders	37	28,0	13	17,1	19	40,4	8	30,8
Somatophorm disorders	17	12,9	6	7,9	4	8,5	4	15,4
Alcohol abuse / dependency	15	11,4	13	17,1	4	8,5	1	3,8
Other disorders	9	6,8	3	3,9	5	10,6	1	3,8

The difference in number is due to the fact that 12 torture victims and 8 non-tortured individuals do not have both tests, but only SCID-I or CAPS.

From the overall number of clients diagnosed with posttraumatic stress disorder, only 21,8% of torture victims and 19% of non-tortured have the isolated PTSD. The remainder of about 80% of clients with PTSD also have some of the combined current psychiatric disorders (Table 26). In both sub-groups the most frequent is the comorbidity of PTSD with some of the depressive disorders (current major depressive episode, dysthymic disorder and non-specific depressive disorder). Comorbidity with anxiety disorders is somewhat more frequent in non-tortured individuals, while the comorbidity of alcohol abuse occurs more often in torture victims.

With regard to symptomatology the most prominent difference was in clusters of hyper-arousal (Table 27).

Table 27. Difference between mean score values per symptom groups and in overall score in CAPS

CAPS-DX		N	M	SD	t	P <
Intrusion symptoms	non-tortured	75	8.99	7.60	-.92	0.06
	tortured	213	11.15	8.67		
Avoidance symptoms	non-tortured	75	12.99	10.33	-.63	0.53
	tortured	213	13.90	10.95		
Hyper-arousal symptoms	non-tortured	75	9.61	8.00	-.13	0.03
	tortured	213	12.12	9.03		
TOTAL SCORE	non-tortured	75	31.59	24.37	-.59	0.11
	tortured	213	37.17	26.81		

Although negative scores in the area of subjective, social and professional functioning were higher for torture victims, they were not statistically higher to a significant extent (Table 28).

Table 28. Subjective discomforts, social and professional functioning

		N	M	SD	T	p =
Subjective discomforts	non-tortured	75	1,72	0,99	-1,52	0,13
	tortured	213	1,92	0,98		
Social functioning	non-tortured	75	1,39	1,05	-0,82	0,41
	tortured	213	1,49	0,93		
Professional functioning	non-tortured	75	1,29	1,04	-0,43	0,67
	tortured	213	1,35	1,00		

On the Impact of event scale (IES), filled in by many more clients than were diagnosed based on the CAPS-DX interview, significantly higher scores were registered in clients torture victims than non-tortured clients, both on overall score and in sub-scales of intrusion and avoidance symptoms.

Significantly higher score was also registered for torture victims on the IES sub-scale related to dissociative symptoms and memo ry disorders (Table 29).

Table 29. Difference in mean score values on the Impact of event scale

Impact Of Event Scale	Groups	N	M	SD	t	df	P <
Intrusion symptoms	non-tortured	332	18.67	10.20	-5.37	824	0.01
	tortured	494	22.48	9.86			
Avoidance symptoms	non-tortured	332	20.91	10.18	-3.98	824	0.01
	tortured	494	23.71	9.76			
TOTAL SCORE	non-tortured	332	39.58	18.75	-5.06	824	0.01
	tortured	494	46.20	18.20			

DISCUSSION

IAN Centre fro Rehabilitation of Torture Victims was established with the aim of providing assistance to torture victims in FR Yugoslavia (now Serbia and Montenegro). In the initial project we have made no discrimination between "war" and "civilian" torture victims, but in practice it has turned out that almost all clients who came to seek assistance in CRTV during past two and a half years came with an experience of torture or other trauma related to war or exile. Over 95% of clients were refugees or internally displaced persons. Almost all clients with torture experience have been subjected to torture in their domicile countries - Croatia, Bosnia and Herzegovina and Serbia (Kosovo). [3]

Although some estimations say that there are probably about 5000 persons who have been detained and tortured during wars between 1991 and 1995 and subsequently exiled to Serbia and Montenegro, CRTV was approached by a significantly smaller number of people (it should be taken into account that contact with numerous torture victims was the result of centre's proactive work and not clients themselves - namely, 708 clients were treated through mobile team interventions).

