PSYCHOLOGICAL PROFILE OF FORCIBLY MOBILIZED PERSONS

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SUMMARY

In the period between May 2003 and May 2005, the "Center for Rehabilitation of Torture Victims" – International Aid Network – IAN Belgrade (CRTV), has provided psychological assistance to more than 500 clients, 438 out of which have undergone a detailed admission and diagnostical procedure, as a part of the overall psychological-psychiatric treatment. Out of the total number of clients, 140 were forcibly mobilized refugees, 116 were torture victims in camps in Croatia and Bosnia-Herzegovina, and 180 were refugees without the traumatic experience of imprisonment and torture, or forcible mobilization.

The aim of this article is to compare the above subgroups of clients, having in mind their general socio-demographic and clinical profile. It specifically aimed to determine possible differences in the consequences of ill treatment experienced by the forcibly mobilized persons and torture victims in camps, considering the nature of ill treatment (torture), as well as the difference in the presence and intensity of psychiatric and, in particular, posttraumatic symptomatology. The information was gathered by means of sociodemographic questionnaire, Structured Clinical Psychiatric Interview (SCID), Clinician Administered PTSD Scale (CAPS), Impact of Event Scale-Revised (IES-R), Symptom Check List-90-Revised (SCL-90-R) and Manchester Short Assessment Quality of Life Scale (MANSA).

Analysis of the obtained data has demonstrated a significant difference between the general refugee population and specific subgroups of the same population, including forcibly mobilized and tortured persons, in view of the

presence of psychological consequences. In the specific groups psychic disturbances are significantly more manifest, and the quality of life significantly lower. By the intensity of psychopathological phenomenology, the group of forcibly mobilized persons is much closer to the torture group, which indicates the fact that forcible mobilization may bear the same consequences as any other clearly defined act of torture.

The second part of the article presents a comparison between the groups of forcibly mobilized and tortured persons, considering the posttraumatic symptomatology, and considering the presence of comorbid psychiatric diagnoses. It was established that torture victims have a significantly higher lifetime prevalence of PTSD, but also that there was no significant difference in the presence of current PTSD, although torture victims typically manifest a more severe clinical picture of PTSD. The explanation offered was that the specific type of psychological torture, combined with the implementation of the sense of guilt and betrayal, had almost as devastating an effect on the development of severe PTSD as physical torture in enemy camps.

Based on the results presented in this article, it was concluded that forcibly mobilized refugees are no different than torture victims in view of the intensity of psychic disturbances and presence of current PTSD, and also, that there is a significant difference in lifetime prevalence of PTSD and specific profile of psychiatric syndromes, i.e. comorbid psychiatric diagnoses. The article suggests that the difference arises from specific differences related to the status of the victim, nationality of the torturer and the victim, purpose and intent of the torture/ill treatment (extorting confession and revenge over torture victims in camps, as compared to "disciplining" and manipulation over the forcibly mobilized), the ways of coping with trauma and valorization of the suffered trauma by the victims themselves, but also by their surroundings.

INTRODUCTION

Trauma is most certainly one of the most frequently mentioned psychiatric terms in the last decade. Definition of traumatic experience regained its importance due to the increasing presence of psychological trauma in numerous social conflicts in the modern world. Social crises happen every day, and the researchers are faced with the task to explore the nature of stressogenous reactions, in order to enable efficient treatment of the consequences of trauma, as well as creation of prevention programs.

Wars and frequent interpersonal conflicts are typical examples of interpersonal traumas, where, unlike in natural or technological disasters, the human factor is the main source of traumatic experience. When the infliction of pain and suffering to others is intentional, for the purpose of realization of different goals and interests, it is when trauma takes the form of torture[1]. There is a great number of registered prisons and camps in the territory of former Yugoslavia where torture was applied as political means and a common way of treating the detainees.

Consequently, the vast majority of clients of the International Aid Network (IAN) Center for Rehabilitation of Torture Victims (CRTV) consist of former detainees and members of the "Association of Ex-Detainees from War in 1991", who fall under the category of torture victims. The remaining clients are refugees and displaced persons who required assistance due to severe psychic disturbances, as a result of war-related conditions, or family members of the victims of torture.

After many years of providing assistance to clients exposed to war, the Center staff noticed a new group of clients who stood out by their specific characteristics. They were males with the status of refugees in FR Yugoslavia, who were forcibly mobilized in an action conducted by the Republic of Serbia Ministry of Internal Affairs in the summer of 1995, and then returned to the Republic of Serb Krajina or the Republic of Srpska, where they were handed over to paramilitary or military formations in the territory and forced to enter into conflict for their side.

The phenomenon of forcible mobilization during the wars in the territory of ex-Yugoslavia in 1990-ies is not unprecedented in the world. Information on cases of forcible mobilization in refugee areas in Afghanistan, Liberia and Ghana

1 Torture is defined in the UN Convention against Torture, Article 1 (1984), as "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."

are available over the Internet, with the authors focusing particularly on the problem of forcible mobilization of underage persons. However, except detecting the problem and attracting media attention, there are no detailed accounts on the circumstances, and especially not on the consequences of the incidents of forcible mobilization of refugee population (Muir J, 2001; Frelick B, 2004; Côte d'Ivoire, 2004).

Working with this particular group of CRTV clients, it was established that their situation is characterized by specific legal, social and psychological features, arising from the fact that the abuse (torture) over them was conducted by members of their own nation and by their own country, which is what distinguishes this group from the other categories of clients.

In an attempt to explore these features, we need to analyze the existing differences in psychopathological symptomatology in the persons who survived different types of traumatic events, such as war-related trauma, forcible mobilization or psychological and physical torture in military camps and prisons.

