AMANI TRUST

“At the boiling point of the pain”. Report of a pilot study examining the efficacy of psychotherapy for torture survivors.

31 May 2002

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This report was produced by the Mopane Group for the AMANI Trust. The Mopane Group was established in 2001 and consists of mental health professionals (clinical psychologists and social workers) who provide consultations, clinical services and related research in the area of traumatic stress.

This work was supported by the British High Commission, the Royal Norwegian Embassy, the Swedish Embassy, and USAID.

Background to the Study

For the purpose of this report we will not be reviewing the rapidly deteriorating political situation in Zimbabwe. However, it does form the back-drop for the following report. In the last two years Zimbabwe has seen as escalating number of victims of organised violence and torture (OVT)[1]. Since the Constitutional Referendum in February 2000 many violent acts on human life have been committed in the run up to the Presidential elections of March 2002. Thousands of people have been displaced from their homes, hundreds have been physically and emotionally tortured and more than two hundred have died as a result. This is the context to the specific situation we now face. The effects of organised violence on the victims in the current crisis situation (pre-election period) are not the only concern for Amani and the Mopane Group. There is also a shared concern for the long-term effects of widespread social violence in a country that has experienced three serious outbreaks of similar violence in the past three decades. Therefore our investigations are motivated by:

1. concern for crisis management of current victims;
2. developing and implementing effective services for longer term care;
3. participating with other organisations in identifying factors which contribute to repetitive outbreaks of violence of an extreme and repetitive nature.

It was against this general background that Mopane undertook a pilot project for the Amani Trust. As a pilot, the aim of the study was not restricted to a specific research question. The study was designed as open ended and qualitative. However, within this general proviso, a number of research questions might be delineated. These included:

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[1] **There are a very large umber of reports that cover the organised violence and torture. See the following:** *Analysis of Zimbabwe Presidential Election, March 9th, 10th, and 11th 2002, in Terms of SADC Parliamentary Forum Electoral Recommendations, First Edition: 14 March 2002, AMANI TRUST (MATABELELAND), ZIMBABWE; NETWORK OF INDEPENDENT MONITORS, (KWAZULU NATAL) SOUTH AFRICA; PHYSICIANS FOR HUMAN RIGHTS (DENMARK); AMNESTY INTERNATIONAL (2000), Zimbabwe: Terror tactics in the run-up to the parliamentary elections, June 2000, LONDON: AMNESTY INTERNATIONAL; IRCT (2000), Organised Violence and Torture in Zimbabwe, Harare and Copenhagen, 6th June 2000, COPENHAGEN: IRCT; IRCT/RCT (2001), Organised election violence in Zimbabwe 2001, COPENHAGEN: IRCT & RCT; IRCT (2001), Organised Violence and Torture in Zimbabwe, Harare and Copenhagen, 24 May 2001, COPENHAGEN: IRCT; Zimbabwe Human Rights NGO Forum (1998), A Consolidated Report on the Food Riots 19—23 January 1998, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum, (1999), Organised Violence and Torture in Zimbabwe in 1999, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2000), Who is responsible? A preliminary analysis of pre-election violence in Zimbabwe, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2000), Report on political violence in Bulawayo, Harare, Manicaland, Mashonaland West, Masvingo, Matabeleland North, Matabeleland South and Midlands, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2000, A report on Post-Election Violence, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2000), Report on Pre-election Political Violence in Mberengwa, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2001), Report on Election-related Political Violence in Chikomba, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2001), Human Rights and Zimbabwe's June 2000 election, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2001), Who was responsible? A consolidated analysis of pre-election violence in Zimbabwe, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2001), Politically motivated violence in Zimbabwe 2000–2001. A report on the campaign of political repression conducted by the Zimbabwean Government under the guise of carrying out land reform, HARARE: ZIMABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2001), Evaluating the Abuja Agreement, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2001), Evaluating the Abuja Agreement: Two Months Report, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM.*

- the appropriateness of a formal counselling service/model for the Amani client population,
- the ways in which the counselling was affected by the surrounding climate of ongoing violence and political uncertainty,
- given that each client was only to be offered a one-off session, what were the resources inherent in their narratives that might be mobilised to enhance a healing process,
- and in what ways were these healing processes enhanced by the experience through counselling of active witnessing and validation.