We can speculate about reasons for which most of these people have not requested any form of assistance in CRTV: lack of information about CRTV existence (especially in the country, in derelict and isolated refugee camps), avoidance of re-traumatisation by those who avoided any contact that could remind them of their traumatic experience, relatively good life (health) functioning with little or no problems related to torture experience or, to the contrary, inability to seek assistance due to severe consequences of torture. Simpson (1993) claims that torture victims who have been studied are usually not typical: those who had little or no problems do not seek assistance, while some of those with severe

3 The appendix to this paper contains a partial list of detainee camps/ prisons weher IAN CRTV clients had been tortured (key source for this list were the Lists of sociodemographic data).

consequences are never in a position to request help, as well as those who have not lived long enough to be registered as victims.

As stated previously, 59% of registered clients were torture victims. The rest were mainly refugees and internally displaced persons seeking assistance due to serious psychic problems resulting from war experience, while family members of torture survivors account for an even smaller number of clients. These people came to CRTV having obtained the information through friend, institutions or in the media; even when their understanding of the CRTV role did not correspond to programmatic aims of the centre, they have not been denied assistance.

Some of these people were convinced they were torture victims because their understanding of the concept of torture was too broad. In any case, these individuals did have serious psychic and other problems, related to war-induced trauma. Some of them thought torture also encompasses policy of instability, ethnic discrimination, various forms of intimidation and demonstration of force, with more or less overt threats by their neighbours, members of majority population, encouraged by the raging media campaign directed by the state from which they finally fled, judging that their lives and lives of their families were in danger. Some of them believed that torture also included what they saw as "house arrest", irrespective of the fact that their impossibility to leave their apartments did not come enforced by the state, but their general living circumstances including freedom of movement and speech were significantly threatened due to neglect by government bodies and their failure to protect the rights and security of their citizens not belonging to majority population. Such is the example of about a hundred CRTV clients, citizens of Pristina and other towns in Kosovo, who did not dare go out of their homes into the street or go to a shop during 1999 and 2000 only because they are Serbs. They survived only thanks to individual friendships or care and mercy of their Albanian neighbours who thereby exposed themselves to the risk of being attacked by extreme nationalists of their own ethnicity.

Special category of people are men with refugee status in FRY who have been forcibly taken to Republic of Serb Krajina (Croatia) or Republika Srpska in Bosnia and handed over to the paramilitary or military forces in these territories and forced to engage in war activities in these units. The question arises whether forcible mobilisation in itself constitutes an act of torture or would this be the case only if physical force or retaliation were applied.[4] Similar to this was the relatively frequent work obligation related to forced labour in life threatening circumstances: digging trenches at the frontlines between to warring parties or forced participation in de-mining the terrain.[5]

4 Client "MM043" who filled in the "Types of Torture" questionnaire and provided an affirmative answer to certain questions, was forcibly taken to the frontline but was not officialy detained in a registered detention facility nor subjected to acts of torture in terms of interrogation.

5 Client "ŽŠ004" of Serbian nationality, resident of a town in Central Bosnia in which there were conflicts throughout the war, was forced by Muslim authorities to perform life threatening activities on a daily basis, unarmed in the zone of combat, digging trenches, clearing the terrain and crossing through parts of territory suspected to be mined.

In practical work with clients we have made no discrimination between torture survivors and other CRTV clients. Depending on observed problems and diagnosed state of clients' health, adequate psychological, psychiatric, medical and legal assistance was provided.

The two compared groups of clients were different in their general demographic characteristics. While in the group of "non-tortured" clients men were only slightly more numerous then women, in the group of "tortured" they accounted for four fifths of the overall number. This registered gender misbalance was not unexpected given the active role of men in war, which makes them a more likely target for neutralisation, capture and exposure to military and police investigation procedure of the enemy side, often including torture with the aim of extorting information, intimidation, humiliation or brutal revenge.

Age difference was linked to gender structure of the compared groups: men and women torture victims were of the same age, but the non-tortured individuals were predominantly men over 60 or women up to 40 years of age. As concerns marital status, the difference between groups was that separated men and widows were more numerous in the non-tortured group (in the overall number of separated individuals there were 40 men and 2 women, while in the overall number of widowed individuals there were 33 women and 8 men). Higher number of widows than widowers was most probably the consequence of husbands being killed in war, while the significantly higher number of separated men could indicate the problem of breaking up of mixed marriages, leaving the wife in her domicile community.

