WAR TRAUMATISATION AND ITS PSYCHOLOGICAL CONSEQUENCES ON WOMEN OF GULU DISTRICT

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ABSTRACT

Most of the respondents in the study had experienced at least one torture event. The commonly reported physical torture experiences included beating and kicking, forced hard labour, deprivation of food, water and medicine and tying (Kandoya).

The psychological methods of torture reported included verbal threats; killing of relatives, detention and sleeping in the bush/swamps. Among women sexual abuse was predominant with rape, attempted rape and forced marriage being common.

The government army (NRA/UPDF) accounted for a quarter of all torture cases, and the rebel army LRA (Kony) for 70% of all torture cases meted out to the respondents. Torture usually took place at home affecting significantly more females than males. Psychiatric disorders diagnosed included post traumatic stress disorder, depression, alcohol abuse disorder, generalised anxiety disorder, panic anxiety disorder, agoraphobia, social phobia, somatoform disorder, and suicidal thoughts. In addition, impaired function was reported in work, family relationships, and sexual function. Six percent of the respondents had homicidal thoughts.

Introduction**

Gulu District in Northern Uganda has gone through and continues to experience the longest civil conflict in the history

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* A collaborative intervention by ISIS-WICCE and African Psycare Research Organization (APRO), compiled by Kinyanda Eugene, M.B., Ch.B., M. Med (Psych) and Psychiatrist and Seggane Musisi, M.B. Ch. B., Dip. Psych. (RCPCC), Consultant Psychiatrist. Published with permission from Isis-WICCE through Ruth Ojiambo Ochieng.

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of Uganda from 1986-to date (Isis-WICCE 2000). This conflict has had a devastating effect on the lifestyle of the people of this district. There has been torture including robbery, rape, gunshots, landmines, bombs, harassment, maiming, and killing of people, massive abductions of the youth and displacement of entire communities into camps (Isis-WICCE 2000, Panos Institute 1995, UNICEF/World Vision 1997, Amnesty International 1999).

A head count in November 2000 indicated a total of 346,512 people lived in 22 of the more than 30 camps in Gulu northern Uganda resulting from the 15-year insurgency.

Two studies were carried out with the support of ISIS-WICCE in 1999 and 2001. The first was carried out in 1999/2000. This was an in-depth study of Women's experiences in the war situation that has characterised northern Uganda for the last one and a half decades. The study was aimed at providing a basis for future interventions with regard to facilitating the women with coping, providing an advocacy and lobbying tool for law reform, and the enforcement of the existing laws related to human rights violations, and sensitising the public, women's NGOs, the Uganda Government, and the community about the consequences of armed conflict on women.

A dissemination of findings workshop was held in October 2000 in Gulu. In May 2001, a short term medical intervention was organised by Isis-WICCE in collaboration with the Gynaecological Association of Uganda, the African Psycare Research Organization (APRO) and the Department of Orthopaedics of Makerere University. The objectives of the medical intervention study was to:

(1) document the physical and mental health problems of the women in the war affected district of Gulu;
(2) effect an intervention to alleviate the health plight of the population with particular emphasis on addressing women's health problems; and

(3) document the results of the medical intervention in the war affected district as an advocacy tool for wide-scale intervention in this field by government and other partners.

Intervention Design

A multi-stage cross-sectional descriptive study was undertaken to document the gynaecological, orthopaedic, general surgical problems as well as psychotraumatic experiences and their psychiatric sequelae in Awer camp of internally displaced persons in Gulu District, Uganda. Under the auspices of ISIS-WICCE, a multi-discipline team including Gynecologists, Psychiatrists and Surgeons was assembled for the medical intervention and documentation in Awer Internally Displaced People's Camp and her satellites of Olwal, Pagak, Kaladima and Parabongo all in Lamogi sub-county in Kilak County of Gulu District. The choice of health specialties reflected the health problems identified in an earlier study.

The intervention employed a primary health care approach to the alleviation of the most serious health problems of the people in the IDPs through the use of community participation and existing health care structures in the districts. The intervention also aimed at building local capacity through training, supply of drugs (to a limited extent) and equipment and provision of specialised supervision from the National referral hospital. Health staff and local leadership at all levels within the district were used to ensure sustainability of the service through community and district health service participation.

Methodology

The team trained camp volunteer counselors (CVCs) who were used to screen the population and refer those with problems to the health centers. Four semi-structured questionnaires (a general camp screening questionnaire, and one for each of

the three medical interventions namely: gynaecological, psychological and surgical screening) were designed and pre-tested.

The CVCs documented the problems identified using semi-structured interview schedules and carried out counseling where necessary. The specialists from the referral hospital also trained eight medical staff at Gulu district Hospital and from some health centers on the screening and management of the simpler problems. The trained medical staff referred the more advanced/complicated cases to the specialists. Training was also offered in documenting all the cases managed and those referred for specialist care. During the last week of the intervention, the team of specialists performed a wide range of surgery on complicated cases of patients screened earlier. The less complicated cases were scheduled for operation by the local Gulu-based team.

Background of Study on War Traumatisation

The World Medical Association's Tokyo Declaration of 1975, defined Torture as *"the deliberate systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession or for any other reason"* (IRCT/RRCTV 1995). By definition therefore, what the people of Gulu have gone through constitutes torture in a setting of war.

