Torture in children

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Abstract

This is a review article that studies the problem of torture in children. Torture in children is a significant worldwide problem, but there are no official or reliable independent statistics to measure the magnitude of the problem.

The definition of torture in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment applies to adults and children. The Convention on the Rights of the Child defines children as "every human being below the age of eighteen years".

Torture in children happens during peace times and during political violence and war conflicts. The majority of torture victims happen during peace times. The high-risk groups are impoverished children living in the street, children deprived of parental care, children in conflict with the law, and children in detention.

During political violence and war the high risk children are the children detained during political violence, child soldiers, children internally displaced in refugee camps, detained children during the war against terrorism and children tortured by peacekeeping forces.

The perpetrators of torture in children are the members of the same forces that torture adults, generally the police, civil police, security guards trained by police, prison guards, and military forces.

The paper identifies some preventive measure and develops recommendations for action at the local, national and international level.

Keywords: Torture, violence, children, human rights

"I only wanted to be a child, but they would not let me."

A statement written in the tomb of a street child killed by police in Guatemala.

Violence, exploitation and abuses against children happen frequently at home, at school, in the work place, the community, during peace time, and in armed conflicts. Violence against children is widespread in all parts of the world, and hidden from the eyes of the general public. Recently, these violations have been the subject of several conferences, reports, and declarations of non-governmental organizations.[1-3] The basic message of these studies is that *no violence against children is justifiable and all violence against children is preventable*.[4]

This paper will not analyze all those abuses but only those in which the perpetrator is an agent of the state or abuse which happened when the child was under the protected custody of the state. Torture of a child

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is the most serious violation of the basic human right to personal integrity and respect for human dignity.

The objectives of this paper are:

1. To review the most relevant literature on this subject.
2. To identify significant issues related to torture against children.
3. To identify effective strategies and preventive programs.
4. To develop recommendations for action at the international, national, and local levels.

Background information

Human rights instruments

Definition of torture

Torture is the most serious violation of a person's fundamental right to personal integrity and a pathological form of human interaction.

The United Nations (UN), in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) in 1984, adopted the following definition:

For the purpose of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.[5]

This definition has been universally accepted by the 146 countries that have currently ratified the Convention.

In summary, torture is defined as a political act inflicted by a public official, with the intent and purpose of extracting a confession or information, punishment, intimidation, coercion, or discrimination. The most important criteria in the definition of torture are the intention and purpose, not the severity of the pain. Torture often occurs during detention when the prisoner is powerless and under the control of authorities. The use of force and the infliction of pain under these circumstances violate the principle of proportionality, forbidden by international law.[6] Torture has been defined by other organizations, such as the World Medical Association, and by individual countries in their national laws, but the UN definition is the most applicable and widely accepted for governments.[7]

Most countries in their domestic laws criminalize torture but not cruel, inhuman or degrading treatment or punishment (CIDT). The countries that practice torture use a more restrictive definition of torture and make the severity of pain the most important criterion of the definition. Later these countries may increase the threshold of severe pain to just short of organ failure. This allows the practice of torture to continue while officially denying its use.

This definition of torture is the same for adults and children but we have to be aware that the threshold of pain for children is lower than for adults.

Definition of children

Article number one of the Convention on the Rights of the Child (CRC) defined

children as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier." The convention was adopted in November, 1989, and entered into force on September 2, 1990.[8]

"Each child has the right to his or her physical and personal integrity, and protection from all forms of violence. Children, as human beings, are entitled to enjoy all the rights guaranteed by the various international human rights treaties that have developed from the Universal Declaration of Human Rights".[4]

Article 2 of the CRC states that "State Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members."

Article 37 of the CRC specifically declares that State Parties shall ensure that: "No child shall be subjected to torture or cruel, inhuman or degrading treatment or punishment, neither capital punishment nor life imprisonment without the possibility of release shall be imposed for offences committed by person below eighteen years of age."