Brief summary of the literature

This study has been influenced by our reading of similar literatures in relation to the psychological and social effects of the trauma resulting from organised violence and torture. While we will not be reviewing that literature in depth in this report, it does seem important to note that there is a large body of literature relating both to similar experiences elsewhere in the world and also within the specifically Zimbabwean context. The consensus from cumulative international work would seem to suggest that the psychosocial trauma caused by OVT is characterised by symptoms characteristic of Post Traumatic Stress Disorder (PTSD), which might include clusters of the following: depression, anxiety, sleep disorders, fatigue, intrusive thoughts and emotions, nightmares, irritability, withdrawal and startle reactions (Kinsie et al 1984), and may well have multigenerational effects within the families of victims, as well as within the societies in which these upheavals are experienced (Danieli 1986). This latter is an important point since it would add weight to the view that appropriate interventions now might well reduce the risk of severe multigenerational transmission. Danieli's work should also alert us to another truism of the OVT literature; namely that survivors often censor themselves in retelling their experiences in order to avoid traumatising their listeners. However, Summerfield (2000), among others, warns against applying models of pathology to populations displaying normal distress reactions in the face of severe and violent social events. He stresses that healing lies primarily in the development of political cultures of human rights and social justice, and appeals for research into resilience factors.

Zimbabwe has been the site for some important research on the epidemiology of common mental disorders(defined as non psychotic disorders involving elements of anxiety and depression) in community populations which has suggested that between 30 –40% of clinic attenders are suffering from some form of common mental disorder (Patel, Todd & Winston 1997/1998). Subsequent studies indicate that in around 10% of the population chronic common mental disorders may be attributable to experiences of organised violence and torture (Reeler, Mbape, Matshona, Mhetura & Hlatywayo 2001). It is important to note that these studies predate the outbreak of the current wave of organised violence prior to the Constitutional Referendum in

2000; Reeler et al were talking to their informants about the chronic physical and psychological suffering consequent upon their experiences of OVT in the Liberation War of the 1970s. Given the widespread nature of the violence since 2000 we must anticipate high levels of fresh trauma and retraumatisation in these communities. Elsewhere in Zimbabwe, in work with Matabeleland communities traumatised by the 1980s Gukurahundi experience (Eppel 1998), reports of work with traumatised communities suggest that they may have other cultural resources which could be mobilised to enable healing and reparation, in particular in relation to rituals of reburial and cleansing. The Matabeleland work also importantly highlights the importance of attention to damage to the social fabric of communities and also notes that post Independence state violence may be experienced as more traumatic (perhaps because the perpetrators were previously seen as liberators) than that which occurred during the Liberation struggle (when suffering was anticipated but much comfort was gained from the importance of the cause).

We have been influenced by this work and by accounts of therapeutic work arising out of narrative theory that seemed appropriate in a context when the importance of witnessing is paramount. For example, we have been profoundly affected by Weingarten's (2000/2002) work on witnessing and the possibility that compassionate witnessing positions may help to ameliorate the effects of trauma, and challenging the consequences of deliberate silencing on our lives and communities. In this regard we find ourselves in agreement with earlier Amani work:

> *"…it is clear that storytelling is power. It has been salutary indeed to see the effects of the stories being witnessed. The value of 'story telling' and 'witnessing' cannot be emphasised enough in the therapeutic process." Reeler 1998: 11.*

Methodology

Two counsellors/research assistants were employed for this project. Both had previous training and experience in counselling although neither had worked with victims of organised political violence prior to this study. Counsellors were instructed that only one session was possible with each client and the emphasis in that session should be on facilitating free flow of the client's story.