In earlier times the main purpose of torture was to get information or a confession to punish or to terrorise (IRCT/RRCTV 1995). Today, particularly in Third World countries including sub-Saharan Africa, the purpose of torture is political: to destroy the individual or to break him/her spiritually and then use the broken person to spread terror throughout the rest of the community (Zwi A., Ugakde A. 1989 and IRCT/RRCTV 1995). This observation is borne out by two studies that were carried out among women war survivors in Luwero by Isis-WICCE and

a review of patients' records at the African Centre for Treatment of Torture Victims (A.C.T.V.) in Kampala, where political reasons for torture were reported in 100% and 80.4% respectively among the respondents (Musisi S. *et al.* 1999 and 2000). Other reasons given for torture in the A.C.T.V. study included criminal investigations, mistaken identity and extortion of money by criminal rackets (Musisi S. *et al.* 2000).

The methods of torture are either physical or psychological. It is however worth noting that the physical methods of torture often times lead to psychological sequelae. The methods of torture are predominantly similar the world over though with some regional differences. The physical methods include systematic beating and kicking, rape, burning, bayonet injuries, forced hard labour, deprivation of food, water and medicine (Musisi S. *et al.* 1999, 2000). The psychological methods of torture are primarily aimed at the mind of the victim and include verbal threats, attempted rape, interrogations, mock executions, detention, being forced to flee and live in the bush or in displacement, false accusation, abductions, forced to witness the killing or torture of others and destruction and or stealing of property.

In Uganda the regional specific methods of torture include a severe form of tying called the "Kandoya" which is used in the Great Lakes Region (Musisi S. *et al.* 2000, Kinyanda E. *et al.* 2000). In the "Kandoya" method of tying, the arms are flexed at the elbow, are tied behind the victims' back with the ropes going through the mid arm section and tightened until the elbows meet. This physical form of torture results in neuromuscular damage of the arms, anterior chest wall, and forearms with victims later unable to use their hands (Musisi S. *et al.* 2000, Kinyanda E. *et al.* 2000).

Psychological Sequelae of Torture

Torture leads to psychological and physical disorders (UNICEF/ Government of Uganda 1998, Musisi S. *et al.* 1999

Skylv G. 1992; McNally R. J. 1992, Kadenic M. 1998). The most commonly recognised psychological disorder of torture is the post traumatic stress disorder [P.T.S.D.] (Tomb D. 1994, American Psychiatric Association 1994). P.T.S.D. follows a traumatic event that is characterised by actual or threatened death or serious injury or a threat to the physical integrity of self or others (Tomb D. 1994, American Psychiatric Association 1994). The person's response to this traumatic event usually involves intense fear, helplessness or horror (American Psychiatric Association 1994).

Post Traumatic Stress Disorder

Post traumatic stress disorder is characterised by three clusters of symptoms namely:

- Symptoms of persistent ***re-experiencing*** of the traumatic event in the form of flashbacks, (film of the event), recurrent distressing dreams of the event (nightmares), and psychological distress at reminders of the trauma (e.g. soldier's uniform).
- The second cluster of symptoms are persistent ***avoidance*** of stimuli associated with those of the trauma. This may take the form of avoidance of thoughts, places and activities that are reminders of the traumatic event.
- Lastly there is the cluster of symptoms of persistently ***increased physiological arousal,*** which may take the form of difficulty in falling asleep, irritability or outbursts of anger, difficulty in concentrating, exaggerated startle response and hypervigilance (Tomb D. 1994, American Psychiatric Association 1994).

Like many psychiatric disorders post traumatic stress disorder is commonly present in conjunction with other disorders (McNally

R. J. 1992). The most common comorbid psychiatric disorders associated with P.T.S.D. are depression, anxiety disorders, alcohol abuse, somatoform disorder, and personality changes (Musisi S. *et al.* 1999, Kinyanda E. *et al.* 2000, McNally R. J. 1992 and Tomb D. 1994). The features associated with these common comorbid psychiatric disorders are described below.

Depression

Depression is a psychiatric disorder that is characterised by the following symptoms: sad mood, reduced interest in formerly pleasurable activities, poor sleep, loss of energy, feelings of worthlessness, feeling excessively or inappropriately guilty, poor concentration, recurrent thoughts of death or suicidal plans or even suicidal attempts (American Psychiatric Association 1994). In the Luwero study among women war victims depression was reported in 12.5% of the respondents (Musisi S. *et al.* 1999).

Anxiety Disorders

This is a group of disorders that are characterised by symptoms of excessive apprehensive expectation, worry—with person's experiencing difficulty controlling the worry—symptoms of restlessness, feeling on the edge, being easily fatigued, difficulty in concentrating, being irritable, muscle tension and sleep disturbance. The anxiety disorders include generalised anxiety disorder, panic disorder, social phobia, and agoraphobia (American Psychiatric Association 1994, United Nations High Commissioner for Human Rights 1999).

Generalised Anxiety Disorder

In generalised anxiety disorder, the above symptoms are persistently experienced. Experiencing these symptoms is not re-

stricted to particular social events or environments (American Psychiatric Association 1994, United Nations High Commissioner for Human Rights 1999).

Panic Disorder

In panic anxiety disorder the individual experiences the above anxiety symptoms in attacks. The anxiety symptoms in panic anxiety build up quickly and suddenly in the individual creating a fear of a catastrophic outcome. The patient gets rapid over breathing resulting in dizziness, ringing sounds in the ear, headaches, feeling weak and tingling sensation in the feet and arms and discomfort in the heart region of the chest. The individual usually interprets the later sign as an impending "heart attack". These symptoms usually resolve much more slowly within an hour with the individual being symptom free in between attacks (American Psychiatric Association 1994, United Nations High Commissioner for Human Rights 1999).

Social Phobia

In this disorder, anxiety symptoms are experienced in situations in which a person may be observed and criticized such as going to restaurants, parties and community meetings. Social phobic people tend to avoid such situations with anticipation of going to such places capable of provoking anxiety symptoms (American Psychiatric Association 1994, United Nations High Commissioner for Human Rights 1999).