Children are not a homogenous group and the definition covers different ages and stages of development. The American Academy of Pediatrics divides children into four development stages according to age:

Prenatal: first year
Early childhood: 1 year to 4 years.
Middle childhood: 5 to 10 years.
Adolescence: 11 to 21 years.

The children in each of these age groups could be a target for torture by a government with different types of abuses.

Categories of violence and torture in children

By age group

Prenatal and early childhood: 1 to 4 years

Abduction of children born in detention, when their mothers were killed for political reasons has been reported in Argentina and Uruguay. This is one of the most egregious violations of the rights of a child. A good example is the fight of the "Abuelas of the Plaza de Mayo" in Argentina.

Early childhood and middle childhood: 5 to 10 years

Forcing children to witness atrocities against parents, family members or caregivers:

These actions can be considered cruel and inhuman treatment and, in some cases, amount to torture. This practice could constitute a war crime or crime against humanity when committed as a systematic attack against civilian populations in times of war.

Children are obliged to witness the violent detention and torture of parents. Multiple examples have been documented in Latin America during Argentina's "Dirty War." Children have also witnessed the killing of family members as documented during the Rwandan and Guatemalan genocide.[9, 10]

Adolescence: 11 to 21 years

Torture during detention for minor crimes.
Torture for political participation.
Torture for religious participation.
Torture for sexual orientation.
Torture during detention for ethnic persecution.
Torture during detention in adult prisons.
Torture during war time.

By place of occurrence

The UN study of violence against children selected several settings in which violence is

taking place in the *home and family, in schools and educational settings, in state care and justice institutions, in places of work, and in the community.* Using this classification, torture can occur only in the institutional and community settings.[4]

Institutional torture occurs in situations of children in detention facilities, violence in the context of the administration of justice (pre-trial detention) and capital punishment. Within a community setting, the report describes police violence in the street and torture by the judiciary.

Violence in institutional settings administered by the state

- Torture of children in institutional care.
- Torture of children in custody and detention.
- Violence and torture against children with disabilities in state institutions.

Many children live a significant part of their lives under the control and supervision of authorities or justice systems. These institutions vary in scope and can be long term residential or institutional care, emergency shelter, homeless shelters, and foster care. Some children are in special medical facilities for the disabled or psychiatric wards. Other children are in custody or detention. These institutions have responsibility to provide protection and guidance to the children under their care, but instead, these children are subjected to violence and torture.

Violence in the community

- Violence by law enforcement agents.
- Violence and torture of children living in the street.
- Violence and torture against sexual minorities.

High risk children

Children at the highest risk of being *tortured during peace times* are the street children in their different categories:

- Impoverished children living in the street
- Children deprived of parental care generally are poor children that have been abandoned by their biological or adopted parent. These children are entitled to protection and assistance from the state, and are eligible for placement in foster care or orphanages, but ultimately ended up homeless.
- Children in conflict with the law.
- Children in detention.

Children at high risk of torture during political violence and war conflicts:

- Detained children during political violence.
- Child soldiers.
- Children living in internally displaced persons camps in country of origin or in refugee camps.
- Detained children during the war against terrorism.
- Children tortured by peacekeepers.

Torture of children during peace times

Torture of impoverished street children and children in conflict with the law

There has been a significant migration from rural areas to cities in developing countries. The newcomers do not receive any help and they tend to settle in precarious cardboard towns on the periphery of big cities. They create a belt of poverty call "favelas" in Brazil, "callampas" in Chile, and "villa miseria" in Argentina. The income of those living in poverty or extreme poverty cannot sustain a family. At an early age, the children are obliged to work for survival.

It is a reality that the street is both a home and a workplace for many children. In the street, they work in undocumented street jobs cleaning shoes, selling cheap merchandise, or they are pushed towards crime. These street children face dangers of all kinds during their daily ambulation: drugs, drug traffickers, prostitution, or even murder by death squads in some countries.