During the 13 week pilot stage, 84 sessions were offered by the Mopane Group to Amani for clients to be referred for a one-off session. The methodology employed for the study was based on taping and transcribing clients sessions. Due to circumstances within the context outlined above, Amani was only able to utilise 31 of the total sessions offered. Of the 31 sessions only 23 were finally transcribed due to equipment failure. In addition a small amount of quantitative data was obtained from Amani for those clients whom they had referred. This quantitative data

includes basic demographics and total scores on the Self-Report Questionnaire-8 (SRQ8) which provides a basic measure of trauma related symptomatology at the time at which the client was originally assessed by the Amani staff. This information was obtained towards the end of the pilot project and it may be important to note that the counsellors did not have access to this information at the time of their session with each client.

The purpose of the pilot study was explained to all the clients and their consent was obtaine`d to tape the sessions. None declined. It was explained that the sessions would be entirely confidential and that the transcripts would be anonymous and would not include any names of people or places. Some clients requested a copy of the taped sessions whilst some other clients needed further reassurance regarding confidentiality.

The majority of the clients chose to conduct the session in Shona and this required careful translation into English. Thus, a system of proof reading by counsellors to ensure an accurate translation of the interview was essential.

Transcripts were then analysed using two modes of analysis. Firstly a series of themes was drawn out from the total group of transcripts by means of interpretive phenomenological analysis (IPA). Secondly, a smaller group of transcripts was analysed as narratives using narrative analysis. We believe that this combination allowed both attention to common themes as well as closer inspection of individual modes of expression and experience.

Clients

Seventy-four percent of the clients were men with the majority (82%) being under the age of 40 years. Only three women were referred. The mean age for the group was 32.7 years. Most were married with children (70%). Almost all the clients needed medical attention as a result of physical injury due to OVT and this was provided as a priority by Amani before being referred to the counselling session. Sixty percent of the group had been seen by Amani within four weeks of being referred for a counselling session. The remaininder had been seen by Amani several months previously. This may be due to the client experiencing multiple traumas and visiting Amani more than once. A majority of the clients was displaced and had lost their homes, so were being temporarily housed and in the care of Amani. Thus, most clients had no shelter, possessions, food or security when they initially approached Amani. Forty-eight percent of the group had been educated up to secondary level and 35% had only a primary level of education. Only one client had a tertiary education.

Findings

Of the total group more than half (56%) had a total score on the SRQ-8 of four or more[2]. 17% of this group scored higher than seven. Two clients had suicidal tendencies and were referred back to Amani who then referred them to a psychiatrist for medication.

Seventy-eight percent of the group had been physically tortured and 65% had experienced emotional torture. The physical torture largely involved being beaten (kicked, punched, hit with a weapon, attempted suffocation, and rolling naked on hot sand) and the emotional torture mostly involved being threatened and/or humiliated. The threats included death threats and further beatings. Also, threats were made regarding physical torture for the client's spouse (in most cases wives) including rape and sexual assault. In some cases it was announced publicly within the community that it was permissible for anyone to have sexual relations with the victim's wife.

Emotional torture accompanied the physical torture in most cases. Forty-seven percent of the group had experienced extreme humiliation that included being stripped naked in front of a large group, women in the group laughing at the person's nakedness, and the person being made to act like an animal (barking like a dog and/or leaping like a frog were the most common**).** The following is an excerpt from one client's story. His story was very similar to most of the client's experiences.