Agoraphobia

Persons with this disorder experience anxiety symptoms when they are away from home, in crowds or in situations in which they can not easily leave. Such anxiety provoking situations

include being on buses, trains, places that cannot be left suddenly such as crowded markets, and supermarkets. In these circumstances, the symptoms experienced are similar to those of other anxiety disorders. As this condition progresses, the individuals become confined to their homes and become house bound (American Psychiatric Association 1994, United Nations High Commissioner for Human Rights 1999). In the Luwero study 20.8% of the war women respondents suffered from anxiety disorders (Musisi S. *et al.* 1999).

Somatoform Disorder

This disorder is characterised by multiple physical complaints suggesting a physical disorder but for which there is no demonstrable organic basis. For example, a person who was subject to multiple rapes by her torturers may report continuous lower abdominal pain despite not having any evidence of any gynaecological problem. The underlying problem in somatoform disorder is psychological. The somatoform symptoms reported in the A.C.T.V. study included chronic headaches, musculoskeletal aches, pains and fatigue, recurrent "fever" complaints, chronic lower abdominal pain (Musisi S. *et al.* 2000).

Alcohol Abuse

This refers to any mental, physical or social harm resulting from excessive alcohol consumption. The physical problems that may result from alcohol abuse include liver disease such as cirrhosis, cardiac disease and diseases of the nerves. The mental illnesses that may result from excessive alcohol consumption include psychosis (madness) delirium and amnesia (black outs). Excessive alcohol abuse may also result in social problems such as neglect of family, impaired occupational functioning and

domestic violence (American Psychiatric Association 1994, United Nations High Commissioner for Human Rights 1999). Alcohol abuse disorders are known to be associated with post traumatic stress disorder (McNally R. J. 1992).

Gender and the Psychological Sequelae of Torture

Gender has an important bearing on torture phenomenology. The female gender appears to determine the methods of torture used and later the psychological complications experienced by the victims of torture (Paker M., Paker O., Yuksel S. 1992; and Allodi F., Stiasny S. 1990). Physical torture in women is frequently directed at their sexuality in form of rape (Paker M., Paker O., Yuksel S. 1992; Allodi F., Stiasny S. 1990). Women also tend to be subjected to the more psychological methods of torture as compared to men (Paker M., Paker O., Yuksel S. 1992; and Allodi F., Stiasny S. 1990). The psychological methods of torture to which women are subject to often take the form of sexual humiliation and abuse—short of rape *per se* (IRCT/ RRCTV 1995).

The psychological complications reported by women also differ from those reported by men, with women suffering from a wider range of psychosomatic problems (somatisations) and sexual dysfunction (Paker M., Paker O., Yuksel S. 1992; and Allodi F., Stiasny S. 1990).

The comorbid psychiatric disorder associated with post-traumatic stress disorder also differ between the sexes (McNally R. J. 1992 and Paker M., Paker O., Yuksel S. 1992). In women, the most common psychiatric disorders are depression, generalised anxiety disorder, alcohol abuse and panic disorder, (McNally R. J. 1992). In men the most common comorbid disorders are alcohol abuse, depression, generalised anxiety disorder, and antisocial personality disorder (McNally R. J. 1992).

The other factors that have a bearing on the torture experience and psychological sequelae include one's age, firmness of political belief system, cultural background, previous psychological function, duration of torture, level of education and presence of physical sequelae of torture (McNally R. J. 1992).

Treatment of Torture Victims

The psychological effects of war torture if not recognised and treated run a chronic course as illustrated by the Luwero Isis-WICCE study (Segane-Musisi S. *et al.* 1999). In that study, 54.2% of the war traumatised women still reported features of post traumatic stress disorder with 72.0% of them having impaired occupational functioning, 14 years after the war had ended (Musisi S. *et al.* 1999). There is however, overwhelming evidence that the psychological sequelae of torture are amendable to treatment (Musisi S. *et al.* 2000, Tomb D. 1994, Paker M., Paker O., Yuksel S. 1992 and Keane T. M., Albano A.M., Dudley D. B. 1992).

In conclusion the report presented here will document the trauma experiences of the people of Gulu and the associated psychological sequelae in an effort to galvanise Ugandan society and the world community in general to stop this war and to marshal up a plan to rehabilitate the shattered lives of these people.

The Medical Interventional Study

During the 10-day screening period at camp level described in Chapter One, a total of 1077 clients were seen, of whom 1018 were 15 years and above. For purposes of the psychological study, only clients 15 years were enrolled because the psychological screening instruments used were only valid for this age group. Clients with minor psychological problems were given simple supportive counseling by the CVC's while those with

more severe forms of psychological distress and those with physical problems were referred to the Health centre at Awer camp for second stage interventions.

At the Health centre at Awer camp, clients referred by the CVC's with psychological problems were seen by the mental health team. This mental health team consisted of a general doctor (who runs the mental health clinic at Gulu Hospital), a psychiatric clinical officer, a senior Nursing Officer (who had received training in war trauma counseling) and counselors from a locally based non-governmental organization the—People's Voice for Peace.

A total of 213 clients were seen (198 adults and 15 children) with only the adult clients being included in the study.

Those clients sent to the health centre for psychological problems underwent further psychological assessment using a structured questionnaire. They were then offered drug treatments (if indicated), supportive counseling or referred to Gulu hospital for further management depending on the assessed need.

Clients in need of specialised psychiatric assessment and treatment were referred to the Mental Health Clinic at Gulu Hospital. The results of the psychiatric interventions at Gulu Hospital are not given in this report due to the extended and in-depth nature of the required interventions. These clients are still receiving ongoing treatment and counseling.