Findings of numerous studies point to the presence of different factors influencing the reaction to traumatic events, so that the responses should be understood in the context of these factors.

Aldwin, Levenson and Spiro (1994), state that the connection between exposure to military actions and PTSD symptoms is partly mediated by the estimates of desirable and undesirable effects of military service. Being aware of the undesirable effects, such as losses in the field of career and relationships, and living through different negative emotional states, is positively correlated with the level of PTSD symptoms, symptoms of depression and the way of coping with the stressful situation. On the contrary, understanding the positive effects of stress, such as development of coping ability, is negatively correlated with the level of PTSD symptoms.

Momartin et al (2003) did not detect any difference in the risk of developing PTSD between the group with the highest exposure to human rights violation (imprisonment in concentration camps, torture) and the group exposed to general war-related traumas. On the other hand, Silove et al (2002) have discovered that torture presents a major risk for development of PTSD as compared with other studied traumatic factors.

Clinical study of specific types of torture victims is highly significant for the treatment. The existing information can be used to identify the persons who need clinical assistance to overcome the traumatic events. It can also be used for the development of an efficient therapeutic approach and adequate treatment, for the purpose of enhancing the clients' ability to face the consequences of stress and regain their pre-torture level of functionality.

One of the fundamental questions that this paper aims to answer is: ***can the trauma that the forcibly mobilized persons were exposed to can be marked as torture?*** The conclusions in this article will be drawn based on the type and

intensity of psychological consequences that the violent act has left on the victims' mental health. A clearer picture will be obtained by comparing these consequences with the ones caused by other war-related traumas in the refugee population, on the one hand, as well as with the consequences arising from the torture experience in military camps and prisons, on the other.

The experience of torture is usually extremely dramatical – when encountering this kind of violence, the very foundations of human existence can be shattered: faith, sense of security and closeness to others. Destroying the basic foundations of a person's life and defying the principle of respect of basic human needs, can have serious, often permanent consequences on the mental health of the tortured individual. This can cause various psychological disorders and problems in overall psychosocial functioning of the person. Typical disorder developed as a result of torture is the posttraumatic stress disorder (PTSD). However, we should emphasize that psychopathological consequences of traumatic experiences include a wide spectrum of different types and combinations of symptomatology.

In line with the above facts, it can be expected that forcible mobilization, as an experience with strong traumatic potential, can cause the development of PTSD. The article aims to test this assumption, by answering the question: ***whether and to what extent PTSD symptomatology is present in the forcibly mobilized persons?***

The presence of PTSD can be an indicator of the objective severity of trauma, but it primarily indicates the subjective experience of the severity of trauma, which depends directly on the specific affected personality. In this, circumstantial way, by assessing the consequences, certain conclusions can be made on the quality and type of the cause.

In the history of exploring the structure of posttraumatic symptomatology, the main starting point was the study of a number of specific risk factors for chronic response to stress. In general, the *intensity of trauma* was considered as crucial for the development of PTSD. However, results indicate that the effects of the intensity of trauma are not uniform in character. Having in mind different characteristics of the traumatic event, the overpowering experience of trauma can be caused by various factors. The question can be raised on the exact meaning of the intensity of trauma. Can it be measured only by the intensity of the torture experienced? Or the subjective interpretation of the events is necessary as well? What elements influence the subjective interpretation of the traumatic event? We support the strategy of focusing on the influence of *specific features of traumatic event* as well, on the exposure and the development of symptoms. For, only a detailed study of such differences would enable us to fully understand the variety of mutual effects of the factors of traumatic events, exposure to traumatic stress and severity of traumatic experience.

The findings presented in this article could make a valuable contribution, especially to the therapy of forcibly mobilized persons, as a specific group of

torture victims. Due to their specific circumstances, it can be assumed that the forcibly mobilized persons will have a distinctive psychological profile as compared to the victims of torture in enemy camps, as well as to refugees. One of the important dilemmas, whether forcible mobilization can be defined as a type of torture or not, will be clarified through the analysis of intensity and types of consequences on the victims' mental health, as well as through a comparison with the psychological consequences in the remaining two groups, refugees and torture victims. With this in mind, one of the hypotheses was that forcibly mobilized persons would manifest stronger posttraumatic symptomatology than the refugees, and the question remained whether their results would be significantly different from the results in the group of victims of torture in enemy camps.

METHOD

Respondents and procedure

The study encompassed data obtained from 436 clients of the International Aid Network (IAN) in Belgrade, in the period between May 2003 and May 2005. The respondents were refugees from the 1991-1995 war-stricken areas who applied for the refugee status in FR Yugoslavia (Serbia and Montenegro). Specific subgroups in this sample of refugees consisted of men forcibly mobilized during the war on the territory of former Yugoslavia and victims of torture in camps and prisons during the wars in former Yugoslavia 1991-1995.

The subgroup of forcibly mobilized persons consisted of 140 respondents. The study included all the clients whose medical records included entries of sociodemographic data, as well as test scores, as a part of psychological battery usually applied for the purpose of registering symptomatology and setting the diagnosis of the clients. All the respondents were arrested by the police of the Republic of Serbia Ministry of Internal Affairs in the summer 1995, in spite of their refugee status in the territory of FRY, and subsequently transported across the state border. More than 90% of the respondents were detained in the paramilitary units' camp in Erdut, East Slavonija, and a smaller number in Beli Manastir, Manjaca and Knin. The majority of the forcibly mobilized persons – clients of IAN, spent 3-10 (some of them over 30) days in the camps, where they were, in almost all cases, exposed to mental and/or physical torture. After such procedure, a large number of the forcibly mobilized persons were sent to combat units of the Army of the Republic of Serb Krajina or Army of the Republic of Srpska, and a part remained as members and/or under direct control of paramilitary units, where they spent between 1.5 and 4 months (most often about 3 months) as armed soldiers.