> ***"… youths came to my home to destroy my property and took away property that was meant for a bridge. After a while they came and abducted me and took me to their base. I was severely beaten. I got many lashes. They used a bicycle chain. After that I was released. They came again after three weeks, they tortured me. (Again later)….they abducted me. They said they had failed to make us do what they wanted. They took us to the war vets at Base Twleve. There we were undressed. They tied our hands and legs and we were severely beaten. They threw me into a hole and was ordered to bark like a dog. When they took me out they applied an itchy plant all over my body. Our area is extremely hot so we were made to roll in very hot sand. We had to do army drills until our bodies had blisters all over because of the hot sand and the itchy plant. They beat us again and poured water on us because we were critical. They left us there and we struggled to walk home."***

[2] *The SRQ-8, or the Self-Reporting Questionnaire-8, is an 8-item psychiatric screening instrument that was developed in Zimbabwe, and has been widely used in epidemiological and other psychiatric investigations. It was developed from the SRQ-20, an instrument developed by the World Health Organisation. All scores in excess of 4 on the SRQ-8 are indicative of psychiatric disorder, but do not indicate the type of psychiatric disorder.*

More than half the group (52%) said that their homes had been destroyed (usually by burning), although, this figure could be higher as it was difficult to obtain this data. The majority of the clients seen had been displaced either through the loss of their homes or because of the threat of death if they returned home.

Qualitative data

Many of the clients complained of symptoms which could be related to post-traumatic stress disorder (PTSD). These included intrusive thoughts, flashbacks, restlessness, anxiety, nauseousness, stomach aches, headaches, chest aches, difficulty sleeping, being fearful and agitated. Some clients were so desperate and hopeless that they thought of suicide.

One client stated *"… I am worried sick because I do not know my child's condition. That is why I look sad and withdrawn. Sometimes I feel like killing myself because I can't look after my family".*

All clients were extremely worried about what would happen to them and their families and how would they be able to look after their families in the current context. These symptoms are certainly consistent with a diagnosis of post traumatic stress disorder (PTSD) although we are aware that this is a controversial diagnosis in the literature.

Most striking for us as researchers was that the trauma emerged from the transcripts as deeply social in nature. We believe this element requires highlighting since it represents a divergence from the literature and begs further study. In the context of the narratives, clients began with often detailed descriptions of the violence they had been subjected to but very quickly moved to descriptions of the social impact. There are detailed descriptions of the effects on family and neighbours when the victim first arrived home, as well as longer term musings on the effect of the victimisation and displacement on the client's ability to continue providing for their families. However there was also considerable concern about the perpetrators, many of whom were known to the victims; thus there is a recurring refrain about the effect of these events on future social relations within the community. One man wonders what he will call his neighbours' children (who were also his tormentors) when they next meet. These social elements highlight ways in which whole communities have been torn apart by the insidious nature of this violence

and its consequences for future social relations in communities where there has been strong levels of social cohesion until now.

Themes

Very clear themes were evident in all of the clients stories. Abduction, physical and emotional torture, destruction of homes and possessions causing displacement were recurring themes. Most clients were in physical pain due to the injuries as one client states:

" At times I have problems with chest pains. At times I feel like I have asthma. At times I cannot bend. This happened from the time when I was injured."

In some cases, clients had lost loved ones due to the OVT and were in a state of grief as with this following client:

"There are so many painful experiences but killing my son, ah! That is very painful. There are times when I am sitting just resting and I expect my son to walk in the door….. it is painful. …. It is still so painful. I'll never forget this pain, never."

Others had been separated from their loved ones and still did not know where they were and if they were safe.

One client says**, *"Of all the things that happened to me, one thing that pains me most is the family I left behind. This worries me a lot. I left my wife and child. …. Right now I do not know how things are at home. Maybe they were beaten up, or maybe they were killed, I don't know…. I left everything there."***

The strong themes of emotions were loss, grief, isolation, anxiety, fear, anger, and suspicion. The theme of anxiety and fear was most often linked to how the clients were going to be able to look after family members and be able to 'get their lives back to normal again'.