Measurements

The camp screening protocol contained socio-demographic variables, questions on the trauma experiences, a psychological distress assessment questionnaire, the modified WHO self-reporting questionnaire—WHO-SRQ-25 (WHO 1994). A case on the modified WHO-SRQ-25 screening instrument was defined as a respondent who scored at least 6 on the non-psychotic symptoms or a score of at least 2 on the psychotic symptoms (WHO

1994). This cut-off point has been established in validation studies undertaken in Ethiopia in conditions similar to those prevailing in Gulu (WHO 1994, Kebede D. and Alem A. 1999). Gynaecological assessment questions, orthopedic, and general surgical assessment questions as well as questions on referrals were also included in the questionnaire.

Health centre psychological assessment protocol

The assessment protocol that was used at the health centre contained socio-demographic variables, ICD-10 PCP checklists for depression anxiety disorders, somatoform disorder, (WHO 1992). The C.A.G.E. questions for assessment of alcohol abuse were used with the following questions:

(i) Have you ever felt that you should **CUT DOWN** on your drinking?
(ii) Have people **ANNOYED** you by criticizing your drinking?;
(iii) Have you ever felt **GUILTY** about your drinking?
(iv) Have you ever had an **EARLY** morning **(EYE OPENER)** drink as a first thing in the morning to steady your nerves or to get rid of a hangover?

These four questions are known as C.A.G.E. from the initial letters of the words, *cut, annoyed, guilty* and *early eye opener.* A respondent with at least 2 positive answers is considered to have an alcohol abuse problem. This instrument has been used widely to screen for alcohol problem (Kebede D. and Alem A. 1999). Finally, the protocol also contained DSM IV PTSD screening questions (American Psychiatric Association 1994).

Results

Results from the camp intervention

In the screening interviews carried out at Awer camp, 1077 respondents were interviewed of which 1042 (96.7%) were aged 15 years and above. Twenty-four (2.3%) respondents of these had incomplete data sets and were excluded from analysis leaving 1018 completed records. For purposes of this psychiatric report, it's only the results of those who were 15 years and above that will be reported. Table 3.1 below, shows the demographic variables of the camp respondents.

Table 3.1

Camp of Residence, Gender and Age of Respondents

Camp of Residence	Number	Percentage (%)
Awer	204	20.1
Olwal	174	17.2
Pagak	289	28.6
Kaladima	157	15.5
Parabongo	188	18.6
Gender		
Male	372	36.6
Female	646	63.4
Sex Ratio: Male: Female = 1: 1.7 (1:2)		
Age: Range 15 – 89, Mean 39.3, Standard deviation 2.83		
Educational status (n=918)		
No formal education	293	31.9
Primary level	533	58.1
Secondary level	60	6.5
Post secondary level	32	3.5
Marital status (n=948)		
Never married	89	9.4
Married/cohabiting	641	67.6
Separated/divorced	51	5.4
Widow/Widower	120	12.7
Single mother/father	47	5.0

From Table 3.1, the respondents were more or less evenly distributed in all the 5 satellite camps of Awer namely: Awer,

Olwal, Pagak, Kaladima and Parabongo. The male to female ratio was 1:1.7. They ranged between 15-89 years of age with a mean of 39.3 years (S.D=2.83). Most of the respondents 826 (90.0%) had no formal education or only a primary level education with 32 (3.5%) having a post secondary education. The majority of respondents 641 (67.6%) were either married or cohabiting with 120 (12.7%) widowed mainly as a result of war. Fifty one (5.4%) of respondents were separated or divorced with 47(5.0%) living as single mothers or fathers.

Table 3.2 Distribution of torture experiences according to Gender

Variable	Total N=1018		Gender				Chi square P-value
			Male (n=372)		Female (n=646)		
		%	Number	%	Number	%	
Experienced at least one torture event**	905	88.9	346	93.0	559	86.5	>0.00*
Physical torture**							
Beating and Kicking	445	43.7	216	58.1	229	35.4	<0.00*
Bayonet injuries	56	5.5	45	12.1	11	1.7	<0.00*
Forced to perform hard labor	173	17.0	104	28.0	69	10.7	<0.00*
Tying (Kandoya)	128	12.6	102	27.4	26	4.0	<0.00*
Deprivation of food, water & medicine	195	19.2	99	26.6	96	14.9	<0.00*
Gunshot injuries	60	5.9	39	10.5	21	3.3	<0.00*
Burning	22	2.2	11	3.0	11	1.7	<0.19
Sexual Torture	134	13.1	24	6.4	110	17.0	<0.00*
Completed Rape	49	4.8	6	1.6	43	6.7	<0.00*
Attempted Rape	50	4.9	9	2.4	41	6.3	0.01*
Forced Marriage	35	3.4	9	2.4	26	4.0	0.18
Relative killed in war**	612	60.1	262	70.4	350	54.2	
Spouse	61	6.0	15	4.0	46	7.1	

Table 3.2 (Continued)

Children	144	14.1	59	15.9	85	13.2	<0.00*
Others (aunt, uncle, Grand parent)	407	40.0	188	50.5	219	33.9	
Psychological Torture**							
Verbal threats	472	46.4	192	51.6	280	43.3	<0.01*
Interrogations	112	11.0	76	20.4	36	5.6	<0.00*
Military detention	226	22.2	112	30.1	114	17.6	<0.00*
Sleeping in bush/ swamp	629	61.8	238	64.0	391	60.5	<0.28
Abduction	339	33.3	159	42.7	180	27.9	<0.00*
Destruction/looting of family property/ livestock	528	51.9	231	62.1	297	46.0	0.00*
Forced to fight in war	50	4.9	40	10.8	10	1.5	<0.00*
Forced to Kill	25	2.5	19	5.1	6	0.9	<0.00*

Key: * *Statistically significant associations.*

** *Some respondents reported more than one torture event.*

Most of the respondents 905 (88.9%) reported having suffered at least one war-related torture experience with more males 346 (93.0%) reporting having experienced more torture events than females 559 (86.5%). This difference between the sexes was statistically significant (p<0.00) with 110 (17%) of the women reporting rape or attempted rape or forced marriage.