These groups of children have been abandoned and ignored by society. They are powerless. They are fighting for survival hour by hour, day by day. Torture and maltreatment by police is part of their daily life. They do not seek medical care. Nobody offers them relief for their suffering. Citizens have become blind to these children. These invisible children walk in the city boulevards, eating when possible, once a day or a few times a week.

Mullis and Cook[11] studied thirty street children in Rio de Janeiro, Brazil. They compared these thirty children with children of the same age group selected from local schools and living with their parents. They measured two groups' ability to obtain food, to grow by body mass index (BMI), and their levels of social support.

The majority of street children (80%) are not living with their parents. Only 20% of them visit their family daily, and 30% had no contact with family. The majority of street children (87%) reported found a place to sleep 7 days a week, but 27% reported not having a residence. Both groups were able to obtain some daily food, but the quality of the food was better in school children and these supported children scored higher in BMI measurements.[11]

Reason for detention

The most frequent reasons for detention were:

- Captured in fraganti stealing a wallet, food, or opening a car.
- Suspected of a criminal offense.
- Aspiration of glue fumes: considered by police as an addiction, but used by street children as a suppressant of hunger and cold.
- Children's refusal to give money collected while begging to a police officer requesting a bribe.
- False accusation of petty crimes such as stealing or disorder in the street.
- No reason (illegal detentions).

Place of torture

Torture and maltreatment happen in the street when police detained or transported children to the police station or to the outskirts of the city where they were often abandoned. Torture also happens during detentions at police headquarters, in prisons, or while children reside in government custody.

Magnitude of the problem

An Amnesty International survey in 2000 found that 75% of countries practice torture systematically despite the *absolute prohibition* of torture and cruel and inhuman treatment under international law, even when these countries have signed the CAT.[12]

Torture of children is a significant worldwide problem, but there are not official or reliable independent statistics to measure the magnitude of the problem.[12]

Child violence by security forces is extremely frequent in the streets or during detention, sometimes without complaints from the public. The rights of children are not generally recognized, these abuses are not reported nor investigated, and few perpetrators are held accountable for their crimes.

The victims do not have the capacity to report, because they do not have political

power and they consider these maltreatments as normal. If the violation is not reported, if human services organizations or governments agencies do not register these events, the problem does not exist at the national or international level, and there is no cause for action.

Few organizations have published reports on the torture of children. Amnesty International, OMCT, Save the Children (UK), Casa Alianza (Central America), Human Rights Watch (HRW), and United Nations Children's Fund (UNICEF). UNICEF denounces police abuse and torture of children in their reports and publications under the heading "Children In Conflict With The Law".[1, 2, 13-15]

Covenant House (Casa Alianza) has published the most complete report of documented cases of torture of street children in Honduras and Guatemala. Casa Alianza documented 133 cases of torture between 1990 and 1997, 63 from Honduras and 70 from Guatemala. Each case the report provides a description of the event, the torture methods applied, and photographs of the lesions and a statement of the action taken to prosecute the perpetrator. The majority of tortured children discussed in the report were boys 122 (91.7%) and only 11 (8.3%) were girls, as shown in Table 1.[16]

Table 1. *Torture of children in Honduras and Guatemala. Honduras from March 1990 to August 1997. Guatemala from 1992 to August 1997.*

	Male	%		%	Total
Honduras	57	90.5	6	9.5	63
Guatemala	65	92.8	5	7.2	70
Total	122	91.7	11	8.3	133

Source: Table prepared with information from: Informe de tortura a niños de la calle en Guatemala y Honduras. Covenant House. America Latina 1990-1997. Publicación de Casa Alianza, 1997.

