

AMANI Trust
26 Connaught Road
Avondale
HARARE, Zimbabwe
TEL: (263-4) 308115
FAX: (263-4) 335724

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**An Investigation into the Sequelae of Torture and
Organised Violence in Zimbabwean war veterans.**

A P Reeler, LLB,BA,MSc
Clinical Psychologist

M Mupinda, BSW,DPPM
Social Worker

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INTRODUCTION

This report is the product of a collaboration between the AMANI Trust and the Zimbabwe National Liberation War Veterans Association(ZNLWVA). The AMANI Trust was requested by the ZNLWVA to assist in the development of a programme to assess and treat war veterans suffering from psychological disorders as a consequence of their wartime experiences. Following a series of meetings, a proposed collaboration was agreed covering the following areas of training and research.

1.Training programme for ZNLWVA: Harare Hospital Clinic

A proposal for the training and supervision of primary care staff at the War Veterans Clinic at Harare Hospital was agreed. AMANI would train primary care and other nursing staff in the assessment and management of survivors of organised violence, using an approach developed by AMANI for the primary care and community settings. AMANI was to be responsible for all training and teaching, and would attend the clinic on a weekly basis. AMANI would provide all teaching materials, all materials for clinical recording, and all supplementary materials. AMANI would be responsible for training health staff in counselling techniques and group therapy, and would provide ongoing supervision to the staff trained for three months after the trainees complete the training course. This aspect of the collaboration has not taken place for a variety of administrative reasons.

2. Research project into the problems, physical and psychological, of War Veterans

A joint research project aimed at assessing and describing the medical and psychological conditions suffered by veterans was to be undertaken by the ZNLWVA and AMANI. The aim here was to provide a scientific appraisal of the veterans attending the War Veterans Clinic at Harare Hospital. The study would provide a comprehensive description of the medical and psychological problems of war veterans, as well as providing the first baseline data on the frequency of PTSD among war veterans.

A detailed proposal for the research was submitted to the Ministry of Health, the respective hospitals, and the Medical Research Council of Zimbabwe (MRCZ).

The study was to be the joint responsibility of the ZNLWVA and AMANI. Permission was granted by the Ministry of Health and the Superintendent of Harare Hospital, and a response from the MRC(Z) is still being awaited.

This report details the clinical findings from 5 months of attending the clinic at Harare Hospital.

BACKGROUND

The consequences of organised violence are many and complex, and include both physical and psychological effects. Since this is a new field there are still controversies about the effects and how best to classify them. The definition of organised violence too is complex, having to cover a wide variety of causes and effects on people. The following definition gives a good indication of the scope of the problem:

**"Organised violence is the interhuman infliction of significant avoidable pain and suffering by an organised group according to a declared or implied strategy and/or system of ideas and attitudes. It comprises any violent action which is unacceptable by general human standards, and relates to the victims's feelings. Organised violence includes inter alia 'torture, cruel, inhuman or degrading treatment or punishment' as mentioned in Article 5 of the UN Declaration of Human Rights(1948). Imprisonment without trial, mock executions, hostage taking or any other form of violent deprivation of liberty also fall under the heading of organised violence. The effects of apartheid, destabilisation, civil war, the forced displacement of people, and political violence constitute organised violence. Violence which occurs in these situations as a direct consequence of political repression, although it may appear random, is of a structural nature, involves violations of basic human rights and can only disappear when human, social and political relationships are profoundly changed."
(PAZ.1992)**

This definition, formulated during several Southern African meetings, describes the range of factors that must be relevant to any description of the health consequences of organised violence(1-2). The causes range from war and torture through to imprisonment and forced displacement, whilst the effects range from personal injury to social oppression. Thus, in Southern Africa, the decades of war and violence have created a justifiable concern for their effects. Despite this concern, detailed information and research is scarce, and the study of the effects of organised violence in the Southern African region is in its relative infancy.

In Zimbabwe, some work has been done with vulnerable populations, such as refugees **(3-4)**, and more recently work is progress in an area that suffered during the Liberation War of the 1970's **(5-6)**. However, it is fair to comment that little substantive work has been done on the effects of organised violence in Zimbabwe.

This report examines existing knowledge about the health consequences of organised violence, comparing the general findings with the data derived from screening and assessing Zimbabwean war veterans.

The effects of trauma

There were many previous attempts to give expression to the effects of trauma. These earlier descriptions had been classified mainly by reference to the precipitating event, and "concentration camp syndrome", "post-Vietnam syndrome", and "rape trauma syndrome" are all well-known examples of this approach to classification. The recognition that diverse stressors could produce remarkably similar effects was codified in 1980 with the invention of Post Traumatic Stress Disorder **(7)**. This was quickly followed by clinical studies and research, and resulted, in 1987, in the amended definition and description given in the revised version of DSM-III **(8)**. There are also plans to further amend this last definition **(9)**.

Post Traumatic Stress Disorder(PTSD) provides a description for disorders and symptoms in which the stressor is of a "catastrophic" nature. The term can be applied to a wide variety of catastrophes; from motor traffic accidents to earthquakes, but also includes the large numbers of soldiers who suffer disorders after a war. In modern wars, where it has been estimated that up to 80% of the casualties may be civilian, and mostly women and children, the term must also be applied to the civilian casualties of war. The "catastrophic" nature of trauma is described according to a dimensional concept of stress, in which stress varies, on Axis IV of the DSM, from minimal (minor violation of the law) through to catastrophic (concentration camp experience).