The CRTV project did not envisage material aid for clients and they were informed accordingly before coming to CRTV - therefore the percentage of those who requested material assistance was relatively small.

Material (property status, income, expenses) and existential problems (social status, employment, housing) were very prominent among CRTV clients. Over one half of clients in both groups have stated the precarious material and existential situation as one of their most difficult current problems. Over two thirds of clients have lost their property due to exile. None of the clients had a steady employment during treatment in CRTV. Almost all those with stable employments before the war have been working on the black labour market, getting underpaid jobs, usually below their real professional qualifications. Many of them were involved in petty commerce (black market, smuggling), which was tacitly condoned by the state in the years of economic sanctions. Data on socio-economic status registered for our clients do not differ in the two surveyed groups, since their current social and material status is greatly determined by their common destiny of exile. Data from this research are mainly in accordance with data obtained in other studies. Unlike Bosnian torture victims who have been employed in 18% of cases (in comparison with their pre-war employment status of 24%), torture victims – CRTV clients are in a more difficult position as currently completely unemployed: they did not have a chance to return to their pre-war workplace after cessation of conflict, in contrast with some of Bosnian torture victims who had this opportunity.

Nevertheless, although the exile has led them to pauperisation and social devaluation, very few of them wish to return to their communities of origin.

Negative attitude towards return, as could be expected, is more pronounced among torture victims whose traumas stem mainly from the community of origin. Such high percentage of persons who expressed a which to move to a third country could be explained, by the generally difficult economic situation in FRY (now Serbia and Montenegro) and especially the precarious economic situation of the refugees themselves (as already stated in the overview of employment structure). The other reason could be of political nature and would relate to the feeling of insecurity in a country that was more or less actively involved in several wars in the Balkans over the past decade. Individual (and family) feeling of insecurity is probably linked to the illegal action in 1995 when by order of the then authorities Serbian police arrested and handed over refugee men to military and paramilitary organisations in Republika Srpska (Bosnia) and Republic of Serb Krajina (Croatia).

In general, CRTV clients are somewhat reserved towards their new environment - over two thirds of them stated they had unpleasant experiences only because of their refugee status. About a half of clients feels accepted in the new environment. This percentage is significantly higher among torture victims. It should be taken into consideration that the new environment for them represented a concrete and symbolic release and refuge from the trauma of captivity and torture, as well as that torture survivors, at least in the beginning, have a higher orientation towards freedom from suffering than towards regaining social and economic status (which is probably more relevant for the non-tortured individuals). Torture victims were more inclined to establish new relations of friendship among local population.

Significantly higher number of clients - torture victims had physical trauma during the war, which leads to conclusion that these were mostly torture related injuries. Nevertheless, this should be taken with caution since torture victims (who in our sample were predominantly men) have taken part in combat activities during which they could have been wounded. In accordance with these data are the ones pertaining to discomforts related to physical injuries: significantly higher is the number of torture victims.

A large number of clients have been diagnosed with a medical (somatic or psychiatric) disorder for the first time during treatment in CRTV. Although CRTV offers general medical and psychological-psychiatric assistance, the focus of work was on the latter, for which CRTV had adequate material and human resources since the very beginning. The number of torture victims with combined psychic and somatic problems was significantly higher than the number non-tortured individuals with such problems, which could be explained on one hand by the direct adverse effect of captivity and torture on physical health, and on the other by indirect adverse effect of the prolonged psychic trauma (chronic PTSD) on somatic health.

There were only 11% of clients who came to CRTV without health problems in first contact (equal percentage of tortured and non-tortured) and these are most probably clients who requested only legal or material aid.

A substantial number of newly diagnosed disorders could be explained by the correct and systematic approach to clients offered by CRTV. Refugees and internally displaced persons rarely went to private medical institutions for medical assistance due to their poor socio-economic status. Although the state health institutions were more accessible for refugees and IDPs, they were unable to provide such a detailed and systematic examination.