Method of torture and killing of children

The methods of torture in children are the same to those used on adults. Different reports have described children being exposed to extremes of heat and cold, deprived of food and water, deprived of sleep, punched, kicked, beaten with different instruments, whipped, burned with cigarettes and fire, electric shocks, hanging, cuts with sharp instruments, stripped naked and sexually assaulted and raped.[12, 17]

Casa Alianza has documented methods of torture in the children's cases of Central America: humiliation, punching, kicking, beatings with a police baton or the butt of a gun, phalange (beating the soles of the feet), burning with cigarettes, stabbings, intentional biting by police dogs, hanging of children by their arms, pouring of caustic glue on face and hair, and subjecting them to sexual torture and rape.[18]

Type of torture in girls

In Honduras, six girls were detained. Five (83%) of them were raped and the others were severely beaten. In Guatemala, five girls were detained. Only one was raped, two were severely beaten, and two were stabbed to death.[16]

Killing of street children

Several reports have documented the killing of children in detention who have been tortured during police detention.[17, 18]

There have been reports of unlawful killings of street children by police, security officers, and death squads. There are reports of these killings from countries such as Brazil, Colombia, Honduras and Guatemala.[16, 18-20]

Killing of street children in Brazil

The world was shocked in 1980 when newspapers around the world reported the killing

of street children by police and death squads in Brazil. Death squads were operating in nine of the 27 Brazilian states at that time.[19]

Death squads were hired by shopkeepers to get rid of alleged criminals and petty thieves. Death squads were staffed by off-duty police officers, civil police and military. The police estimate that 500 homeless children were murdered each year, mostly while they slept. Until 2000, some death squads were still active. Both children and adults were victims of death squads.[21, 22]

Roldao Arruda published a report in the newspaper *O Estado de Sao Paulo* on 1,000 children killed in 1990. He concluded that 30% of these deaths were caused by the police, 50% by death squads calling themselves "justiceiros," and the remaining 20% by unknown criminals. Most of the policemen have yet to be convicted for killing street children.[23]

Killing of street children in Honduras and Guatemala

The Covenant House (Casa Alianza) report of the 133 cases reveals that thirty one (23.3%) of these children were killed. Twenty of those were killed by the police or military and eleven were killed by unknown perpetrators. It is suspected that the killers were agents of law and order, as shown in Table 2 and 3.

Table 2. *Torture of children in Honduras and Guatemala 1990-1997. Total of tortured children who were killed, based on 133 reported cases.*

	Total torture	Killed children	%
Honduras	63	15	23.8
Guatemala	70	16	22.8
Total	133	31	23.3

Source: Table prepared with information from: Informe de tortura a niños de la calle en Guatemala y Honduras. Covenant House. America Latina 1990-1997. Publicación de Casa Alianza, 1997.

Methods of killing

The principal methods of killing street children in Honduras and Guatemala were gun shots (mostly in the head) followed by beating and stabbing, as shown in Table 3.

Torture of children during political violence and war

Torture of children during political violence and military dictatorship

Chile

Chile was one of the longstanding democracies in Latin America. A bloody military dictatorship ruled the country from 1973 to 1989. Since 1990, the country has been a democratic state with free elections.

Chilean President Ricardo Lagos set up a National Commission on Political Detention and Torture in 2003. The objective of the commission was to determine the number and identity of those who suffered imprisonment and torture for political reasons during the Pinochet military dictatorship. The commission received the testimony

Table 3. *Torture of Children in Honduras and Guatemala 1990-1997. Methods of killing by police or unknown perpetrator.**

	Police	Unknown	Total	%
Honduras				
Gun shot	7	3	10	67
Beaten	1	3	4	27
Stabbed	1		1	6
Total	9	6	15	100
Guatemala				
Gun shot	8	3	11	69
Stabbed	3	2	5	31
Total	11	5	16	100

*) One child was known to have been killed by a civilian

Source: Table prepared with information from: Informe de tortura a niños de la calle en Guatemala y Honduras. Covenant House. America Latina 1990-1997. Publicación de Casa Alianza, 1997.

of 35,865 victims. 27,000 were accepted immediately as valid and over 7,000 are in revision. This is the largest data base of records of detention and torture in the world.