The prevalence of PTSD is rather variable, and has been assessed in two ways: one approach has been to examine prevalence in the general population, whilst the other has been to examine prevalence in "high risk" groups.

The Epidemiological Catchment Area(ECA) Survey estimated the lifetime prevalence of PTSD at about 1.3% in the general population, and at 3.5% in persons exposed to civilian or military violence, whilst a rate of 20% was found for veterans wounded in Vietnam **(10)**. Another community based epidemiological study estimated the lifetime and six-month prevalence rates at 1.3 and 0.44% respectively **(11)**. Those with PTSD had greater job instability, a family history of psychiatric disorder, parental poverty, and child abuse. The National Vietnam Veterans Readjustment Study reported lifetime prevalence rates of 30.9% for males and 17.5% for females, whilst,forthose exposed to high war zone stress, the current prevalence rates were 38.5% and 17.5% for men and women respectively **(12)**. The results of community-based epidemiology thus suggests that the prevalence increases as a function of experience with trauma.

In studies of "high risk" groups, a strong association is also consistently found between organised violence and psychiatric disorder, with PTSD being the most common diagnosis. The most studied high risk population has been war veterans, and studies of war veterans consistently demonstrate a relationship between the experience of violence and psychological disorder. Torture clearly represents the most extreme form of exposure to violence, in that the effects are premeditated and designed, the process usually involves attacks of both a physical and psychological nature, and, most importantly, torture has an explicitly political purpose in a clear socio-political context **(13)**. One estimate sees "government- sanctioned torture" as being present in 78 countries in the world **(14)**, whilst another estimate reckons that between 5% and 35% of the worlds refugees have suffered at least one torture experience **(15)**.

Studies of the prevalence of post traumatic disorders in torture survivors clearly demonstrate high rates of PTSD in torture survivors **(16)**. For example, in a study of Turkish prisoners, it was shown that 85% of the sample had been tortured **(17)**. Of the tortured group, 39% showed PTSD, whilst none of the non-tortured group had the disorder, and, of those who showed physical sequelae of torture, 71% had PTSD. Another study, from Gaza, showed that more than 70% of political prisoners had received more than one form of torture, with 30% showing PTSD **(18)**.

Studies of the effects of torture consistently demonstrate that the likelihood of disturbance and ill-health will increase with the presence of physical torture: studies show that Post-Traumatic Stress Disorder(PTSD) increases as a function of exposure to physical torture **(16-19)**. These survivors will frequently have both physical and psychological sequelae as a consequence of their torture **(16, 20-22)**.

Similar effects are found in groups exposed to war and other related trauma. For example, high rates of psychological disorder have been found in survivors of concentration camp experiences, with the most common symptoms being those of PTSD - startle reactions, emotional numbness, intrusive thoughts and nightmares **(23-25)**. In the studies of survivors of Nazi concentration camps, there was a consistent clustering of symptoms, which included the following: depression, anxiety, sleep disorders, fatigue, recurring nightmares, irritability, ruminations, isolation, and startle reactions.

In populations currently experiencing war, there is strong evidence for high rates of psychological disorder. One study from Sri Lanka, for example, showed a prevalence of about 64% in the general population, with a wide variety of disorders seemingly related to war trauma **(26)**. Studies from Africa are rare, but one study from South Africa showed very high rates of PTSD (87%) amongst persons internally displaced by the violence in Natal **(27)**. Some preliminary work in Zimbabwe suggests that there are an appreciable number of torture survivors in Zimbabwe **(5-6)**.

Disappearances have become an increasingly common method of political oppression, and this is an area where much work is needed to understand the individual and communal consequences. Studies of this population show a wide range of effects, ranging from higher mortality rates in the fathers of the disappeared to psychological disorders in the second-generation children **(28-29)**. These effects may be more marked in Africa, where individual experience is so often defined by reference to the family, and where every individual misfortune is a misfortune for the whole family. When an individual dies, it is crucially important for the whole family that traditional rites are observed, and failure to this is always seen as leading to misfortune for the family. Thus, when a person disappears, the whole family suffers, and the family may suffer from misfortune, quite apart from being unable to grieve in the proper fashion **(30)**.

Some general findings can be drawn from the published work. there is a strong association between organised violence and psychological disorder. This effect is found in many different groups: soldiers, war victims, torture survivors, concentration camp survivors, refugees, internally displaced persons, etc. There is a strong indication that there is a "dose -response" effect: that the likelihood of disorder increases with the more direct the experience of violence. This hypothesis would therefore predict much higher rates of disorder in torture survivors than in people who merely witness an isolated incident of trauma, such as a motor traffic accident.

Current understandings about trauma

Perhaps one of the first areas to examine is the "dose-response" theory. The degree of exposure to violence seems to affect the course of PTSD, and an American study on children attacked by a sniper at school showed this clearly **(28)**. One month after the attack, 77% of the children who had been in the playground when it was attacked showed PTSD, whilst 67% of the children who had been inside the school also showed PTSD. Fourteen months later, 74% of the former group still showed PTSD, whilst only 19% of the latter were still suffering from the disorder. However, not all studies show such a clear-cut effect, and there are many conflicting reports.