The subgroup of torture victims consisted of 116 men, clients of the Center for Rehabilitation of Torture Victims, within the framework of IAN. All of them

had the traumatic experience of imprisonment and torture in the enemy camps and prisons during the war.

The subgroup of refugees in the narrow sense consisted of 180 persons with the refugee status in FR Yugoslavia, originally from the war-stricken areas – mostly from Croatia and a smaller number from Bosnia-Herzegovina – with the experience of different types of war-related trauma, but not the trauma of imprisonment and torture, or forcible mobilization.

The testing was conducted in the counseling units of the International Aid Network (IAN). The respondents had been seeking psychological and legal assistance and they voluntarily accepted to participate in the testing. Detailed psychological exploration was routinely performed in the Center prior to the treatment, as its results represent the guideline for the future counseling and psychotherapeutic work. The clients were subsequently provided with the adequate type of treatment. The record-keeping activities included creating data bases on all the clients, documenting their testimonies, as well as gathering information on all other materials and sources related to torture and human rights.

Instruments

The detailed diagnostical procedure was the same for all patients. It included structured clinical interview and instruments for the assessment of type and intensity of traumatic event, posttraumatic symptomatology and general psychiatric symptomatology. It should be mentioned that a number of respondents failed to provide all the data required by the tests. The following psychological instruments were used:

1. **Client list – general questionnaire** consisting of basic demographic data, registration of problems the client seeks help for, the therapist's psychological assessment of the client and the type of intervention applied by the therapist.
2. **Structured Clinical Psychiatric Interview by DSM-IV** Classification for Axis I disorders (SCID-I; First, Gibbon, Spitzer & Williams, 1996). This instrument represents the golden standard for reliable psychiatric diagnostics, according to the American classification of psychiatric disorders.
3. **Clinician Administered PTSD Scale** (CAPS; Blake et al., 1990). Similar to the previous instrument, CAPS is a structured interview, providing reliable information on the presence of posttraumatic stress disorder, whether in the moment of testing, or in an earlier period of life.
4. **Impact of Event Scale – revised version** (IES-R; Weiss & Marmar, 1997) is an instrument for self-assessment of posttraumatic symptoms.
5. **Symptom Check List Scale – Revised Version** (SCL-90-R; Derogatis, 1983) was used for self-assessment of a wide range of psychopathological symptoms.

6. **Manchester Short Assessment of Quality of Life** (MANSA; Priebe, Huxley, Knight & Evens, 1999) – inventory for self-assessment of quality of different life domains. The scale includes 16 questions, with 12 of them to be answered on the scale of 1 to 7 (1-couldn't be worse; 2-very dissatisfied; 3-mostly dissatisfied; 4-neither satisfied, nor dissatisfied; 5-mostly satisfied; 6-very satisfied; 7-couldn't be better).

Statistical analysis

In processing the results, standard descriptive and analytic statistical methods were used. Statistical processing was performed using the statistics software on personal computers.

RESULTS

Average age of the forcibly mobilized IAN clients was 43.31±8.15 (span 27-64), as opposed to the slightly older groups of clients in the torture victims subgroup - 48.13±10.90 (span 23-73) and refugees subgroup - 48.85±12.96 (span 18-79).

Table 1. *General socio-demographic characteristics of forcibly mobilized persons*

Demographic characteristics	**%**
Level of attained education	
No education	2,0
Primary school	29,6
Secondary school	60,2
Student	1,0
College	3,1
University	4,1
Employment	
Employed	36,4
Unemployed	63,6
Marital status	
Single	21,8
Married	70,9
Widowed	0,9
Divorced	6,4

As can be seen in Table 1, the majority of subjects have secondary school education. A considerable percent of respondents have completed primary school, and a minor number of respondents fall under the remaining categories.

Employment structure of the forcibly mobilized clients demonstrates their quite unfavorable living situation. Approximately two-thirds of clients are unemployed, and only one out of three has a job.

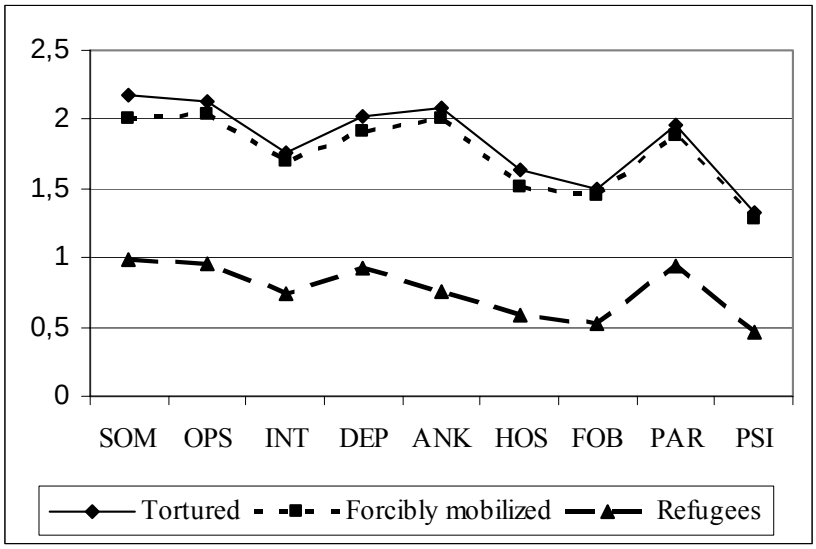
The majority of clients are married, a smaller number are single, and the number of clients falling under the categories of widowers and divorced is negligible.