The commission published a Spanish report and an English executive summary. The commission reported that 27,255 persons were detained and tortured, 23,856 of them (87.5%) were men and 3,399 were women (12.5%).

The report also confirmed that 1,080 of victims (3.96%) were children, as represented in Table 4. The distribution by age shows that the majority of the children (98.1%) were adolescents. Unfortunately, no further analysis will be possible because their testimonies will remain confidential and no one will have access to them for the next 50 years.[24]

Terrorist and subversive activities was the justification for detention and torture in 978 of these cases (92.5%).

Foundation for the Protection of Children Injured by States of Exception (PIDEE), an organization oriented to the rehabilitation of child victims of repression during the military dictatorship in Chile, was founded in 1979. More than 3,000 children received services until 1992. Some of the children were physically tortured during imprisonment and the majority witnessed the violent invasion of their home, destruction of their belongings by security forces, military, or police, and witnessed the beating and detention of their parents or another member of their family. Although some only witnessed the brutal detention of their parents and were not directly tortured, the psychological impact was so intense and prolonged that the experience is equivalent to psychological torture.

The children's behavior and family life changed dramatically. The children became aggressive, irritable with constant crying, exhibited nervous tics, stuttering, and exhibited extreme dependence on adults. Symptoms also included eating problems (anorexia or bulimia), sleeping problems such as difficulty getting to sleep, bed wetting, and nightmares, poor school performance due to memory loss, difficulty concentrating, dyslexia, fear of the dark, and fear of those in uniform. These children lost their childhood.[25]

PIDEE developed individual, family and group therapy, psycho pedagogy methods, and cultural workshops. Children also received drama, music and art therapy. During play and art therapy children talked and drew about death, jail, absence of the father, unemployment and the wish that the detained parent would return home.[25-27]

The return to a normal life depends on the loss of fear that the traumatic experience will not be repeated. The return of the detained parent also improved the chances of return to a normal life, but unfortunately, this was not always possible. In spite of this, most treated children developed their capacity to adapt to the new situation.

Table 4. *Children detained during the military dictatorship in Chile. September 1973 to March 1990.*

Age	Number	Percentage
16 to 17	766	70.9
13 to 15	226	20.9
Under 12	88	8.2
Total	1080	100.0

Source: Table prepared with the information of the report of National Commission on Political Detention and Torture, 2005.[24]

Argentina

Military dictatorships ruled Argentina from 1976 to 1983. During this period, many babies were kidnapped. Many of these parents were killed. In other cases, pregnant mothers were taken to clandestine centers.

Babies born in these centers and kidnapped from their parents were adopted by military families with a new name and identity. The objective of this crime was to remove the children from subversive families to give to "good" families.[28]

The grandmothers of these babies organized themselves and became "Abuelas (Grandmothers) de Plaza de Mayo" with a mandate to fight for the return of their grandchildren and to defend the right to an identity.[29, 30]

Since 1977, over 400 children have been recorded as missing. The Abuelas have investigated all adoptions in local and federal courts during this period. They have also examined all registered births in governmental offices. In 1997, the Abuelas began a national campaign among young people to investigate their identity if they have any doubts about their lineage.[29, 30]

The Argentinean government created the National Committee for the Right Identity (CONADI) in 1992. The main objective of the agency is to scientifically investigate identities. The process includes the use of a database of the missing children, investigation of the legality of an adoption, and blood analysis of immunogenetic tests conducted by the National Bank of Genetic Data. These genetic analysis permits conclusively include or exclude an individual from a biological family. By February, 2009, the Abuelas identified 97 of the disappeared children.[29]

The Philippines

A study of child torture victims in the Philippines reported 415 cases of torture in children over two decades from 1976 to 1995. This period is reflective of the three military dictatorships of Ramos, Aquino, and Marcos. The victims in this study have several factors in common: poverty, relative geographic remoteness, growing industrialization with strong presence of military forces to protect industries, and political families residing in close geographical proximity. These poor, rural, heavily militarized areas, with little communication outside the region, make for very difficult conditions in which to report and document human rights abuses. All these factors favor impunity for perpetrators.