The most reported forms of physical torture included beating and kicking 445 (43.7%), followed by forced hard labour 173 (17.0%), and deprivation of food, water and medicine 195 (19.2%).

The other methods of physical torture reported included bayonet injuries 56 (55%), tying (Kandoya) 128 (12.6%), gunshot injuries 60 (5.9%), and burning 22 (2.2%).

Most of the respondents reported a relative having been killed in war 612 (60.1%). In 61 (60%) of the cases, this was a spouse, 144 (14.1%) a child/ren and in 407 (40.0%) was other relative.

Other methods of psychological torture commonly reported included verbal threats 472 (46.4%), sleeping in the bush/swamp 629 (61.8%), abductions 339 (33.3%) and destruction/looting of family property and livestock 528 (51.9%), interrogations 112 (11.0%), being forcibly recruited to fight in war 50 (4.9%), and forced to kill 25 (2.5%).

All methods of physical and psychological torture were reported by both sexes but there were proportional differences among the male and females on certain methods of torture. Male respondents reported being proportionally subject to more of the following physical methods of torture: beating and kicking ($p<0.00$), bayonet injuries ($p<0.00$) hard labour ($p<0.00$, tying (Kandoya) ($p<0.00$), deprivation of food, water and medicine ($p<0.00$) and gunshot injuries ($p<0.00$). Women respondents reported proportionally being subject to more of the sexual torture ($p<0.00$) e.g. rape ($p<0.00$), attempted rape ($p=0.01$) or forced marriage ($p=0.18$) although the later relationship did not attain statistical significance.

Looking at the psychological methods of torture, males were proportionally subject to more of it: killing of their relatives ($p<0.00$), verbal threats ($p<0.00$), interrogations ($p<0.00$), military detention ($p<0.0\,0$), abductions ($p<0.00$), destruction/looting of family property/livestock ($p<0.00$), forced to fight in war ($p<0.00$) and forced to kill ($p<0.00$).

Most abducted women were sexually abused whereas the abducted men were forced to fight and kill. Table 3.3: shows the period (years) when the torture took place, the reasons for the torture as given by the respondents and the perpetuators.

The period when torture took place was mainly during the 1986 to 2001, a 15-year period as reported by 660 (97.5%) of the respondents. The main reason that was reported by the respondents for torture was political 409 (61.6%) with other reasons reported including religion 11 (1.6%), criminal 112

(16.9%) and mistaken identity 132 (19.9%). The main perpetrators of torture were the rebel armies, 488 (69.5%) mainly the Lord's Resistance Army of Kony 342 (48.5%) and previously Lakwena's Holy Spirit army 125 (18.0%). This was followed by the national army, NRA/UPDF, 178 (25.4%).

Table 3.3 The Timing, reasons and perpetrators of the torture Experiences

Variable	Total	
	Number	%
Period of Torture* (n=679)		
1971 - 1979 (2 periods)	88	1.2
1980 - 1985 (1 period)	11	1.6
1986 - 2001 (3 periods)	660	97.5
Reason for Torture* (n=664)		
Political	409	61.6
Religious	11	1.6
Criminal	112	16.9
Mistaken identity	132	19.9
Perpetrators of Torture* (n=702)		
Police Officers	6	0.9
Prison Officers	9	1.3
Local defense Personnel	10	1.4
Army	178	25.4
Uganda Army	4	2.3
UNLA	4	2.3
NRA/UPDF	170	24.3
Rebel Army	488	69.5
UPDA	21	4.4
LRA (Kony)	342	48.5
Holy Spirit Lakwena	125	18.0
Environment torture took place* (n=712)		
Home	537	75.4
Work place (garden)	32	4.5
Prison	5	0.7
Rebel camp	37	5.2
Refugee Camp	14	2.0
Rood blocks	17	2.4
Military barracks	42	5.9
Others	87	12.2

Key: ** Some of the respondents gave more than one response to these variables.*

Torture among most respondents took place at home 534 (75.4%). Other places where torture took place included the workplace (shamba) 32 (4.5%), rebel camp 37 (5.2%), refugee camp 14 (4.2%), roadblock 17 (2.4%) and military barracks 42 (5.9%).

Table 3.4
Psychological distress, substance use and homicidal thoughts by Gender

Variable	Total (n=1018)		Gender				Chi Square p-value
			Male (n=372)		Female (n=646		
	No.	%	No.	%	No.	%	
Psychological Distress*							
Cases	815	80.1	286	76.9	529	81.9	0.05*
Use of substances of abuse**							
Cigarettes	178	17.5	137	36.8	41	6.3	<0.00*
Alcohol	404	39.4	183	49.2	221	34.2	<0.00*
Marijuana	2	0.2	1	0.3	1	0.2	NS
Having Homicidal thoughts							
Positive	65	6.04	22	5.5	43	6.4	0.57

Key: NS = not specified

Psychological distress was measured using the WHO-SRQ-25 instrument. A case was defined having at least a score of 6 on the non-psychotic symptoms or a score of at least 2 on the psychotic symptoms of the modified WHO-SSRQ-25.