One clients states, ***"I am deeply pained by the destruction of (my parent's) home. Now both parents are old, and to imagine them starting afresh to build up when things are so expensive, for them to reach where they have been now, this pains me a lot".*** **Another client said *"I'd say there are two things. Firstly, they introduced a fear in my life. I'm afraid all the time, afraid that they will come back for me at any time. Secondly is the uncertainty of how I will survive and fend for my children."***

Many clients were in physical pain, hungry and exhausted and this has to be taken into account when considering the provision of longer term clinical services. The clinical services cannot be run in isolation and would need to link up with other organisations who would address the physical needs of the clients.

The social impact of OVT is enormous within the Zimbabwean culture. Clients expressed feelings of both desperation and confusion as to how young people could beat up older people and in some cases people from their own village. One client did not know if he could return to his home as it had been his neighbour's children who had been involved in his physical torture.

Another client says, ***"When I am alone and sleep I think a lot about this fateful event, especially the fact that many women saw me naked. This pains me a lot and if I think about it I don't feel alright. I reach a point whereby I think that before going through such an ordeal I should have killed myself".*** The individual's experience of torture is even greater when seen within the social context.

When asked what was helping the clients cope many responded that prayer and a belief in God kept them going. Also, being with others who believed in the same political cause was very supportive. Many expressed a desire for revenge and believed that with revenge their own healing could take place.

One client said, ***" In my mind I feel hurt. If I were to be given a gun and go back to my rural home, I would have killed someone there. I would have shot someone. I suffered a lot. It was terrible. I experienced horror."***

Another client also expressed how he felt revenge would help: ***"I feel anger, pain, bitter and so forth has been reduced by two percent because I still want revenge. If I could go back to revenge that will settle everything."***

This is a concern as it contributes to the repetition of the violence.

Beliefs

A significant belief system was evident in the transcripts. A majority of the men in the client group felt that men should be strong and should provide for and protect their families. This created extreme concern and guilt about being responsible for the desperate situation. They felt burdened and worried about their family's future.

One client comments: ***"What pains me the most is that my family have nothing to survive on. Of course all these other things are painful. The most painful that is that even if I am to go back to my place, I have nowhere to start from".***

Many held onto a belief in God and prayer and this helped them to cope. Others believed that talking with others believing in the same cause helped a great deal. The three women believed their responsibility was to worry about the care of the children and to 'run the household' - cook the food, ensure cleanliness and to comfort the family.

Patterns

The pattern of violence was most often that large numbers of youth who would attack the victim at night when he was either alone or with his family. Often the victim was abducted and physically and emotionally tortured. In many cases the victim's home was destroyed usually by burning and the client was forced to flee from his/her home and village.

We have taken an excerpt from one transcript that describes a client's experience of the OVT. We found that this description was a strong theme throughout the transcripts.

An excerpt from one narrative:

PAIN

When I came to Harare I was deeply in severe pain.

If it was boiling water, it was at the boiling point of the pain.

I still feel this severe pain even though I haven't been harassed or tortured again.

I think of those at home. I think of my mother and the pain she is going through.

I think of the pain felt by those at home.

I think of the destruction of my home.

I think of the separation with my relatives, those whom I am not in touch with, the fear of going back to my rural home, my home where for the rest of my life I have been free to go to. I have no means and the freedom of doing all these things.

The pain constantly calls again. I always find myself pondering over the pain. I only relax for a short time.

The pain keeps on coming.

No action was taken against these people. I know that it is legal that if someone does you wrong, you go and report to the police and the person is arrested if he deserves prosecution, but you find out that people keep on committing such acts,

one doesn't know that he is doing wrong and does not repent, this is what pains me most.

If the country is in this state, what difference is there between a dog and a human being.
If I don't enjoy the freedom to go to my home place, the place where I was born, this pains me.

Since birth, I have never experienced such pain.

Also I have a lot of problems which need my attention in the same year at the same time.
I never expect the future solutions to my problems to come to an end. I wish an end of era to such problems, except that I was lucky to get an organization which is helping me.