For example, one study showed a clear relationship between impact torture and disorder **(16)**, whilst another series of studies demonstrated that psychic trauma alone produced disorder **(31-32)**.

This conflict is somewhat modified by a recent empirical study, which demonstrated that, although PTSD was a probable result of physical injury, it was more a consequence of the perception of injury than the actual severity of the injury itself **(33)**. Thus, there remains a controversy over the dose-response theory, and the findings that attitudinal variables, or the subjective perception of trauma, seem to have a determining effect on the acquisition of post traumatic disorders requires further work.

The study of the natural history of post traumatic disorders has also been subject to conflicting findings. Although there is little doubt that PTSD usually follows trauma, there has been some debate about the course of post traumatic disorders, especially over the notion that there is a delayed subtype. This argument has been partially resolved by a recent study from Israel, examining veterans who sought psychiatric help between 6 months and 5 years after the 1982 Lebanon War **(34)**. This study suggested that 40% of cases represented delayed help-seeking, 33% was exacerbation of subclinical PTSD, 13% was reactivation of old PTSD, and 10% was delayed onset PTSD.

The study of the long-term course of post traumatic disorders has been best documented in studies of Holocaust survivors, some of which demonstrate clinical disturbance in second and third-generation survivors **(35)**. However, it is not clear that the disturbance measured in the grandchildren of concentration camp victims can be described as PTSD, and there is debate as to whether studies have unequivocally demonstrated inter-generational effects of post traumatic disorders **(36)**. An additional complication lies in recent work indicating vicarious traumatisation in people who work with victims of trauma **(37-38)**. Vicarious traumatisation lends at least theoretical support to the argument for intergenerational effects, but the concept of vicarious trauma still requires good empirical validation.

All of this epidemiological work has been substantially supported by the more empirical work. Laboratory studies have shown PTSD sufferers to have marked and significant response to noxious stimuli, with sufferers showing both psychological distress and physiological reactivity to battle sounds, war imagery and the like, and marked avoidance of these stimuli: 80% of PTSD sufferers in one study terminated exposure to audiotaped combat stimuli as opposed to 0% healthy combat veterans **(39)**.

Studies of sleep show traumatic dreams occurring in both REM and non-Rem sleep, as well as difficulties in both falling asleep and maintaining sleep. In general, the sleep studies show a wide range of differences between PTSD sufferers and other populations, both civilian and military. Other studies, investigating intrusive cognitive activity, have shown marked effects of intrusive cognitions, with PTSD sufferers showing positive interference for Vietnam-related words (BODYBAG), but

not for other intrusive words (GERMS) **(40)**. Thus, some of the key features of PTSD, sleep disturbance, intrusive cognitions, psychological reactivity and physiological distress, seem to be supported empirically, and there is support for the notion of a specific disorder produced by trauma, and capable of being delineated from other disorders.

Thus, it seems clear that exposure to violence has severe, persistent and delayed sequelae, with a possible dose-response effect, but there still remain some difficulties, and some critics of the idea of PTSD being the unifying concept for post traumatic disorders. The major critics come from amongst those working with torture survivors, who are critical of many aspects of the PTSD definition **(41-42)**, whilst others suggest that there may still be such a thing as a "torture syndrome" apart from PTSD **(43)**. Reeler (1993) has argued in favour of a torture syndrome, whilst also arguing against a narrow medical definition of the effects of trauma such as torture **(43)**. There are also other critics who argue against a narrow medical definition for the effects of torture **(44)**, and this debate will continue for some time.

Effects of Torture

Studies on the effects of torture have a particular value in the field of traumatic stress studies, for torture provides a very clear example of trauma, and an area in which it is sometimes possible to examine the effects of both physical and psychological factors.

Studies of the physical effects of torture and organised violence clearly show a wide range of physical sequelae **(20-22)**. The effects can range from neurological impairments, usually produced by violent beatings, to minor scarring, produced by burns or electrical torture. Physical torture produces a wide range of sequelae, usually related to the type of torture applied **(20)**, and also produces a wide range of physical complaints in survivors.

The most frequent complaints of torture survivors relate to somatic illness, with neurological symptoms (85%), cardiac symptoms (75%), gastrointestinal symptoms (70%), and motor symptoms (90%), being the most frequent. Of these groups of symptoms, motor symptoms are most likely to reveal a physical disorder, and are usually related to physical injury sustained during beatings or other physical abuse. Somatic complaints, in general, are likely to be an indication of psychological disorder.

Torture is usually described from one of two orientations: those arguing in favour of a torture syndrome, and those arguing in favour of the PTSD concept. The evidence for a torture syndrome is presently unconvincing, although it is argued that the notion of a torture syndrome is too narrowly conceived at present **(43)**. It is also apparent that the PTSD concept has difficulties, and, for example, several studies of torture survivors show that the definition of PTSD does not describe all the morbid group **(16-17)**.

