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Community-based rehabilitation for survivors of organised violence: Some preliminary findings

A P Reeler
&
M Mupinda

The AMANI Trust

Address for correspondence: 26 Connaught Road
Avondale
HARARE
Zimbabwe

BACKGROUND

There is now a substantial literature dealing with the consequences of repressive violence on individuals and families **(1)**. The literature details the effects, on individuals, of torture and violent injury, as well as the effects of exposure to violent situations, and also deals with both the short-term and long-term effects. 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. These survivors will frequently have both physical and psychological sequelae as a consequence of their torture.

This literature also details the effects on persons who were either directly injured during military actions, or who witnessed violence during military actions, or who lived in areas where there were frequent military actions. Studies show that the likelihood of PTSD rises with the degree of exposure to what is termed "high war zone stress". There is also a growing literature about the effects upon the family of violence and torture inflicted on a family member. Here the literature dealing with the Holocaust is probably the most developed.

There is also a new group of victims, the families of person who have been "disappeared", and this literature demonstrates both short-term and long-term consequences **(2,3)**. This group should also include persons and families who have had the experience of a family member disappearing during military actions. These may or may not be families in which there is a history of political activism, but all are classified together in terms of the families' experience: all have had a member disappear during times of war. 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.

Finally, we must consider the effects upon the caregivers themselves, a group who are also receiving increasin attention. Contemporary studies have clearly shown the effects on care-givers of working with survivors of repressive violence (4,5).

THE AMANI TRUST

The AMANI Trust was set up in the wake of several regional conferences and workshops to provide assistance to survivors of repressive violence. Initially operating under the umbrella of the Psychiatric Association of Zimbabwe, the AMANI Trust was established as an independent NGO in November 1993. The objectives of the AMANI Trust's activities are well-described by the Vienna Declaration and the mandate for these objectives is described in a series of reports of meetings **(6,7)**.

AMANI has been involved already in a wide range of activities to date. AMANI mounted a community-based programme for refugee camp workers during 1992 and 1993 **(8,9)**. Fifty camp workers were trained in the detection, assessment, and management of psychological disorders, and several hundred refugees were helped during this programme. Most recently, AMANI ran a regional training workshop for persons working with victims of organised violence, and participants came from Malawi, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe.

AMANI has established relationships with various human rights organizations, nationally, regionally, and internationally. AMANI has also become affiliated to the International Rehabiliation Council for Torture Victims (IRCT), and is represented on this Council.

PROJECT AREA

Mount Darwin and Rushinga are two administrative districts in Mashonaland Central Province of Zimbabwe. Situated in the north-east of the country, these two districts were very early involved in the Liberation War of the 1970's, with the first attack of the ZANLA forces coming in December 1972 at Altena Farm in Centenary, an adjacent district. Mount Darwin, with Rushinga, comprised "Chaminuka" operational area for the ZANLA forces, and, with "Nehanda" and "Takawira" operational areas, formed the first major offensive of the war. These three areas were part of "Hurricane" operational area by the security forces of the Rhodesian government.

These two districts were involved very early in the liberation war, because of their proximity to Mozambique, and the long, easily penetrated border. It is not surprising, therefore, that they are districts with some of the worst records for human rights violations during that war. Much of the recording during this time was done by the Catholic Commission for Justice and Peace(CCJP), and it is noteworthy that reports of torture and ill-treatment were coming in as early as March 1973.

The rural people of Mount Darwin were subjected to extreme pressure and deprivation during these years. In order to control the guerrillas' access to the populace, a policy of forced villagisation was instituted: termed "keeps" or "protected villages", the population was forced to reside in these villages by night with a strict dawn-to-dusk curfew imposed. Between 1973 and 1978 almost 750 000 rural people were forced into keeps throughout Zimbabwe. The life within these villages was extremely hard, and, in the north-east, malnutrition, starvation, overcrowding, and inadequate sanitation were commonplace, as the investigations of the CCJP demonstrated. As one person commented:
"They put us behind the wire, they said, to protect us. But they were not protecting us; they were treating us like animals" (David Chikwanha, Chiweshe).

After the Altena Farm attack, the security forces instituted severe reprisals against the population that was felt to be supporting the ZANLA forces. Schools, clinics, mills, shops, and beerhalls were closed; property was confiscated and destroyed; collective fines were imposed for failures to report the guerrillas; and mass arrests were made, with detentions and interrogations, involving torture, following. By 1975, the CCJP had compiled comprehensive reports on the activities of the Rhodesian security forces, including one on the north-east.

The torture and ill-treatment of civilians is amply attested by human rights reports, as well as by many other commentators. Moore-King, a former Rhodesian soldier, bluntly catalogues the kinds of treatment meted out by security forces: beatings, suspensions, electrical torture, submarino and suffocations, mock executions, and real, arbitrary killings. This is well attested by the civilians and guerrillas who experienced these human rights violations, and should also include those who were the victims of ZANLA reprisals.