Most of the respondents screened at the camp had significant psychological distress 815 (80.1%). Substance use was mainly alcohol 404 (39.4%), followed by cigarettes 178 (17.5%) and marijuana 2 (0.2%). Abuse of substances was proportionally more

by males than females (p<0.00). No respondents reported sniffing petrol, nor use of khat (mairungi). Sixty-five (6.04%) respondents reported having homicidal thoughts (thoughts of killing others). Both females 43 (6.4%) and males 22 (5.5%) reported these feelings in similar percentage and the gender difference did not attain statistical significance (p=0.57). Factors found on the WHO-SRQ-25 instrument to be associated with psychological distress at univariant analysis are summarised in Table 3.5

Table 3.5: Univariant Analysis of Factors associated with psychological distress on the WHO-SRQ-25 Scale

Variable	Cases of Psychological distress		Chi square P-value
	Number	%	
Gender (n=815)			
Male	286	76.9	0.05*
Female	529	81.9	
Camp of Residence (n=809)			
Awer	113	55.4	
Olwal	118	68.2	<0.00*
Pagak	227	95.8	
Kaladima	153	97.5	
Parabongo	148	79.1	
Educational Status (n=815)			
No formal education	215	73.6	
Primary level	437	82.0	0.01*
Secondary / post secondary level	77	82.7	
Marital Status (n=815)			
Never married	117	73.6	
Married/cohabiting	527	82.2	0.03*
Separated/divorced	38	74.5	
Widow/widower	102	85.0	
Single mother/father	31	65.0	
Having child/ren (n=815)			
Present	605	84.6	<0.00*
Not present	210	69.3	

(Table 3.5: *Continued)*

Experience a torture event (n=815)			
Positive	757	83.6	<0.00*
Negative	58	51.3	
Having gynaecological Complaints (n=815)			
Present	445	85.6	<0.00*
Not present	370	74.3	

* *Statistically significant associations.*

The factors that were significantly associated with psychological distress as measured by the WHO-SRQ-25 at univariant analysis were: gender with the proportion of cases among females 529 (81.9%) more than among males 286 (76.9%) (p=0.05); camp of residence with Pagak and Kaladima having proportionally more cases (95.8%) and (97.5%) respectively than the other camps (p<0.00); educational status, with respondents with formal education having proportionally more cases than those with no formal education (p=0.01); marital status, with the married and the widower/widow having proportionally more cases than the single, separated/divorced and single parents (p=0.03).

The other factors that were significantly associated with psychological distress included: having children, with 605 cases (84.6%) compared to those without children 210 (69.3%) (p<0.00); a history of experiencing a torture event, with 757 cases (83.6%) compared to those with no history of torture 58 (51.3%) (p<0.00); and having gynaecological complaints, with 445 cases (85.6%) compared to those without gynaecological complaints 370 (74.3%) (p<0.00).

Age group, religion, employment status, use of substance of abuse and having surgical complaints was not significantly associated with psychological distress at univariant analysis.

3.6.2 Psychiatric intervention at the Health centre Level

The mental health team interviewed 215 CVC—referred respondents at Awer Health Centre of which 198 (92.1%) were 15 years and above.

All the 5 satellite camps were represented among the respondents. The male to female ratio was 1:2 with the mean age of 37.8 (standard deviation 14.8) and an age range of 15 to 80 years.

Table 3.6
Psychiatric disorders as seen by the mental health team at Awer Camp by Gender

Variable	Total (N=198)		Male (n=66)		Female (n=132)		Chi square P-value
Disorder**	No	%	No.	%	No.	%	
Post Traumatic Stress Disorder (PTSD)	79	39.9	26	39.4	53	40.2	0.92
Depression	104	52.5	35	53.0	69	52.3	0.92
Alcohol abuse Disorder	36	18.2	17	25.8	19	14.4	0.05*
Generalised Anxiety Disorder	9	4.5	4	6.1	5	3.8	0.47
Panic Disorder	120	60.6	36	54.5	84	63.6	0.22
Agoraphobia	80	40.4	17	25.8	63	47.7	<0.00*
Social phobia	40	20.2	18	27.3	22	16.7	0.08
Somatoform Disorder	144	72.7	44	66.7	100	75.8	0.18
Having Suicidal Thoughts	45	22.7	16	24.2	29	22.0	0.75

Key: * *Statistically significant associations*
** *Some respondents had more than one psychological disorder.*

Post traumatic stress disorder was present in 79 (39.9%) of respondents seen at the health centre by the mental health team. Other psychiatric disorders reported included depression 104

(52.5%) and alcohol abuse disorder 36 (18.2%). Anxiety disorders were common with generalised anxiety disorder at 9 cases (4.5%), panic disorder at 120 cases (60.6%), agoraphobia at 80 cases (40.4%) and social phobia at 40 cases (20.2%). Somatoform disorder with 144 cases (72.7%) was the most common psychiatric disorder found. Forty-five (22.7%) of the respondents also reported suicidal thoughts and 65 (33%) reported homicidal thoughts.

All the above psychiatric disorders were reported in the two sexes. However alcohol abuse disorder was proportionally reported more among males 17 (25.8%) than among females 19 (14.4%) ($p=0.05$) and agoraphobia proportionally more among females 63 (47.7%) than among males 17 (25.8%) ($p<0.00$). Social phobia was proportionally reported more among males 18 (27.3%) than females 22 (16.7%) but this difference was not statistically significant ($p=0.08$). Both males and females reported equally high rates of depression, anxiety disorders, PTSD, somatoform disorder and suicidal thoughts.

The presence of psychiatric disorder was associated with significant psychosocial dysfunction amongst the affected respondents. This dysfunction was investigated using a simple subjective self-reporting scale. Comparisons were then made looking at frequencies. Table 3.7 summarises the findings.