Stuart Turner and his associates have argued strongly in favour of a dimensional model for describing the effects of torture, and have provided some interesting evidence for this model **(42,45)**. This model argues that the effects of torture are best described by four dimensions: (a) incomplete emotional processing (PTSD); (b) depression; (c) somatoform complaints; and (d), the "existential dilemma". This model has had some support, but the debate remains about how best to classify the effects of torture, and whether there are limitations to the PTSD concept.

In summary then, studies of torture survivors show high rates of psychological disorder among survivors, with PTSD being a frequent, but not exclusive diagnosis. Torture survivors show a wide range of sequelae, both physical and psychological, and the most useful description of the effects of torture seems to be a dimensional model of overlapping symptom clusters.

Organised violence and torture in Zimbabwe

Although there have been several studies examining refugees within Zimbabwe **(3-4)**, no detailed studies have been conducted on survivors of the Liberation War of the 1970's. AMANI mounted a community-based programme to assist survivors of violence in Mount Darwin District. Mount Darwin District was chosen because of the history of human rights violations during the Liberation War, as well as the persistent incursions of Renamo guerrillas during the 1980's and 1990's. The findings from this programme are detailed in a series of reports and papers **(5-6,30)**.

Between March and September 1995, a total of 182 persons with psychological disorders were identified at 2 hospitals, as well as 57 survivors of organized violence. As regards the survivors of organized violence, this was a significant group in terms of numbers, about 34% of

all psychological cases in the outpatient setting. Very high rates of physical torture were reported, with both samples report beatings at about the same rate, but the more unusual forms of torture - abnormal postures, submarino, and electrical shock - were reported more frequently at Karanda. High rates of psychological torture were reported by both samples.

The sample reported very high rates of witnessing of violence by family members, and, disturbingly, very high rates of witnessing by children. Furthermore, the sample also reported very high rates of witnessing torture and executions by the survivors who were assessed. The survivors report high rates of torture, killings, and disappearances in other family members. The disappearances are a significant problem reported by these survivors, and AMANI is currently carrying out a small investigation of the consequences of disappearances on families. The preliminary data indicate that families are deeply troubled by the disappearances **(30)**.

The injuries reported by survivors complimented the kinds of violence and torture reported. In general, the Karanda sample reported higher rates of physical symptoms than the Mount Darwin sample, but both samples reported high rates of the symptoms that would be expected to be the consequence of physical abuse. Back pains, hearing problems, joint pains and diminished motor capacity were frequent complaints. The psychological symptoms indicated many symptoms that are congruent with diagnoses of post traumatic disorders. However, not all cases of torture resulted in PTSD, and Mixed Anxiety-Depressive Disorders and Depressive Disorders were also commonly seen in this clinical population.

CONCLUSIONS:

This brief review of the literature supports the view that organised violence has traumatic consequences for individuals and families. The literature suggests a dose-response effect, with the likelihood of PTSD increasing as direct exposure to violence increases, with torture representing the most severe form of organised violence identified to date. The effects of torture and organised violence are thus severe, causing lasting impairment and possibly second-generation effects in the families of survivors.

The limited literature from Zimbabwe indicates that victims of violence can be found in high-risk populations such as refugees, as well as in communities that have suffered from high rates of violence in the recent past. Preliminary reports indicate high rates of PTSD and psychological disorder in persons who have experienced organised violence, either directly or indirectly. There are also suggestions that disappearances are a significant cause of both individual disorder and family dysfunction **(30)**.

AIMS OF STUDY

The proposed research study aimed to provide a comprehensive description of the effects of torture and organised violence amongst war veterans in Zimbabwe. However, until the research study is undertaken, the present summary, from the clinical screenings and assessments provides the only useful data base on war veterans.

As was seen from the review above, the range of effects can be very broad indeed, from physical to psychological, and the populations affected can also vary considerably, from torture survivors through to the caregivers themselves. The present study restricted itself to a limited set of aims, focusing on the psychological effects of organised violence. With the limited data available and the limitations of a clinical study, a narrow set of questions can be examined. These can be described as follows:

- (i) frequency of psychological disorders, including PTSD, in war veterans;**
- (ii) description of demographic and clinical features in war veterans suffering from psychological disorders;**
- (iii) examination of screening and assessment procedures.**

METHODS

A small pilot investigation indicated that about 40% of the war veterans attending the compensation clinic at Harare Central Hospital scored positively on a psychiatric screening instrument. This was higher than comparable estimates for primary care settings **(46-47)**, and was more in line with those obtained in a refugee setting **(3-4)**. This suggested that the war veterans clinic was a prima facie "high-risk" group, and the clinic was a suitable setting for an examination of the objectives indicated above.

A three-stage assessment procedure was used, which can be briefly described as follows:

- 1. Initial screening**
 - **Self-Reporting Questionnaire (SRQ-20)**
- 2. Assessment of Consequences of Torture and Organised Violence Battery**
 - **Present Health Status**
 - **History of Experience of Violence**
- 3. Clinical Assessment of PTSD**
 - **Clinician Administered PTSD Scales(CAPS)**

Patients were initially screened using the Self-Reporting Questionnaire(SRQ-20), a valid and reliable psychiatric screening instrument that has had wide use within Zimbabwe. This group was then assessed in greater detail using a structured interview, the Assessment of the Consequences of Torture and Organised Violence Battery. The Clinical Administered PTSD Scale(CAPS), a recently developed clinical interview, was administered in order to determine whether the patient was suffering from PTSD **(48-50)**.