In 1975, a dawn-to-dusk curfew was imposed along the Mozambique border, and severe penalties prescribed for breaking the curfew. In practice, curfew breakers were invariably shot, and always punished. Beatings, rapes, killings, and torture were commonplace. The enacting of the notorious Indemnity and Compensation Act of 1975 (with retroactive application to 1972) did little to curb the excesses, and indeed gave security forces the impunity to kill and maim at will. Attacks on villages became more frequent, with the government explanation of civilians being "caught in crossfire". Such explanations, when investigated by CCJP, were often less plausible, and, for example, one such incident, at Karima village near Mount Darwin, suggested no presence of ZANLA forces, and much more a deliberate massacre to intimidate the local population.

Thus, throughout the 1970's, the people of Mount Darwin and Rushinga were subjected to continuous stress, ill-treatment, deprivation, torture, and killing. They suffered materially too, with property being destroyed as punishment, livestock being confiscated, and fines being imposed, both individually and collectively, for failure to assist the security forces. It is probable, in the words of one district person, that everyone either directly experienced violence or witnessed it. No epidemiological studies have been done to date, but informal interviews frequently turn up victims among the informants.

Demographic characteristics of field area

Mount Darwin is a large rural areas, comprising 4 547 square kilometres. Mount Darwin district is estimated by the 1992 Census to be about 165 828 persons, with approximately 50% of the population in both districts is under the age of 19, so well under half the population was not alive during the war years described above. The population is stable settlement, however, since approximately 91% of the sample enumerated during the census were normally resident in the districts.

Economically, the major activity is farming, but mining and commerce have increased during the independence years. In Mount Darwin about 59% of the population is estimated to be economically active, whilst unemployment is high - about 34% . Agriculture can be difficult since the district is in the low annual rainfall zone, and has suffered extensively during the repeated droughts of the 1980-1990's.

Health care is provided by hospitals at Mount Darwin District Hospital and Karanda Mission Hospital. In the district there is an infrastructure of clinics and rural health centres, but the availability of the health care facilities is offset by the great distances that people must travel to avail themselves of health care. The distances are also complicated by the relative paucity of roads and public transport.

With this background in mind, AMANI carried out during January 1995 an examination of the need for a community-based rehabilitation service in these the districts.

AMANI'S PROGAMME

If we were to take seriously the problems of Zimbabwean survivors in Mount Darwin, then any strategy must consider all the issues from rehabilitation in the medical sense to rehabilitation in the social sense. This meant designing a strategy that will allow the possibility of offering health care and social support. All of these components have a place, and cannot be separated if we are to take the needs of survivors seriously.

Detailed programmes were worked out for activities at Karanda and Mount Darwin Hospitals. AMANI is training all nursing staff, and other selected primary care workers at these hospitals, which will amount to about 90 workers in all. Thus, one practical side-effect of the AMANI programme is that, by the end of 1995 virtually all front-line health care staff in the 2 districts will have received training in basic management of psychological disorders. The health workers will also be trained in an approach to assessment and basic management of survivors of violence.

The training programme attempts to provide skills in several areas as follows:

1. Basic skills training:

Since many of the care-givers will not be experienced in the management of psychological disorders, it is intended that all care-givers receive a basic training in the identification, assessment, and management of psychological disorders. The approach that is being used here was developed for primary care settings in general psychiatry, and has been used succesfully in the refugee setting. Care-givers are being taught

to identify, assess, and manage clients, with an emphasis on counselling and problem-solving. A basic manual is available **(10)**, and all trainees will receive regular supervision.

The professional staff of AMANI will provide this supervision, as well as being the first referral route and the consultants of first choice for the care-givers. The basic skills training will be an important pre-requisite for more specialised training in the management of survivors.

2. Torture survivors:

Further training in the management of torture survivors and the disappeared will follow the basic skills training. This will involve training in more detailed assessment of forensic issues, advanced counselling skills, and group therapy skills. A manual for this phase has been completed(11).

3. Group therapy and community liaison:

Since it is likely that the morbid population is very large, it will be important that the community take an active a part as is possible in the work. Thus, it will be important to create support groups and community bodies. This will require the care-givers to acquire skills in group work and community action. This will require some skills training, and some of this will be given in the earlier stages of the programme.

However, the care-givers will need to develop methods to involve the community in both care-giving and organization, and it must be a goal to hand over the programme to a large extent to the community.