Most of the respondents reported good work function 155 (78.3%), good family relationships 173 (87.4%) and good sexual function 167 (84.3%). However a significant number reported work impairments 43 (21.7%) despite the hardships of war impaired family relationships 25 (12.7%) with 14 (7.1%) having separated/divorced. Thirty one (15.7%) of respondents had impaired sexual function with more female respondents 17 (12.9%) reporting stopped or discontinued sexual function as compared to males with no reports of discontinuation.

Table 3.7: Effect of Psychiatric Disorder on Function, Psycho-social health seeking behaviour and referral to Hospital.

Variable	Total (N=198)		Male (n=66)		Female (n=132)	
	No.	%	No.	%	No.	%
Work Function						
Good	155	78.3	47	71.2	108	81.8
Moderately impaired	31	15.7	12	18.2	19	14.4
Unable to work	12	6.1	7	10.6	5	3.8
Family Relationships						
Good	173	87.4	56	84.8	117	88.6
Moderately impaired	11	5.6	6	9.1	5	3.8
Severed/Separated/ Divorced	14	7.1	4	6.1	10	7.6
Sexual function						
Good	167	84.3	56	84.8	111	84.1
Moderately impaired	14	7.1	10	15.2	4	3.0
Stopped/discontinued	17	8.6	0	0	17	12.9
Health seeking behaviour						
Visit to Traditional healer	192	97.0	64	97.0	128	64.6
Visit to Medical Clinic	58	29.3	21	31.8	37	18.7
Visit to a Hospital	31	15.7	8	12.1	23	11.6
Referrals to Hospital						
Mental Health Clinic						
Counseling	6	3.0	2	3.0	4	3.0
Psychiatric medication	35	17.7	14	21.2	21	15.9
Other Specialists						
Gynaecologist	7	3.5	0	0.0	7	5.3
Physicians	2	1.0	1	1.5	1	0.8
Surgeons	8	2.5	5	7.6	3	2.3
Special Investigations						
Lacor Hospital	7	3.5	4	6.1	3	2.3
Gulu Hospital	1	0.5	0	0.0	1	0.8

Previous health seeking behaviour for mental illness included visiting a traditional healer 192 (97.2%), visiting a medical clinic 58 (29.3%) and visiting a hospital 31 (15.7%).

During the medical intervention the camp volunteer counselors offered supportive counseling to those with mild

degrees of psychological distress and referred those with more severe forms of psychological distress to the health centre of Awer. Those referred with psychological problems to the health centre at Awer were seen by the mental health team at the clinic. The referred patients were further assessed and given drug treatments, supportive counseling or referred to Gulu Hospital for more in-depth assessment and treatment.

The referrals to Gulu Hospital attended the mental health clinic there for counseling 6 (3.0%) and psychiatric medications 35 (17.7%). Referrals were also made to other specialties including gynaecology 7 (3.5%), internal medicine 2 (1.0%), and surgery 8 (2.5%). Some respondents were sent for special laboratory investigations at Lacor Hospital 7 (3.5%) and Gulu Hospital 1 (0.5%).

3.7 Discussion

Torture whether in war or peace is prohibited internationally (UN Convention Against Torture), regionally (African Banjul Charter of Human and People's Rights), and by various chapters and articles in the Ugandan constitution (1995 Uganda Constitution, Chapter 4, Article 24). However, war-related torture is still widespread in the Northern District of Gulu (Isis-WICCE, 2000; Constitution of the Republic of Uganda 1995; United Nations High Commissioner for Human Rights 1999; Amnesty International 1999.

Most of the respondents (88.9%) interviewed from Awer camp of internally displaced persons reported having experienced at least one war-related torture event. Both physical and psychological methods of torture were reported. The most commonly reported physical torture methods included beating and kicking (43.7%), being forced to perform hard labour (17.0%) and being deprived of food, water and medicine (19.6%).

The most reported psychological methods of torture included having relatives killed in the war (60.1%), verbal threats (46.4%), sleeping in the bush/swamp (61.8%), abductions (33.3%) and destruction/looting of family property and livestock (51.9%). The pattern of physical and psychological methods of torture reported is similar to that reported in earlier studies of war traumatised victims in the central district of Luwero (Segane-Musisi S. *et. al.* 2000, 1999).

Men in this conflict in Gulu appear to be particularly targetted for torture with more men (93.0%) proportionally reporting exposure to a torture event than women (86.5%) ($p<0.00$). Contrary to some studies which report that men tend to be more exposed to physical methods of torture while the women are more exposed to psychological methods of torture, the men in Gulu appeared to be exposed to both methods of torture proportionally more than the women (11, 15, 16). Male respondents were proportionally subject to more of the following physical methods of torture than women: beating and kicking ($p<0.00$), bayonet injuries ($p<0.00$), forced to perform hard labour ($p<0.00$), tying (Kandoya) ($p<0.00$) deprivation of food, water and medicine ($p<0.00$) and gunshot injuries ($p<0.00$).

Male respondents were also proportionally subject to more of the following psychological methods of torture, killing of a relative as a result of war ($p<0.00$), verbal threats ($p<0.01$), interrogations ($p<0.00$), military detention ($p<0.00$), abductions ($p<0.00$), forced to fight in war ($p<0.00$), and forced to kill ($p<0.00$). Sexual torture was predominantly reported by women. This was in conformity with the literature from elsewhere showing that women were subjected more to methods of torture that were directed at their sexuality than men: rape, ($p<0.00$), attempted rape ($p=0.01$), and being forced into marriage ($p=0.18$)) (IRCT/RRCTV 1995; Paker M., Paker O., Yuksel S.