INSTRUMENTATION

As indicated above, series of instruments were used, which are briefly described below.

1. Self-Reporting Questionnaire(SRQ-20):

This 20 item psychiatric screening instrument was developed by the World Health Organisation during a multi-centre collaborative study **(51)**. Since then it has been widely used throughout the world, and the reliability and validity of the instrument has been well-researched.

The SRQ-20 has been widely used in Africa and Zimbabwe **(47)**, and several local studies have used the instrument **(3-6,46,52)**. The use of the instrument has been systematised into a manualised approach for primary care nurses **(53-56)**.

2. Violence Battery:

This instrument was designed by AMANI for the use of primary care and community-based staff. It is based on previous work done elsewhere **(20)**, and consists of three structured interview forms. A manual detailing the use of these forms and the assessment of victims of torture and organised violence has been prepared for health and community workers **(57)**.

The first of these forms, the Present Health Status form, covers brief questions about past medical history, and 22 questions about current symptoms. The second of the forms, the History of Experience of Violence, covers the person's experiences with organised violence, and involves detailed questions about the forms of violence, including witnessing of violence and disappearances. A detailed narrative history of the violence is also obtained from the victim.

The third form, which should be completed by a medical practitioner, involves a medical examination of the patient, looking for the sequelae of the violence. In practice, this form was rarely used, and the data collected using this form are not reported here.

3. Clinician Administered Post-Traumatic Stress Disorder Scales:

The Clinician Administered Post-Traumatic Stress Disorder Scale (CAPS) is a recently developed instrument for the assessment of PTSD **(48)**. The instrument has been shown to have good validity and reliability **(49-50)**, and reviews have suggested that the instrument may be preferred to other instruments for the assessment of PTSD. The psychometric properties of the instrument have additionally been shown to be acceptable **(58)**.

MEASURES TAKEN:

Demographic data, information about the experience of organised violence and torture, and measures of psychiatric morbidity were compiled. These data are reported descriptively below.

A number of additional measures were developed from the questionnaires administered, based on certain factors shown to be important in other studies.

1. Violence frequency(Violfre)

The total number of discrete episodes of organised violence experienced by a person.

2. Impact torture(Impactor)

The total number of different types of physical torture and deprivation experienced by a person.

3. Psychological torture(Psychtor)

The total number of different types of psychological torture and sensory overstimulation experienced by a person.

4. Witnessing of violence(Witness)

The total number of different types of organised violence witnessed by a person.

5. Other family survivors(Othfam)

The total number of other family members who also experienced an experience of organised violence.

6. Disapparances(Disapp)

The total number of family members who disappeared during the war. A person is defined as disappeared if the family has not buried the person and the whereabouts of the dead person's grave is unknown.

7. Physical symptoms(Physcore)

The total number of physical symptoms reported by a person.

8. Psychological symptoms(Psyscor)

The total number of psychological symptoms reported by a person.

9. SRQ-20 total score(SRQtot)

The total score, out of 20, reported by a person. Scores in excess of 7/20 are indicative of psychological disturbance, whilst scores in excess of 10/20 are clinically significant and termed "severe".

10. SRQ-20 depression score(SRQdep)

The total number of depressive items on the SRQ-20 reported by a person.

11. SRQ-20 anxiety score(SRQanx)

The total number of anxiety items on the SRQ-20 reported by a person.

12. CAPS frequency score(CAPSfre)

The total score on the Frequency subscale of the CAPS reported by a person.

13. CAPS intensity score(CAPSint)

The total score on the Intensity subscale of the CAPS reported by a person.

It was hoped that the use of a large number of measures would allow the partialling out of causes and effects. Each measure hypothetically measured a discrete factor seen as importantly involved in organised violence and its effects, and cross-tabulations might reveal the relationships between these variables

Means and standard deviations were calculated, and statistical tests of significance were conducted using OXSTAT, a commonly used statistical programme.

RESULTS

A total of 175 war veterans were screened from July through to September 1995, but complete assessments were available for only 53 of this sample. There were a variety of reasons for assessments being incomplete, the major one being that the veterans who completed the compensation process were unwilling to return for interviews that were not felt to be useful. The breakdown of the sample is given below in Table 1.

Table 1.
Sample according to stage of assessment.
(n=175)

SRQ-20 only	19(10.8%)
Incomplete assessment	103(58.9%)
Complete assessment	53(30.3%)

The data reported are thus only of the group for whom complete assessments were done.

Experience of organised violence

The experience of violence is taken from the structured interview, and summarised the data obtained from the History of Violence form. Table 2 over shows the types of torture reported by the war veterans, and includes physical torture, deprivation, and psychological torture. As can be seen, psychological torture, in the form of abuse and threats, and beatings figure strongly as the most frequent forms of torture, but other kinds of torture are also found. This is similar to the findings the community study **(5-6)**.