It is known that epidemiological data on morbidity in general population do not correspond to reality since a great number of diseases remains undiagnosed due to subjective or objective shortcomings in communication between the health system and citizens, and it could be assumed that this is particularly true in the case of refugees and IDPs. This could not be explained by saying that these newly diagnosed diseases occurred more recently and in short period of time, since 85% of torture victims and 70% of non-tortured individuals have had these discomforts for over two years. The present data indicate the fact that there are a vast number of non-diagnosed diseases among refugee and displaced population and that overburdened and organisationally obsolete health and social welfare system was unable to provide adequate treatment to this (sub)population.[6]

Our results were mainly in accordance with the results presented by Van Ommeren and associates (2001) who have researched the impact of torture on the distribution of psychiatric disorders among tortured and non-tortured Bhutanese refugees in Nepal. In our sample the most frequent diagnosis of current psychiatric disorder was also the PTSD, followed by a diagnosis of a depressive or anxiety disorder.

Other diagnoses have been less frequent; it is important to mention that the diagnosis of alcohol abuse or dependency was established twice as often in the group of torture victims: the explanation for this can be found in the uneven gender structure of the torture victims group, and earlier epidemiological studies have shown that men are two to five times more prone to alcohol abuse/dependency (out of 35 clients diagnosed with alcohol abuse/dependency only two were women).

Torture victims and non-tortured individuals in our sample differed greatly by the prominence of psychic problems, measured by SCL-90-R, in all psychopathological dimension of the test. Although the two groups did not have a statistically significant difference with regard to distribution of psychiatric diagnoses (meaning that persons from both groups had the same risk of developing a psychiatric disorder) this test has shown that the intensity of psychic problems was more pronounced in torture victims. These results correspond to the research done by Roncevic-Grzeta and associates (2001), who have used the Hamilton scale of depression to show that torture victims, more than other traumatised groups (such as refugees) demonstrate clinically pronounced depression, as well as with the findings of Strestha and associates (1998) who have registered that torture victims have a higher anxiety and depressiveness score in SCL than non-tortured individuals.

6 These data should be combined with those presented in the paper "Somatic diseases of CRTV clients - one year experience of Median" in this monograph

Most of the PTSD patients have at least one additional disorder and that a significant number of them fulfil diagnostic criteria for two or more psychiatric disorders. One of the reasons cited for such high comorbidity is the significant overlap of PTSD with a variety of psychiatric disorders, especially depressive and anxiety disorders and psychoactive substance abuse. Research on torture victims diagnosed with PTSD has shown the same pattern of comorbidity as the earlier research on war veterans. Our results are in accordance with most of the earlier research. Only 20% of CRTV clients have the isolated PTSD. The remaining 80% of clients with PTSD who have an accompanying combined psychiatric disorder, the most frequent is the comorbidity with depressive disorders.

Results of this research have shown that most of the diagnosed disorders (both in tortured and non-tortured clients) were combined with PTSD, which indicates that psychiatric morbidity of CRTV clients in most cases was related to traumatic stress resulting from war events (combat, torture and exile).

About 60% of torture victims and non-tortured CRTV clients diagnosed with current PTSD (either through SCID-I or CAPS-DX), which is significantly more that determined by de Jong and associates (2001) who have established a PTSD prevalence from 15.8% in Ethiopia to 37.4% in Algeria on their four samples of refugees.

Torture victims, CRTV clients, had PTSD more often than non-tortured individuals, although this was not on the level of statistically significant difference.

This result is in accordance with the results obtained by Momartin and associates (2003) who did not establish a difference in the risk of being affected by PTSD between the group most highly exposed to human rights violations (captivity in concentration camps, torture) and the group exposed to general war related trauma, meaning that this not confirm the findings by Silove and associates (2002) who established that torture predicts PTSD symptoms most highly that any of the researched traumatic factors.

Although the two groups did not differ with regard to the risk of PTSD development, there was a significant difference in terms of prominence of posttraumatic symptoms established by CAPS-DX: symptoms were more intensive in torture victims CRTV clients. Significant difference ($p < 0,05$) was found in clusters of hyper-arousal symptoms, borderline significant difference on clusters of intrusion symptoms, whereas in avoidance symptoms there was no significant difference although the scores were slightly higher in the torture victims group.

Unlike the results in CAPS-DX, which show moderate (although some significant) differences between torture victims and on-tortured individuals, results on the revised Impact of event scale (IES-R) show a convincing difference between the two groups in the overall score in almost all examined clusters with a highly statistically significant difference.

These findings correspond to the results of the above-mentioned research by Strestha and associates (1998) who have found that torture victims have a higher score in almost all PTSD symptoms than the non-tortured individuals.