4. Care for caregivers:

This is a crucial component in dealing with survivors of repressive violence, but is usually either not included in a programme or is only applied when programmes are well-established and care-givers are beginning to experience difficulties. The desirable approach is to recognise at the outset that care-givers will experience problems, both because most care-givers are former survivors themselves, which is the case with most community-based approaches, or because the professional care-givers underestimate the powerful counter-transferential effects of working with survivors of torture.

METHODS

In the identification of survivors of violence, AMANI utilises a three-stage procedure. Firstly, all outpatient attenders are screened by the nurse trainees using a standard psychiatric screening instrument, the SRQ-20. All patients who score more than 7 are then given a detailed structured interview by these same nurses. All those who indicate that they had experience of organised violence are given a detailed interview by an experienced Social Worker. Those who have a clear indication of a disorder involving violence are then admitted to the rehabilitation programme, which is the direct responsibility of AMANI.

RESULTS

Table 1 describes the prevalence of problems due to organised violence amongst the outpatient clinics attendances at the two hospitals.

Table 1 here

Table 2 describes some of the basic demographic data from the violence subsample.

Table 2 here

Table 3 describes relevant data on political persecution taken from the histories of violence given by the patients

Table 3 here

Table 4 describes the actual violence experienced by these survivors, but we do not report the detail on the types of violence, merely the categories of violence.

Table 4 here

Table 5 describes the previous health status of these survivors, which indicates the history prior to the present consultation.

Table 5 here

Table 6 reports the symptoms currently reported by these survivors.

Table 6 here

FINDINGS

The overall prevalence, which reflects all cases (n=79), irrespective of diagnostic category, is very high indeed. This may be due to a sampling error, but, as far as we have been able to ascertain, the trainees are selecting patients on a random basis from the outpatient attenders. This very high rate is similar to that found in a refugee camp setting, and may reflect the extreme poverty of the district, perhaps exacerbated by the current famine. It is worth commenting here that one of the highest prevalence rates previously reported for Zimbabwe was obtained from one of the two hospitalsinvolved in the project.

Patients with a history of a human rights violation are a significant proportion of the morbid group, comprising 34% of all psychological disorders, whilst the overall prevalence of victims of organised violence is 21.4% of all clinic attenders, which is again very high and in the range found in the refugee setting.

The violence subsample is different in some respects from other primary care samples. There is a very high proportion of males, which is different to most primary care samples, and most of these had some military experience, some pre-dating their torture, whilst for others the torture was a precipitant in their joining the guerilla forces. It is important to stress here that very few of the sample were attending for reasons related to their history of torture, and most had no idea that they could be helped or seek compensation.

Most of the sample reported incidents of political persecution during the 1970's, and this corresponds with the history as recorded by human right organisations at the time. As can be seen from Table 3 earlier, many reported harassement, detentions, torture and deaths of members of their families. For example, one man, who was severely tortured by Rhodesian security forces, reported the detention and imprisonment of his nephew, and the disappearance of two of his brothers, and the ill-treatment and torture of several other members of his family.

The data obtained on the victims' own experience of torture again corroborates the findings of the human rights organisations. As can be seen from Table 4, most of the sample were subjected to physical assaults and psychological torture. Deprivation was much less common, as was sensory overstimulation. However, it is pertinent to note that the stories provided by these survivors suggests that the torture was done by various different groups, and at least two survivors were tortured by special interrogation teams from the Special Branch of the British South African Police.

In fact, our data suggests the operation of organised torture teams in Mount Darwin much earlier than 1973. Our findings suggest that, in at least one case, the teams were in operation within weeks of the first ZANLA offensive.

The detailed breakdown of the kinds of torture is not provided, but it is clear that many different techniques were used, including the widespread use of electrical torture, submarino, suspensions, and, above all beatings. Beatings were the standard method of the guerillas, and it is evident that the use of other forms was mainly confined to the Rhodesian security forces. There were differences in the sample according to the reason for their detention and torture, and it is clear that captured guerillas were earmarked for special treatment by the Special Branch, and these received more specialised torture, including sensory overstimulation.

A very high proportion of the sample witnessed both toture and executions, and a significant proportion of those tortured had this witnessed by members of their own families. This corroborates the view of the Justice and Peace Commission that there was a sustained campaign of terror aimed at the civilian

population. This was not entirely caused by Rhodesian security forces, as 2 of the sample had been victims of ZANLA reprisals, and several had witnessed ZANLA reprisals.

The consequences of the violence are seen in both physical and psychological injuries. As could be seen from Table 5, many report injuries consonant with the violence.

Fractures, episodes of unconsciousness, and chronic disease are all reported by the sample. Of the chronic disease, most reported problems with their hearts, but this is not cardiac disease, but palpitations and pains. The unconsiousness refers to both genuine states of unconsciousness, usually produced by blows to the head, as well as fainting produced to intolerable pain. For example, one woman reported passing out from pain when she was hit on her genitalia during a beating from the guerillas.