1992; Allodi F., Stiasny S. 1990). Most abducted women were subjected to sexual abuse whereas most abducted men were forced to fight. Sexual torture of women as a weapon of war has been frequently reported in the literature including recently in Rwanda and Yugoslavia (Skylv G. 1992; McNally R. J. 1992; Paker M., Paker O., Yuksel S. 1992; Allodi F., Stiasny S. 1990).

The period of torture was mainly the 1986 to 2001 period (97.5%), a time when the district has been and continues to experience civil conflict. The main reasons for torture was reported as being political (61.6%), a finding similar to that reported in other studies done in the central district of Luwero (8,7).

The main perpetrators of torture were the rebel army of the Lord's Resistance Army (69.5%) followed by the National Army —NRA (UPDF) (25.4%). Most of the respondents (75.4%) were tortured at home as they went about their daily life and most were local people of low or no education (64.7%).

Significant psychological distress was reported in 80.1% of respondents, a rate higher than the usual 12% commonly reported at primary health care clinics (19). This is not surprising given the high levels of physical and psychological torture they have experienced.

Female respondents (81.9%) proportionally reported more cases of psychological distress than men (76.9%) ($p=0.05$). This was associated with other gender-related factors that significantly affected women namely: marital status ($p=0.03$), having children ($p<0.00$), and having gynaecological complaints ($p<0.00$). These factors predominantly affect women in their social roles as mothers, wives, and providers for food for the family and children.

Other factors that were significantly associated with psychological distress included the camp of residence ($p<0.00$), pointing to differences in the level of available amenities and sense of

security in the different camps. Indeed, during the medical intervention, Pagak satellite camp reported frequent visitations by the rebel soldiers. Experiencing a torture event was also significantly associated with psychological distress ($p<0.00$).

In terms of the psychiatric disorders suffered traumatic stress disorder (39.9%), depression (52.5%), alcohol abuse disorder (18.2%) and anxiety disorders — panic anxiety disorders (60.6%), agoraphobia (40.4%), social phobia (20.2%), and somatoform disorder (72.7%) were commonly present among respondents who were referred to the mental health team at Awer camp. This is in conformity with studies done both locally among traumatised war victims of Luwero and elsewhere in the world where post traumatic stress disorder and its other comorbid psychiatric disorders have been consistently associated with torture (Segane-Musisi S. *et al.* 2000, 1999; McNally R. J. 1992; Skylv G. 1992; Paker M., Paker O., Yuksel S. 1992; Allodi F., Stiasny S. 1990). Again in conformity with studies done elsewhere, cases with alcohol abuse disorder were proportionally more represented among male respondents (25.8%) as compared to female respondents (14.4%) ($p=0.05$) (McNally R. J. 1992).

Anxiety disorders such as agoraphobia, panic disorder, social phobia and the generalised anxiety were very common in both sexes, such high rates of anxiety seem to be part of the psychological distress of those perpetually living in a war-situation. Cases with the anxiety disorder—agoraphobia were proportionally more represented among females (47.7%) as compared to males (25.8%) ($p<0.00$). This is unlike other studies which have reported the generalised anxiety disorder to be more prevalent among women than men, an observation not made in this study (McNally R. J. 1992).

Most of the respondents from the health centre reported good work function (78.3%), good family relationships (87.4%) and

good sexual function (84.3%). But a sizeable proportion of the respondents reported work impairment (21.7%), impaired family relationships (12.6%), and poor sexual function (15.7%) as result of the psychological problems they were having. This is in conformity with the literature, which has consistently shown that moderate to severe psychiatric sequlae of torture is associated with impaired psychosocial function (United Nations High Com-missioner for Human Rights 1999; Segane-Musisi S. *et al.* 1999). Studies in Luwero district yielded similar results (Segane-Musisi S. *et al.* 2000, 1999).

Somatoform disorders were the most common psychiatric disorder found. Somatisation as a communication of psychological distress has been commonly reported in African settings and especially in association with P.T.S.D. (Segane-Musisi S. *et al.* 2000, 1999). Indeed previous studies done in Luwero district had similar findings (Segane-Musisi S. *et al.* 2000, 1999). Such somatisation often leads to misdiagnosis and poor treatment.

Most of the respondents had previously sought treatment for their psychiatric problems from the traditional healers (97.2%) with only (15.7%) having attended the only mental health clinic at Gulu Hospital. This calls for the redesign of mental health service provision in this district given the enormity of the problem of psychological war traumatisation and the few mental health workers in the district. Gulu District presently has only one Psychiatric clinical officer and six psychiatric nurses for a population of approximately 400,000.

Limitations of the Study

- The camp sample was not drawn up by a random probability method. Therefore, community prevalence rates of torture experiences and psychological disorders could not be calculated.

- Data from Gulu Mental Health Clinic could not be reported upon in this study due to the short study period.
- Some of the referrals from the camp to the health centre at Awer did not turn up within the study period and were therefore, lost to the study.

Conclusion

In conclusion, the District of Gulu has experienced and continues to experience severe war traumatisation as a result of the civil war still raging there. This state of war has created a massive population of people with severe war-related psychiatric sequelae which are currently not being addressed.

Given the extent of war traumatisation in this district, there is need to have public health interventions for torture rehabilitation. A primary health care model could be most effective as illustrated by the Isis-WICCE short term medical intervention, where the few district health professionals and community resource persons such as traditional healers and Camp Volunteer Counselors could effectively be trained and utilised.

That 65 (6.04%) of the respondents from the camp had homicidal thoughts and ideas appears to feed into the cycle of violence that has engulfed the Great Lakes Region and Uganda in particular. There is therefore added urgency to have psychological interventions for this population for the future stability of this country and the region as a whole.

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