Table 2. *Mean value difference of symptom dimensions scores on SCL-90-R between the three groups of clients of the International Aid Network - IAN*

SCL-90-R	**Forc. mobilized (N=74)**		**Tortured (N=93)**		**Refugees (N=103)**		**Statistical significance**	
	M	SD	M	SD	M	SD	F	Sig.
SOM	2,01	0,89	2,17	1,05	0,98	0,97	35,93	<0,01
OPS	2,04	0,94	2,13	1,05	0,95	0,73	40,12	<0,01
INT	1,70	0,98	1,76	1,02	0,75	0,75	29,64	<0,01
DEP	1,92	0,90	2,02	1,03	0,93	0,77	35,00	<0,01
ANK	2,01	1,02	2,09	1,12	0,77	0,83	43,60	<0,01
HOS	1,53	0,95	1,64	1,04	0,59	0,57	32,78	<0,01
FOB	1,46	1,04	1,50	1,11	0,53	0,65	24,92	<0,01
PAR	1,88	1,00	1,96	1,05	0,94	0,80	27,71	<0,01
PSI	1,28	0,95	1,32	0,94	0,47	0,58	24,80	<0,01

SOM=somatization, OPS=obsessiveness, INT=interpersonal sensitivity, DEP=depressiveness, ANK=anxiety, HOS=hostility, FOB=phobia, PAR=paranoid disorder, PSI=psychoticism

Figure 1. *Mean values for 9 dimensions derived from SCL-90-R in IAN clients (scale range from 0 to 4)*



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Results of the SCL-90-R test presented in Table 2 show a considerable difference in the manifestation of present psychiatric symptomatology with significantly higher scores in the torture victims group, slightly lower in the forcibly mobilized, and by far the lowest in the refugee subgroup.

As shown in Figure 1, the score values on SCL-90-R, in all test dimensions, are significantly closer in the first two groups, of torture victims and forcibly mobilized, than as compared with the refugee group.

Table 3. *Mean value difference of symptom dimensions scores on IES-R*

	Forc. mobilized (N=104)		**Refugees (N=180)**		**Statistical significanc**	
	M	SD	M	SD	**F**	**Sig.**
IES-INT	2,32	1,04	1,53	1,12	34,36	<0.01
IES-AVOID	2,22	0,75	1,52	1,03	35,82	<0.01
IES-HYPER	2,41	1,05	1,39	1,17	54,60	<0.01

IES-INT=intrusion symptoms, IES-AVOID=avoidance symptoms, IES-HYPER=hyper-arousal symptoms

On the Impact of Event Scale (IES-R) where the respondents assessed the intensity of current posttraumatic problems, the group of forcibly mobilized persons had significantly higher mean scores, especially on the subscale of hyper-arousal symptoms.

On the Manchester Short Assessment Quality of Life Scale (MANSA) the forcibly mobilized had the mean score of 3.21±0.77, and the refugees 4.31±0.79, which constitutes a statistically significant difference ($F=131.13$; $p<0.01$).

Table 4. *PTSP diagnosis established by means of CAPS-DX*

Diagnosis based on CAPS	**Forcibly mobilized (N=140)**		**Torture victims (N=116)**	
	n	%	n	%
Total PTSP	89	63,6	106	91,3
Current PTSP	*82*	*58,6*	*73*	*62,9*
Healed PTSP	*7*	*5,0*	*33*	*28,4*
No PTSP	51	36,4	10	8,7

Pearson's chi-square: $\chi^2 = 43.109$, $p < 0.001$

There is no significant difference between the groups of torture victims and forcibly mobilized persons regarding the presence of diagnosed current PTSD; however, healed PTSD is present in the significantly higher percentage of torture victims. Total lifetime prevalence of PTSD (current + healed) is 91.3% in torture victims, and considerably lower, although more than half (63.6%) in the forcibly mobilized.

Table 5. *Mean value difference of symptoms in current PTSD*

CAPS-DX	PM (N=140)		T (N=116)		Statistical significance	
	M	SD	M	SD	F	Sig.(p)
Symptoms of re-experiencing the trauma						
B1.Disturbing dreams	0,89	0,88	1,32	1,14	16,23	<0,01
B2. Disturbing memories	1,14	0,99	1,68	1,24	20,38	<0,01
B3. Feeling of trauma repeating itself	0,18	0,48	0,36	0,71	7,55	<0,01
B4. Physical discomfort on recollection	1,19	0,97	1,47	0,97	7,86	<0,01
B5. Physiological reaction on recollection	0,92	0,85	1,13	0,98	4,61	<0,05
Symptoms of avoidance and emotional numbness						
C1. Avoiding thoughts, feelings	1,35	1,03	1,69	1,14	8,72	<0,01
C2. Avoiding activities, places, people	0,85	0,86	1,06	1,08	4,12	<0,05
C3. Inability of recollecting the trauma	0,55	0,85	0,69	0,96	2,05	n.s.
C4. Reduced interest	0,97	0,93	1,54	1,24	22,94	<0,01
C5. Detachment and estrangement	0,77	0,99	1,26	1,17	18,19	<0,01
C6. Constriction of general affect	0,91	0,94	1,20	1,10	6,98	<0,01
C7. Feeling of future without prospect	0,69	0,82	1,17	1,24	17,75	<0,01
Symptoms of hyper-arousal						
D1. Sleep disturbance	1,50	1,18	2,14	1,35	22,75	<0,01
D2. Aggravation and anger outbursts	1,09	1,02	1,44	1,16	9,73	<0,01
D3. Difficulties in concentration	1,04	0,99	1,26	1,11	4,16	<0,05
D4. Wariness	0,79	0,90	1,20	1,16	13,31	<0,01
D5. Exaggerated startle response	1,16	0,99	1,23	1,04	0,48	n.s.