With regard to the prevalent cluster of irritability symptoms in torture victims CRTV clients, this finding is in accordance with the results of Mollice and associates (1998) who have established that in ex-detainees the severity of torture experience was related to the cluster of hyper-arousal, as well as with the findings of Henigsberg and associates (2001) who established that former detainees had more prominent symptoms of hyper-arousal, unlike rape victims who had more prominent avoidance symptoms.

Deliberating the total of the stated findings, it is obvious that they involve the search for answers to the question of how much the intensity and type of torture influence the intensity and pathoplastics of psychiatric disorders, especially PTSD. All torture victims have in a certain way been "violated" (in terms of deliberate psychophysical damage inflicted by other people) and have subsequent avoidance symptoms as a form of withdrawal from human contact as well as caution (fear and anxiety) dominantly present in war veterans as a constant degree of awareness (expectance of combat = expectance of interrogation).

CONCLUSION

Results of our research done on the basis of data collected during treatment of IAN CRTV clients indicate some significant similarities as well as differences between persons who have survived torture during recent wars in the Balkans and those persons who were not exposed to torture but did have and experience of serious war related trauma: exile, war plight, loss of close persons, loss of property, physical or psychic disorder as consequence of war.

As regards the socio-economic parameters it was evident that the overall population (both groups with no difference) was largely handicapped, primarily by their refugee status dictating the poor material and existential situation and unemployment.

CRTV clients in most cases do not plan to return to their pre-war community of origin. Data related to adjustment to the community of exile show that they are still undecided about staying in this community or leaving for a new (third) one. It is evident that torture victims have more optimism regarding their new environment than non-tortured clients, which could be explained by their increased threshold of endurance and idealisation of environment where they found freedom.

We have established that both groups have a high morbidity of somatic and psychiatric disorders, much higher than before coming to CRTV. This fact of the newly identified morbidity indicates some shortfalls in the organisation of state run (general) health care, at least when it comes to this population, and the advantage of smaller, specifically oriented, well organised and systematised projects focused on target population.

Torture survivors are at greater risk of somatic and especially psychiatric disorders. Their health problems last longer and carry a higher risk of becoming chronic.

Members of both subgroups are most frequently affected by the posttraumatic stress disorder and far less often by other psychiatric disorders such as depressive or anxiety disorders. There is a very high comorbidity of PTSD and other psychiatric disorders. These findings, as expected, indicate the prevalence of traumatic aetiology of psychic problems in CRTV clients.

Although there are no statistically significant differences in frequency of PTSD among these groups, torture victims do have a more intensive symptomatology, especially in clusters of extreme anxiety symptoms, which is in accordance with available results of most surveys conducted so far.

- **Appendix:** Partial list of detainee camps / prisons (in Croatia, Bosnia and Serbia) where IAN CRTV client had been tortured

Camp/Prison	No of people
Babina Greda	1
Beli Manastir	1
Beograd	1
Bihac	37
Bilice (Split)	2
Bjelovar	27
Bosanski Brod	3
Breza	2
Brcko	2
Capljina	1
Caprnja	2
Celebic	3
Civljane	1
Daruvar	2
Dejcici	1
Dretelj	2
Dubrovnik	1
Dvor na Uni	2
Đakovo	1
Erdut	6
Gabela (Capljina)	1
Gospic	4
Gošica	1
Gradacac	3
Gradiška	2
Grašinci	2
Ilova	2
Karlovac	7
Kerestinac	1
Kladanj	3
Kladuša	1
Knin	3
Lepoglava	7
Lipik	1
Lora (Split)	8
Ljubuško	1
Manjaca	5
Medaš	1
Mocire	1
Mostar	2
Novi Grad	2
Nova Gradiška	4
Odžak	3
Orašje	1
Osijek	12
Ozalj	1
Otocac	1
Pakrac	3
Petrinja	1
Podr. Slatina	1
Požega	5
Prizren	1
Remetinac	18
Sarajevo	5
Šibenik	10
Silos Tarcin	9
Silos-Sarajevo	1
Sinj	1
Sisak	8
Sl Požega	4
Sl.Brod	2
Slunj	2
Solin	1
Split	8
Stupari	3
Tuzla	27
Varaždin	13
Vidoševci	1
Virovitica	2
Visoko	11
Zadar	19
Zagreb	24
Zenica	9
TOTAL	**367**

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