For someone of my age, when I just sit and eat, I'm like vegetables in the garden which are just watered without making any production. I look forward to plan my life, to a bright future. I look forward that what I had accumulated will help me in my life. If this is destroyed by someone who made no contribution towards it, and has no right to do so, it's painful.

What happens when you are in pain and you long for a long life, it's a problem because deep thoughts can bring in illness.

Discussion

It is a striking and repetitive aspect, particularly of the men's stories, that impoverishment, loss of economic self-reliance and attendant social status are all negatively impacted by the experience of victimisation and displacement. We are aware that long term healing also requires a broader programme of economic assistance that is beyond the scope of our work.

Certain voices and experiences are significant by their absence from these narratives. For example, women are grossly under-represented here although the men who speak also point out that their wives, mothers, daughters and other female kin have also been direct victims. In the three transcripts that represent women's experience directly it is striking that their healing must co-exist with their ongoing attention to the needs of their male relatives. We have many questions about how the gendered role of caregiver can proceed with the demands of personal healing. Even more absent are the voices of children: although all these accounts show some evidence of the plight of children either as direct victims or as witnesses. There is clearly a very pressing need to find out how these children are coping and what help they may need to make sense of their very violent worlds. We are also struck by the muted way in which sexual victimisation, in particular, is given voice. We are aware that women, girls and in some cases men may well have been raped and sexually assaulted and humiliated as an aspect of their overall abuse through OVT. With the men we are aware that, since both our counsellors were

female, that there were major cultural and gender obstacles in the path of fully giving voice to these traumatic experiences.

The transcripts make clear that many of the direct perpetrators of violence were themselves young, impoverished community members whose incorporation into the ranks of the militias is highly likely to have included themselves experiencing or being threatened with torture and abuse. There is clearly a need to fully investigate this group in order to establish the most appropriate mode of therapeutic intervention.

Recurrent in these very painful stories is the theme of revenge and the dominant idea that only revenge will give peace to these victims. We are motivated to find alternative, non-violent modes of release and restitution that might bring peace to both victims and perpetrators and the deeply wounded communities from which they both come.

What was also striking is how strongly the clients were negatively affected by the break up of family and community ties. How these people are re-integrated back into their communities will be an important issue to address in the future.

Conclusion & Recommendations

It should be re-iterated that this was a pilot study based only on the 13 weeks prior to the Presidential elections. This data represents a very small sample from the larger group and the total figures of people in need are overwhelming. Further investigation to obtain true prevalence rates will be essential in order to establish the extent of the need. However, we believe that the study provides support for the establishment of a formal counselling service for both primary and secondary victims of OVT. It will be important that such a service provides a clinical service that is sensitive to cultural variations. For example, the pilot provided a one-off session for the individual. We anticipate that a more appropriate service would be able to be flexible with regard to the number of sessions as well as the configurations of clients that might attend such sessions.

Based on both the information collected from the stories told by the clients and the very significant silence on certain information (e.g. rape and sexual assault) there is an enormous need for further support for the people who have experienced trauma and the communities in which they are apart. An established counselling service will need balanced gender representation amongst its staff in order to begin to address these issues.

The psychosocial damage that is evident due to the current and longer-term political violence makes it essential to address the clients at an individual level. However, although the individual

service is effective for those who would benefit from individual sessions, it would also be important to address the victims of the political violence on a group and/or community level. At a group level, gender issues should be considered, i.e. perhaps groups of women within their communities could be given support separate from the men. Focussing on the families within the communities would also be important. Another extension of the core principle of cultural appropriateness would be attention to the social nature of the trauma. Thus we anticipate the need for an established and well funded community outreach programme that would provide a community based clinical service in the context of ongoing research into the social nature of the trauma and its effects on family/community/neighbourhood. One important aspect of this community programme would be liaison with community traditional leaders, both civic and spiritual, in order to help identify those resources within community domains that might be mobilised in the aid of healing. We also anticipate very close working relationships with those organisations whose aims are more focused on sustainable livelihoods and economic empowerment.

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