FM = forcibly mobilized, T = torture victims, tortured

Although the difference in the frequency of current PTSD diagnosis between the groups of tortured and forcibly mobilized persons is small, there is a significant difference in the severity of manifest symptomatology, as seen in Table 5. The

following symptoms are particularly manifest in torture victims: reduced interest and involvement in activities, difficulties falling asleep and sleeping, disturbing dreams, disturbing memories of trauma, feeling of detachment and estrangement from other people, feeling of future without prospect and wariness.

Table 6. *CAPS-DX – additional (related) symptoms in current PTSD*

CAPS-DX – Additional symptoms	**PM (N=140)**		**T (N=116)**		**Statistical significance**	
	M	**SD**	**M**	**SD**	**F**	**Sig.(p)**
Depersonalization	0,05	0,28	0,10	0,40	1,61	n.s.
Derealization	0,14	0,45	0,17	0,54	0,48	n.s.
Reduced awareness of one's surroundings	0,38	0,70	0,33	0,75	0,46	n.s.
Survivor's guilt	0,05	0,28	0,11	0,48	1,76	n.s.
Guilt over what he/she had done or failed to do	0,28	0,68	0,44	0,82	3,88	<0,05

Considering the additional (related) symptoms on CAPS-DX, they are considerably less manifest than the above listed posttraumatic symptoms. The only major difference is the sense of guilt, which is more manifest in torture victims.

Table 7. *CAPS-DX – severity of impairment in current PTSD*

CAPS-DX – intensity of disturbances	**PM (N=140)**		**T (N=116)**		**Statistical significance**	
	M	SD	M	SD	**F**	**Sig.(p)**
Subjective disturbances	1,56	1,05	1,88	0,98	9,63	<0,01
Impairment in social functioning	1,16	0,99	1,46	0,97	8,95	<0,01
Impairment in professional functioning	1,18	0,99	1,33	1,00	2,32	n.s.

Functionality impairment in different life domains is more manifest in torture victims than in the forcibly mobilized persons.

Table 8. *Psychiatric diagnoses established by means of SCID*

Diagnosis based on SCID	**Forcibly mobilized (N=140)**		**Tortured (N=116)**		**Statistical significance**	
	M	**SD**	**M**	**SD**	**F**	**Sig.**
Current major depressive episode	0,22	0,42	0,23	0,42	0,05	n.s.
Previous major depressive episode	0,26	0,44	0,22	0,42	0,55	n.s.
Previous manic episode	0,00	0,00	0,01	0,09	1,21	n.s.
Previous hypomanic episode	0,01	0,12	0,01	0,09	0,18	n.s.
Dysthymic disorder (current)	0,08	0,27	**0,19**	**0,39**	**7,11**	**<0,01**
Psychotic and combined symptoms	0,00	0,00	0,01	0,09	1,21	n.s.
Bipolar II disorder	0,01	0,09	0,01	0,09	0,02	n.s.
Major depressive disorder	**0,27**	**0,45**	0,16	0,36	**5,08**	**<0,05**
Alcohol abuse disorder	0,09	0,28	0,14	0,35	1,77	n.s.
Alcohol dependency	0,04	0,19	0,03	0,18	0,00	n.s.
Non-alcoholic substance abuse	0,00	0,00	0,01	0,09	1,21	n.s.
Non-alcoholic substance dependency	0,00	0,00	0,01	0,09	1,21	n.s.
Panic disorder	0,02	0,15	0,07	0,25	3,51	n.s.
Panic disorder with agoraphobia	0,02	0,15	**0,08**	**0,27**	**4,52**	**<0,05**
Agoraphobia without panic disorder	0,00	0,00	**0,04**	**0,20**	**6,26**	**<0,05**
Social phobia	0,03	0,17	0,03	0,16	0,02	n.s.
Specific phobia	0,08	0,27	0,06	0,24	0,32	n.s.
Obsessive-compulsive disorder	0,05	0,22	0,05	0,22	0,00	n.s.
Anxiety disorder NOS	0,00	0,00	0,02	0,13	2,44	n.s.
Somatization disorder (current)	0,04	0,20	0,05	0,22	0,11	n.s.

Diagnosis based on SCID	Forcibly mobilized (N=140)		Tortured (N=116)		Statistical significance	
	M	SD	M	SD	F	Sig.
Pain disorder	0,04	0,19	0,02	0,13	0,81	n.s.
Non-differ. somatophorm disorder	**0,05**	**0,22**	0,00	0,00	**6,06**	**<0,05**
Hypochondriasis	0,02	0,15	0,02	0,13	0,06	n.s.
Dysmorphophobic disorder	0,01	0,12	0,00	0,00	1,67	n.s.
Eating disorder	0,04	0,19	0,05	0,22	0,39	n.s.
Generalized anxiety disorder	0,08	0,27	0,05	0,22	0,73	n.s.

As shown in Table 4, generally speaking, there are no prominent differences between the mean score values of psychiatric diagnoses established based on the structured interview (SCID). The differences between score values for the following disorders are somewhat more significant: previous major depressive episode, major depressive disorder and non-differentiated somatophorm disorder (more manifest in the forcibly mobilized). Dysthymic disorder, agoraphobia and panic disorder are more frequent in torture victims.