Table 2
Types of torture reported by war veterans
attending the compensation clinic.
(n=53)

Threats(against self or family)	29	
Verbal abuse	27	
Severe beatings		25
Beatings		24
Deprivation		19
Simulated execution	15	
Electrical shock		7
Exposure(heat/cold)	5	
Abnormal positions	4	
Burnings		3
Hanging/suspension	3	
Constant noises		3
Asphyxiation("submarino")	3	
Abuse with excrement		1
Sexual abuse	1	
Rape		2

Table 3 below indicates the incidence of particular types of injury (torture or war injury) reported by the veterans. As can be seen, torture or war injury alone were relatively infrequent, but multiple experiences were extremely common. This pattern of multiple experience is important, and many of the war veterans explained that the previous experience of torture was a deciding reason for their joining the liberation struggle.

Table 3
Incidence of war injury or torture reported
by war veterans.
(n=53)

War injury only		8
Torture only	9	
Both war injury and torture	31	
No war injury or torture	5	

Table 4 below indicates the kinds of indirect trauma (witnessing and disappearances) reported by the veterans. As indicated earlier, indirect trauma, as witnessing, is a frequent precipitant of post-traumatic disorders, and, therefore, the very high incidence of indirect experience of violence reported by the war veterans is of decided importance. It is noteworthy that most veterans reported several different forms of indirect trauma.

Table 4.
Indirect trauma reported by war veterans.
(n=53)

WITNESSING:	
Physical torture	37
Psychological torture	26
War injury	36
War death	30
DISAPPEARANCES:	
One family member	20
Two family members	9
More than two family members	4

The disappearances are equally important, especially with the cultural significance of death in Shona and Ndebele culture. Elsewhere, it has been observed that disappearances have profound family consequences, and it seems likely that disappearances are a strong indicator of family dysfunction (**30**). The veterans frequently expressed personal concerns about the disappearance, as well as indicating familial concern over the same.

Psychological disorder in war veterans

Table 5 below shows the prevalence of psychological disorders in the entire sample screened.

Table 5
Prevalence of psychological disorders in war veterans: SRQ-20 scores.
(n=175)

CASES	SRQ-20 POSITIVE	SRQ-20 NEGATIVE	PERCENTAGE PREVALENCE
175	129	46	73.3%

The prevalence of disorder in this sample is extremely high, higher than any other comparable Zimbabwean sample, but similar to samples from displaced persons in a war zone **(26-27)**. This is perhaps unsurprising, given that the war veterans sample is composed of a selected group of persons with a clear history of trauma, either from war injury or torture. The high prevalence is comparable with other studies of torture survivors.

Table 6 shows the prevalence of severe disorders amongst the sample that proved positive on the SRQ-20. Severity is indicated by SRQ-29 scores in excess of 10 out of 20, and the veterans' sample shows a very high percentage with clinically significant psychological disorders.

Table 6.
Prevalence of severe psychological disorders
in war veterans: SRQ-20 scores.
(n=129)

CASES	>10/20	<10/20	PERCENTAGE PREVALENCE
129	46	83	64.3%

Table 7 below describes the clinical measures taken from the war veterans, summarising the data taken from the structured interview (Present Health Status), the SRQ-20, and the CAPS.

Table 7.
Clinical measures in war veterans.
(n=53)

	MEAN	S.D
Number of physical symptoms	4.9	2.3
Number of psychological symptoms	5.8	2.3
SRQ-20(total score)	11.2	3.5
SRQ-20(depression score)	5.6	2.4
SRQ-20(anxiety score)	4.2	1.6
CAPS(frequency score)	22.5	11.7
CAPS(intensity score)	23.9	12.6

As can be seen, the veterans report a very high number of both physical and psychological symptoms: in fact, the mean number of symptoms reported was 10.1.

This is considerably more than comparable primary care and community samples. Research elsewhere has indicated that the number of symptoms is related to the presence of psychological disorder **(46,51)**, but caution should be adopted in drawing such conclusions with a trauma population where patients may well have both physical and psychological sequelae.

The veterans tended to report more psychological than physical symptoms, and the physical symptoms tended to cluster around back pains, hearing problems, and pains in arms and legs. This cluster would be expected in persons who had received beatings, but was also related to war injuries. The data from the SRQ-20 was similar to previous studies with populations with non-traumatic disorders, with depression alone being twice as common as anxiety alone. Mixed anxiety-depression was the most frequent profile from the SRQ-20, which is again similar to previous studies.

The data from the CAPS indicates mean scores in the range obtained from other veterans samples **(58)**. The scores on the CAPS suggest that the cutting scores used in American studies are likely to be similar for a Zimbabwean sample, but this needs to be confirmed by additional study. Table 8 over describes the correlations between the various measures, described earlier.