It is noteworthy that very few reported previous operations, psychological disorders or neurological disease. The one patient who did report a neurological disorder suffered from epilepsy following torture in which he was beaten about the head with rifle butts and barrels, to the extent that he was bleeding from both his nose and his ears.

As regards their present health, all of the sample are positive on the SRQ-20. As was indicated in Table 6, the sample is mostly in the severe range on the SRQ-20, and report more depression than anxiety. In terms of the symptoms, the patients reported many symptoms that are congruent with a diagnosis of Post Traumatic Stress Disorder, as well as many symptoms that are suggestive of the physical sequelae of torture. Backache, numbness in legs/arms, shoulder/arm pains, pains in legs, and hearing difficulties may all be consequences of the physical assaults received.

Sleep disorder, memory difficulties, headaches, chest pains, palpitations, dizziness and abdominal pains would all fit the various criteria of the DSM-III(R) definition of PTSD.

More comprehensive assessment will be undertaken in due course. However, it is clear from the injuries reported that they conform to the pattern of abuse reported by the survivors.

CONCLUSIONS

The client population seems to conform to the information received from the key informants. There are a high number attending the clinic, which makes the hospital a good base. Most clients present with psychological disability, with torture, ill-treatment and disappearances being the predominant precipitants of disorder. There is a significantly large population of those who suffered direct violence in the form of torture, ill-treatment, and massacres.

Disappearances may be a particularly important issue, since traditional society places great stress on the observance of burial rites, and a common explanation for misfortune and illness is the failure to observe such rites. It is important here to comment that disappearance in the Zimbabwean context seems to range from forcible disappearance to children and parents not returning from attempts to join the ZANLA guerrilla forces in Mozambique. This latter groups will represent those who died crossing into Mozambique, those who died in attacks on bases and refugee camps in Mozambique, and those who died in post-training military activities in Zimbabwe.

As a whole, these data should sensitise health workers to the aetiological significance of organised violence. It is significant mthat we are still seing disorders due to violence more than 20 years after their occurrence. Chronic and delayed forms of PTSD should thus be an alternative hypothesis for the multiple somatic misery seen in many primary care clinics.

When we look to the future, we must consider ways to prevent organised violence and its appalling legacy. This requires health workers to think about a wider field than is usual, about human rights in effect. Health workers must of necessity take a strong position in defense of human rights or face the burden of reparing the damage infliected by callous and cynical governments. Prevention is not just a

matter of education alone, it is also a determined commitment to action. With government-sanctioned torture present in over 78 countries of the world, and many of these in Africa, we cannot afford to be sanguine about the effects, and we cannot afford to pretend that mental health is not political. The politics of mental health is not just about budgets and policies, it is about politics itself, as the history of Southern Africa, and Mount Darwin demonstrate.

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Table 1.
Prevalence of psychological disorders and disorders due to organised violence.
(n=79)

Overall prevalence.	**61.7%**
Violence(as % of psychological morbidity.	**34.0%**
Overall prevalence of violence.	**21.4%**

Table 2.
Demographic characteristics
(n=14)

Gender:	
Male	**71%**
Female	**29%**
Age:	
Mean	**42.9**

Table 3.
Political persecution
(n=14)

Persecution of family:	
Harassement	64%
Detention	29%
Imprisonment	21%
Torture	50%
Death	36%
Detention:	
Received treatment	21%
Had fractures	14%
Other injuries	21%
Disappearances:	
One family member	43%
More than one family member	14%

Table 4.
Torture experience
(n=14)

Types of torture:	
Physical assaults	71%
Deprivation	29%
Sensory overstimulation	7%
Psychological torture	79%
Witnessing torture of others:	
Witnessing assaults	86%
Witnessing executions	43%
Witnesses to own experience:	
Witnessed by family adults	57%
Witnessed by family children	50%
Witnessed by others	71%

Table 5.
Previous Health Status
(n=14)

Fractures	29%
Unconsciousness	50%
Operations	7%
Psychiatric disorder	7%
Cancer	0
Chronic disease	57%
Neurological disease	7%

Table 6.
Present Health Status
(n=14)

Psychiatric screening:	
SRQ-20(Total)	**10.4**
SRQ-20(Anxiety)	**3.5**
SRQ-20(Depression)	**5.3**
Symptoms:	
Sleep disorder	**88%**
Memory difficulties	**88%**
Backache	**75%**
Headaches	**75%**
Concentration difficulties	**75%**
Numbness in legs/arms	**75%**
Shoulder/arm pains	**63%**
Pains in legs	**63%**
Chest pains	**63%**
Palpitations	**63%**
Abdominal pains	**63%**
Hearing difficulties	**50%**
Dizziness	**50%**