DISCUSSION

Position of the forcibly mobilized clients is in itself highly specific. For the majority of such clients, being refugees, the act of forcible mobilization was the repeated trauma, often following the series of previous ones. Literature also states that repeated traumatization can be one of the significant etiological factors in the development of PTSD (Lazarus & Folkman, 1984). There are several possible interpretations of such statements. One of the possibilities is that it plays the role of lens, i.e., enhances the influence of events. Namely, re-traumatization forces the individuals to invest their energy in the constant feeling of painful and discomforting fear, insecurity and anxiety. For that reason, additional traumatic excitations can have an unusually quick and easy negative effect on the already emotionally unstable person. The second type of interpretations state that negative influences of repeated stress accumulate, leading to the increased risk of development of mental disorders. In the forcibly mobilized persons it could create predisposition for higher sensitivity and increase the risk of development of PTSD symptoms.

The specific context of persons forcibly mobilized by members of their own nation is among the socio-cultural factors with significant determining role. Such social milieu modifies the ways of accepting the experienced traumatic event and gives it a specific meaning.

Prior to the commencement of work with the forcibly mobilized, the question was raised whether such persons actually represent a separate category of clients, or the characteristics of the coercion they were exposed to can fall under the category of torture, as defined by the United Nations. If this is the case, it would signify that they represent a subgroup of the earlier defined category of torture victims.

Certain authors still debate on this issue, since, from the theoretical point of view, there are no clear guidelines for the act of forcible mobilization to define whether such coercive act is an act of torture, or it would only be the case with the use of duress or retaliation (Spiric, 2004).

Interpretation of the obtained results can help create a clearer picture of this particular group and provide answers to some of the questions raised. Psychological characteristics as well as symptomatology of the forcibly mobilized persons are the grounds for the review of their psychological profile, and by a comparison with the clearly defined groups of torture victims and refugees, conclusion can be made on which of the groups they are more similar and closer to

Comparison between the three groups in our sample (tortured, forcibly mobilized and refugees) regarding the manifestation of psychic disturbances measured by SCL-90-R, has shown a statistically significant difference between the three groups as regards the psychopathological phenomenology. Intensity of psychic disturbances is the highest in the torture victims group, slightly lower in the group of forcibly mobilized, and significantly lower in the refugee group. These results are in line with the research conducted by Roncevic-Grzete and associates (2001), who, using the Hamilton Depression Scale, demonstrated that clinically manifest depressiveness is more frequent in torture victims than in other traumatized groups (refugees), as well as with the findings of Stresthe and associates (1998) who observed that torture victims have higher anxiety and depression scores on SCL as compared to the non-tortured respondents. Spiric and Knezevic (2004) have discovered significant difference in all 9 dimensions on SCL-90-R between the victims of torture and refugees with the experience of war-related trauma, other than captivity and torture.

Results of comparison between refugees and forcibly mobilized persons indicate that general psychiatric symptomatology is more manifest in the forcibly mobilized. Also, specific posttraumatic symptoms in all three clusters assessed by means of the Impact of Event Scale, are more frequent in the forcible mobilization group than in the refugees. Forcibly mobilized persons rate their quality of life considerably lower on the scale of 1 to 7 (MANSA): average score 3.21 ("mostly

dissatisfied") as compared with the refugees – 4.31 ("neither satisfied, nor dissatisfied").

Since the forcible mobilization group has proved to stand much closer to the group of torture victims than to refugees by the intensity of psychic disturbances, the inevitable conclusion is that the consequences of forcible mobilization are similar to any other act of clearly defined type of torture.

According to our results, there is a major difference in the lifetime prevalence of PTSD (FM=64%, T=91%), which could be expected, since, according to available sources, the prevalence of PTSD in torture victims is by far the highest as compared to any other traumatized group. However, the results do not show significant difference in the presence of current PTSD diagnosis. The lack of significant difference in the presence of current PTSD can be explained in several ways.

According to the clients' accounts, forcibly mobilized persons have spent one to ten days in paramilitary camps during the so-called training, which is, nevertheless, a shorter period of deprivation of liberty than was the case with former war prisoners. The context of the overall situation, as well as their being treated as "traitors of their own nation", mostly included humiliation and threats as a type of psychological torture, while methods of physical torture, except methods of exhaustion and strenuous physical labor, were generally less applied. The assessed threat to life was objectively smaller, since these persons were forcibly mobilized in the name of the state and by their own people, although this was most frequently not in keeping with their subjective experience.

There is, however, a series of other factors characteristic for the position of the forcibly mobilized persons, which have caused the atmosphere of threat during the forcible mobilization to be equally unbearable as during captivity in enemy camps. Victims of torture in enemy camps manifested the natural need for cathartic verbalization, as a way to resolve the trauma. On the other hand, forcibly mobilized persons saw the discussion on traumatic experiences as inappropriate and socially unacceptable, since the torture was caused by members of their own people, with the justification that it was conducted on traitors.

It is well known that in the situation of captivity the criminal becomes the most powerful figure in the victim's life, so his behavior and belief start shaping the psychology of the victim. The forcibly mobilized persons have described the despotic control established by their torturers-compatriots, with the aim to destroy their sense of autonomy. Methods of control were based on systematic, repeated psychological traumatization. The victims' fear was often instilled by erratic and unpredictable outbursts of violence and capricious insisting on details. As mentioned in the literature, threats of death or injury, that were also applied here, are equally efficient as a direct attack on the victim (according to Herman, 1997).

Characteristic type of torture was conducted through weakening of the victims by giving them addictive drugs and alcohol, which in that moment they

perceived as a means to help them survive. This calculated bribery with "small" favors was undermining the psychological resistance of the forcibly mobilized with much more success than constant deprivation and fear. Other methods of torture were manifested by unquestionable demands for respect and admiration, so that the victims would submit voluntarily. The torturers wanted not only to impose the fear of death on them, but also the gratitude that they were allowed to live. Some of the clients described situations when they were convinced that they were going to be killed, only to be saved at the last moment. After several such experiences of "certain death", the victim, paradoxically, begins to see the criminal as a savior, who is giving false support. Having in mind that the forcibly mobilized persons were deprived for a period of time, the described behavior of the torturers becomes the means of coercion, and they themselves a source of fear and humiliation, but, at the same time, illusion of success. The final effect of these techniques was that the forcibly mobilized persons, in their own words, saw the criminal as omnipotent, with whom all resistance was pointless, and felt that their lives completely depended on absolute obedience to the will of the torturer. Based on the obtained data, we can conclude that the previously described specific psychological torture over the forcibly mobilized persons has a similar effect as the drastic methods of physical torture used on the victims of torture in enemy camps.