Table 8.
Correlations between various measures in war veterans:
Clinical history, SRQ-20, and CAPS.
(n=53)

1. Violfre	Psychtor (0.43***); Othfam (0.38**)
2. Impactor	Psychtor (0.01***)
3. Witness	Othfam (0.32**); Disapp (0.37**); Physcore (0.31*)
4. Physcore	Psyscor (0.57***); CAPSfre (0.28**)
5. Psyscor	SRQtot (0.39**); SRQanx (0.31**)
6. SRQtot	SRQdep (0.42**); SRQanx (0.48***); CAPSfre (0.42**)
7. SRQdep	CAPSfre (0.49***); CAPSint (0.39**)
8. SRQanx	CAPSfre (0.29**)
9. CAPSfre	CAPSint (0.63***)

* **p=0.05**

** **p=0.01**

*** **p=0.001**

The correlations suggest several clusters, and some curious relationships. Psychological torture (**Psychtor**) is correlated with physical torture (**Impactor**) and the frequency of violence (**Violfre**), whilst physical torture (**Impactor**) is correlated with witnessing of violence (**Witness**), other family members experiencing violence (**Othfam**), and disappearances (**Disapp**). Logically, the relationships would be expected to be reversed, and this paradoxical finding deserves further study. The measures of the experience of violence suggest that the screening procedure will identify both individual victims of violence (**Impactor, Violfre and Witness**) and the likelihood of other family members having experienced organised violence (**Othfam and Disapp**).

The second cluster, which involves the measures of signs and disorders, shows correlations both between and within the various instruments. The physical symptom score (**Physcore**) is strongly correlated with the psychological symptoms score (**Psyscor**), as well as with the CAPS and witnessing. It is interesting that complaints of physical symptoms are related to indirect rather than direct trauma. The CAPS (**CAPSfre**) correlates well with the SRQ-20, and its subscales, as well as a very strong correlation with the other subscale of the CAPS. It is also noteworthy that the CAPS correlates more strongly with depression (**SRQdep**) than with anxiety (**SRQanx**). The SRQ shows relationships with the other two sets of measures, as well as good agreement between the overall score and the two subscales, which is indicative of good internal consistency.

Table 9 (over) indicates the diagnoses given to the war veterans, given on the basis of the interviews and the instruments administered. No diagnostic interview was used, and the diagnoses are derived solely from the clinical measures. Therefore, it is probable that there is a range of other alternative diagnoses applicable to these veterans, and it will be important for the future to carry out a detailed psychiatric study using a standardised diagnostic procedure, such as the Clinical Interview Schedule or the Present Status Examination. Multiple diagnoses were given where this was indicated by the data from the clinical measures.

DISCUSSION

It is disappointing that a larger sample could not be obtained. However, the sample is large enough to draw at least some tentative conclusions.

The prevalence of psychological disorders amongst the veterans is very high indeed, but not too different to other trauma populations, such as refugees **(3-4)**. It is in the same range as another Southern African study **(27)**, which showed rates of PTSD in the same range. The prevalence of Severe disorders is also very high indeed, and much higher than that found in studies with comparable populations **(3-4)**. In a sample actively seeking material compensation, the high rates might lead to suspicions of "faking bad" for compensation purposes, and, thus, these findings deserve further investigation, preferably in a veteran population that is not actively seeking compensation such as the community.

The reasons behind seeking compensation were mixed, with very few cases of war injury or torture only and more than half(58%) reporting both a war injury and a previous experience of torture. On initial screening, very few offered torture as a reason for attending, and a history of torture was usually only elicited at the second stage. It is important to note that for the majority an experience of torture preceded the war injury, and the experience of organised violence was a frequent reason for leaving the country or joining the liberation struggle. In terms of the times of injury, most seemed to have happened between 1977 and 1979, and many of the veterans reported injuries acquired during raids on camps in Mozambique. These raids were clearly very traumatic indeed, and many reported witnessing scenes of extreme horror.

As regards the types of trauma reported, it can be seen from Table 2 above that significant numbers reported physical and psychological torture. Although beatings, verbal abuse and threats were the most frequent forms of torture reported, other forms of torture were not uncommon, but not as common as in a community sample **(5-6)**. Witnessing of organised violence was very common, and, this corroborates the view that indirect trauma is an important cause of post traumatic disorders. As pointed out above, indirect trauma was frequently reported as the witnessing of deaths and injuries during attacks on camps in Mozambique.

The injuries reported were very variable, with some reporting serious and handicapping conditions, whilst most reported relatively minor physical injuries. The injuries were not experienced as minor, however, and the veterans were both preoccupied by their injuries and expressed considerable concern over the ways in which these injuries affected their lives. A fair number (21%) reported having experienced psychological problems in the past.

In addition to the injuries sustained by these veterans, there was a high percentage reporting experiences of organised violence and disappearances in their family members. The effects on the wider family are important, and suggest that a narrow focus on the veterans alone may not address the rehabilitation needs of this group. In particular, the effects of disappearances may be a significant factor in maintaining psychological disorder.

Overall, the data on the experience of organised violence suggest a group with a significant history of human rights violations, many having multiple experiences as well as other family members with similar experiences. This will have decided consequences for rehabilitation.

The Clinical Measures

The clinical measures indicate high rates of psychological disturbance. The mean number of current symptoms reported was high (10.1), with slightly higher numbers of psychological as opposed to physical symptoms being reported. As indicated above, the number of symptoms on presentation to a health setting has been shown to be a good indicator of the presence of psychological disorder, and, with some caution, this would seem to be the finding here. The caution is to do with disregarding the fact that the physical symptoms reported may well reflect physical injury, and that Physcore is more related to PTSD than ordinary psychological disorder. Many veterans reported poor hearing, pains in their arms, legs and back, and these are very likely a consequence of beatings received or war wounds. It is interesting that the physical symptoms reported correlates with PTSD, as measured by the CAPS, whilst the psychological symptoms correlate with psychological disorder as measured by the SRQ-20.