Motivation and fighting moral of the victims also played an important role in the overcoming of wartime strains. The prisoners in enemy camps had higher tolerance to frustrations precisely for the reason that they fought for the political and national goals, although their life was threatened. On the other hand, public opinion on those who did not go to war voluntarily was extremely unfavorable at the time. The attitude of their environment forced them to betray certain relations, social loyalty or moral values, which resulted in their being subjected to fierce criticism. The study of Aldwin, Levenson & Spir (1994) also confirmed that the assessment of favorable and unfavorable effects of military service, due to the stress in the course of military actions, mediated in the development of PTSD.

In the same way, religious and political beliefs are among generalized resources of resilience that enable the person to organize his/her experiences so as not to succumb to stress. It is well known that the majority of people feel the need for a system of all-embracing values, timeless and universal, giving the meaning to their life. Mutual systematic support of religious and political consciousness among the detainees in enemy camps built up their motivation and vitality to suffer pain, their moral strength and human dignity. On the contrary, due to being labeled as traitors of the nation and, for that reason, negatively assessing their situation, the forcibly mobilized persons have lost that kind of support.

One of the explanations for the major difference in healed PTSD between the forcibly mobilized and tortured persons would be that the trauma of torture victims occurred earlier and that, with the passage of time, more of them have recovered (having in mind that the time of initial trauma of torture victims is as

early as 1991, as compared to the FM – 1995). On the other hand, if the factor of earlier occurrence of trauma is excluded, perhaps the *persistence* of PTSD in the FM is more significant, and its smaller chances of recovery. Therefore, a hypothesis can be made that torture victims develop PTSD more frequently and suffer from a more severe form of PTSD (tbl 5 and 7), but also that they have stronger chances for recovery – ratio of healed and total = 33/106 = 31.1%, meaning that almost one-third of torture victims have recovered in the period of 8-14 years – as opposed to the forcibly mobilized, with the ratio of 7/82 = 7.8%, i.e. not even one out of ten have recovered after 8-10 years.

Stronger recovery potential in the torture victims group can perhaps be explained by the more efficient coping strategy, with directing and guiding the action, while the forcibly mobilized persons are more prone to regression, inefficient, passive reactions, giving up. The persons who have experienced forcible mobilization by their own people react by inadequate adaptive responses, tend to experience negative emotions, blame themselves or others, resort to passive forms of behavior, unlike war prisoners and their affirmative coping, who see stress as a challenge more than a threat, with the outward directed aggression, but also with the proneness to positive emotions and directed towards problem solving and seeking social support.

In the second type of analysis, when it was decided that PTSD symptomatology should be treated as continual variable, significant differences in the symptoms were established between the two groups. Symptoms such as *extremely reduced interest for the involvement in significant activities, feeling of detachment and estrangement from other people and the feeling of lack of prospect or empty future,* are more frequently manifested in victims of torture in enemy camps. Beside the above symptoms, these respondents also experience difficulties in falling asleep and sleeping, recurrent and disturbing dreams related to the traumatic event, as well as wariness, i.e. extreme caution and carefulness.

Most of these symptoms belong to the cluster of symptoms of avoiding the stimuli connected with the stressor and general numbness, on the one hand, and to the sleep disorders on the other. Having in mind that the latter signify unconscious resolving of the traumatic contents, symbolically representing the wartime experience, it can be concluded that central pathological pattern of PTSD in torture victims is represented by different avoidance strategies varying in the dimension of visibility, from the manifest, to the latent level. Our results are in line with the hypothesis of Horowitz (Horowitz & Beckers, 1971), that avoidance of painful thoughts and feelings plays the central part in the development of PTSD. A question, however, remains open, whether the avoidant behavior prevents successful acceptance of traumatic experience, or it can be a form of secondary adaptation, helping the person reduce the intensity of memory-provoked distress.

The second significant result of the comparison between the two groups is the difference in clinical diagnostics. Based on SCID, the most frequently set

diagnoses in the torture victims group were dysthymic disorder and agoraphobia without panic disorder. On the other hand, non-differentiated somatoform disorder was the most prevalent among forcibly mobilized persons, as well as major depressive disorder.

Persistent depression is one the most frequent findings in most studies of the chronically traumatized persons. Chronic hyper-arousal and intrusive symptoms of PTSD are related to vegetative symptoms of depression and create what Niederland has named the "survival triad" – insomnia, nightmares and somatic complaints (according to Herman, 1997). The paralysis of initiative, due to chronic trauma, is combined with depressive apathy and helplessness. Breakup of contacts as a result of chronic traumatization enhances isolation and depression. Altered image of one's self of the chronically traumatized nourishes the depressive rumination of the sense of guilt. Loss of faith joins with depressive helplessness.

Somatoform non-differentiated disorder can be interpreted as a part of depression, since it is defined by the presence of anhedonia, loss of interest, and emotional reactivity (Kecmanovic, 1989). It is a form of adaptation to traumatizing environment. High consumption of energy for the purpose of defense is manifested as somatisation disorder with the tendency to repress the feelings of depression.