A very high proportion report psychological disorders in the severe or clinically significant range. This is somewhat higher than that found in primary care samples or refugees, and is perhaps unsurprising in patients with multiple disorders. It is important to stress here the need to screen for psychological disorders in survivors of organised violence, especially when the survivors themselves are frequently unaware that many of their symptoms are psychological or that they are suffering from psychological disorder.

As regards the diagnoses given, PTSD would be a common diagnosis, but PTSD may not be exclusive of other disorders: depression was frequently reported. Here it is important to note the issues raised above in the Introduction, and, in particular the observations of Turner and his associates, who comment that PTSD may be only one set of symptoms found in torture survivors.

This sample seems to provide some support for this view, with the veterans reporting PTSD symptoms, Depressive symptoms, and Somatic symptoms with some frequency. There is a clear need here for more work on the classification of disorders.

As regards PTSD, the mean score reported by these war veterans was within the range of other studies (**58**). The distribution of the CAPS scores suggests that a cut-off of 19 on the Frequency subscale and 21 on the Intensity subscale would be appropriate for Zimbabwe. This preliminary finding needs to be extended by further work, probably with a two-stage procedure using the CAPS as a screen, validated by subsequent independent psychiatric assessment.

The screening and assessment procedure seems to work well, and there were strong relationships between all three instruments and their derived measures. As can be seen from Table 7 above, there was a strong correlation between the SRQ-20 and the CAPS, and good correlations within the instruments too. The SRQ-20 total score correlated moderately well with its two subscales, 0.48($p=0.001$) and 0.42($p=0.01$) for Anxiety and Depression respectively, whilst the two scales of the CAPS showed a very strong correlation (0.63; $p=0.001$). These results together suggest both good internal and external validity for the two instruments, and also provide some small support for the instruments' reliability. Additionally, it may be that the the symptom checklist, the Present State of Health, and its two subscales may provide a useful short-form screen for assessing the consequences of organised violence. This too deserves further work, again using a two-stage validation procedure.

Finally, substance and alcohol abuse, whilst reported with some frequency, did not appear to be related to disorder. This suggests that these veterans were not in the habit of using substances or alcohol in a self-medicating fashion, and, in fact, were more likely to reduce such use as a consequence of their symptoms.

In conclusion, the assessment procedure seems adequate, the measures seem valid, and there are good intercorrelations between many of the measures. The relationships between the measures of the experience of organised violence suggest that the structured history will identify survivors as well as other family members, and that this is related to a history of significant disorder, both physical and psychological disorder. The medical history correlates well with the other clinical instruments.

RECOMMENDATIONS

This preliminary study indicates that psychological disorders are common amongst war veterans, and demonstrates the need for an effective rehabilitation programme. Most (73%) of those screened were suffering from some form of psychological disorder, with a very high percentage (64%) having clinically significant disorders. It is noteworthy that the disorders were long-standing and chronic, and also that very few had received any form of psychiatric assistance: only 21% reported any previous psychological disorder. Since these disorders can be treated, it should be a priority to offer treatment as well as compensation. It may be that compensation will address some aspects of the problems experienced by the veterans, but a full return to health will require some active intervention.

It should be possible to develop a programme to assist the veterans with their psychological distress. There is considerable evidence to suggest the value of low-cost, paraprofessionally-delivered treatment approaches, and this could be done using the resources of the ZNLWVA itself. This would require the training of nurse-therapists, supervised and supported by a mental health professional. This basic team could then train other suitable members from amongst the veterans themselves, and provide ongoing support, supervision, and a referral chain for these counsellors. The mental health professional could then provide overall supervision, further training and ensuring that the training is adequate, and operating as the consultant of last resort.

There is a decided need to sensitise health workers to the health consequences of organised violence and torture. It is apparent from other settings that there is, in general, a low awareness of the prevalence of psychological disorders, and disorders due to violence remain equally undetected. A series of provincial workshops could have the effect of raising the profile of survivors of organised violence with health workers.

As regards compensation itself, the Act is silent in most respects on the scale of award that may be given for psychological disorder due to trauma. There is a pressing need for the relevant authority to determine a scale of damages for psychological disorder, and it is important here to bear in mind that many of these veterans have been suffering for more than two decades from incapacitating and distressing symptoms. A thorough review of the War Victims Compensation Act would seem worthwhile, especially since it was introduced to meet a pressing need, and was designed before much of the current knowledge about trauma and its consequences was obtained.

It will also be important for treatment to be included as part of the compensation process, and for the health service of the state to be made part of the treatment process. This again could revolve around the kind of programme suggested for the ZNLWVA, using nurse therapists and mental health professionals as supervisors and trainers.

The results reported above can only be taken as a beginning, and it is very clear that considerably more work is needed before we can have both a good understanding of the health consequences of the organised violence that has afflicted Zimbabwe. It is also clear that healing the injured and the disordered will be a task of social reconstruction of some magnitude.

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