Forcibly mobilized persons could not express anger caused by being humiliated by their torturers, since they were members of the same nation, and also not to endanger their own survival. They often have the feeling of powerlessness and lack of control over their life, as if they are afraid of a new retaliation. Present conflicts in their everyday life are only provoking factors, reviving the suppressed hatred, which then develops guilt, sense of sinfulness and self-reproach. What's more, the suppressed anger towards all those who remained indifferent to their fate and who failed to help them, builds up inside of them. Controlled anger and hatred focus on the self, instead of the environment, thus adding to the burden of depression.

On the other hand, the tortured clients, who spent a significantly longer period of time in enemy camps, manifest dysthymic disorder, which can be explained by permanent preservation of inadequate behavior patterns, created during the acute depressive episodes. Reactive depression is known to affect persons with low self-esteem, low threshold of frustration tolerance and extreme dependence on the support and praise of others (Clyton & Lewis, 1981). Unlike them, in dysthymic persons the traumatic experiences seem to have a prolonged effect, which makes it diagnostically unclear whether it falls under affective or character disorders (according to Kecmanovic, 1989). Other authors also state that dysthymia includes numerous chronic, non-psychotic depressive conditions of different origin, and is a frequent consequence of long-term adverse life circumstances (Akiskal et al, 1983, 1984; Keller et al, 1983). The DSM-III-R division of psychosocial needs into acute and chronic enabled the identification of dysthymia caused by long-term adverse life circumstances.

Torture victims also manifest all types of panic disorder (with or without agoraphobia), which is classified among anxiety disorders. According to the behavioral approach, a precipitating event in the life of a person is necessary for the onset of agoraphobia, according to which the symptoms of agoraphobia acquire their meaning. Agoraphobia is stated to occur when intensive anxiety is linked with a specific situation, so, in the future, in order to eliminate the fear, the person would avoid this situation. In persons with increased anxiety, anger and rage acquire a kind of discharge through the symptoms, which their surroundings do not understand, and their origin is often unclear to the persons themselves. This is the case with agoraphobia, where the fear of going out into the street is only a façade for the fear of one's own aggressive drives and tendencies, which could not be expressed openly toward the aggressor in the enemy camp.

Generally speaking, the obtained data indicate the conclusion that there are two ways of reacting to a specific traumatic experience. One way implies externalization of the generated feeling and focusing them outward, on the others, who are "guilty", responsible for what has happened and what they survived. Anxiety is the way for the person to free himself of emotional problems verbally, by complaints and self-observation. It is often accompanied by the experience of inadequate anger, rage that cannot be expressed and, in that way, neutralized. Sometimes the only way to discharge these emotions is to manifest aggression, which, if not allowed, has to be inhibited, repressed, which enhances the original anxiety and hostility even more. When the emotional states of aggressive impulses and anxiety find a socially acceptable release, the possibility for the development of somatization decreases. The other type of reaction involves internalization of emotions and focusing on one's self, as well as re-directing to a specific symptom, whether it is a thought, action or a somatic symptom. For example, the mechanism of internalization is present in the non-differentiated somatoform disorder. Here the person focuses on somatic complaints, which are stated briefly, and sometimes spontaneously associated with the life events. Behind the somatic complaints lie emotional problems such as fear, sense of insecurity, resentment, anger, sorrow, rage and often manifested or hidden aggression that the person is unable to cast off.

CONCLUSION

In the first part of the article, the comparison between three groups (of torture victims, forcibly mobilized persons and refugees) according to the manifested psychic disturbances measured by SCL-90-R, demonstrated that the groups are statistically significantly different. The intensity of psychic disturbances was the highest in the group of torture victims, slightly lower in the forcible mobilization group, and significantly lower in the refugee group. By comparing the posttraumatic symptomatology and self-assessment of the quality of life, we discovered a clear differentiation between the group of forcibly mobilized persons

and the group of refugees without the experiences of forcible mobilization, captivity or torture trauma. By the intensity of psychopathological phenomenology, the group of forcibly mobilized persons is much closer to the group of torture victims, which indicates the fact that forcible mobilization could bear similar consequences as any other act of clearly defined type of torture.

In order to test this assumption, in the second part of the article we have compared the groups of forcibly mobilized and tortured persons in view of the posttraumatic symptomatology and the presence of comorbid psychiatric diagnoses. It was established that torture victims have a significantly higher lifetime prevalence of PTSD, but also that there is no significant difference in the presence of current PTSD, although torture victims typically manifest a more severe clinical picture of PTSD. The explanation offered was that the specific type of psychological torture, combined with the implementation of the sense of guilt and betrayal, had almost as devastating an effect on the development of persistent PTSD as physical torture in enemy camps.

Analysis of comorbid psychiatric symptomatology demonstrated the differences in the distribution of psychiatric diagnoses. This finding has confirmed the assumptions of a separate profile of psychic disturbances in the forcibly mobilized persons, arising from specific circumstances of their arrest and specific type of ill treatment in paramilitary units' camps. The most prevalent psychiatric diagnoses, beside PTSD, were major depressive disorder and somatoform disorder in the forcibly mobilized, and dysthymic disorder and panic disorder in the torture victims group.

Based on the results presented in this article, it was concluded that the forcibly mobilized refugees are no different from the torture victims by the intensity of psychic disturbances and the presence of current PTSD, but also that a significant difference is found in the lifetime prevalence of PTSD and the specific profile of psychiatric symptoms, i.e. comorbid psychiatric diagnoses arising from specific differences related to the status of the victim, nationality of the torturer and the victim, purpose and intent of the torture/ill treatment (extortion of confession and revenge, as opposed to "disciplining" and manipulation), the ways of coping with trauma and valorization of the sustained trauma by the victims and by their environment.

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