By age group, the highest numbers of documented cases were between 15-18 (80%) years of age. Of these, 64% were tortured during arrest. Only 8% of perpetrators were charged with a crime, and most of them were 58% released after detention and torture.

Torture of children during armed conflict

In modern wars, the civilian population is often a target. Children are amongst the first casualties of any armed conflict, always the most vulnerable and innocent of victims. In the last decade alone 1.5 million children have died in wars. Four million have been disabled and a further 10 million traumatized. Many children suffer violence at the hands of enemy forces in several ways:

- They can be detained and tortured to glean information relative to the whereabouts of parents or other family members.
- They can be killed without registration of death and reported as missing children.
- Children are detained and tortured because of suspicion of collaboration with enemy forces.
- Children witness the killing of his/her complete family as in Rwanda and Guatemala.
- Children survive as war orphans.
- Rape of young women during war is a battle strategy as in the Balkan war,

Rwandan genocide, and now in Uganda and the Democratic Republic of the Congo.

During armed conflict in the Philippines, the projected goals of torture of these children were to obtain information about armed resistance groups. Torture was also used in attempts to force a confession, to incriminate others, to take revenge, to create fear in the community, and to destroy the personality of the victims.[17]

As in the case of Amir, described by the paper of C. Green, a child was tortured in front of his father to force a confession. Later, Amir witnessed the torture of his father, which led to his father's death.[31]

Torture of child soldiers

Child soldiers are the children who have been singled out for recruitment below 18 years of age. Armed forces and armed opposition groups exploit them as combatants around the world.

Although most child soldiers are between 15 and 18 years old, significant recruitment starts at the age of 10 and the use of even younger children has been recorded.

Approximately 250,000 children under the age of 18 are thought to be fighting in conflicts around the world, and hundreds of thousands more are members of armed forces who could be sent into combat at any time.

Poverty and years of armed conflict have made it easier for a whole generation of children to be drawn into the armed conflict. For some, soldiering has become a form of survival or has represented a form of identity in a context of widespread trauma. Other children have been drawn, sometimes after years of indoctrination, to the political, ethnic or military agendas of their chosen group. In such situations it is more accurate to talk of indirect force rather than volunteering.

During training children are more afraid of their officers than the dangers to which they are exposed. Cowardice, failure to follow orders without question are severely punished. Beating, whipping, hanging, solitary confinement, sexual abuses, and sometimes punishment by death are frequent during indoctrination and training. Easily manipulated, children are sometimes coerced to commit grave atrocities, including rape and murder of civilians using assault rifles such as AK-47s and G4s. Some are forced to injure or kill members of their own families or other child soldiers. Others serve as porters, cooks, guards, messengers, spies, and sex slaves.

Demobilization of child soldiers cannot happen without substantial support from the international community to provide sufficient financial and technical assistance to all actors involved in the process to ensure a comprehensive and coordinated approach. The authorities, commanders and leaders of armed political groups are responsible to prevent recruitment of children and to allow and facilitate their demobilization.[32-34]

Torture of children living in internally displaced camps

Some 26 millions people worldwide are currently living as internally displaced persons (IDP). They were forced to flee their home because their lives were at danger but they did not cross an international border.

4.6 million people were newly displaced in 2008. The biggest new displacement in the world was in the Philippines, where 600,000 people fled fighting between the government and rebel groups. There were also massive new displacements in Sudan, Kenya, Democratic Republic of Congo, Iraq, Pakistan, Somalia, Columbia, Sri Lanka and

India. The largest internally displaced populations are found in Sudan (4.9 million), Colombia (up to 4.3 million) and Iraq (2.8 million).

Women and children are a high risk group for violence and human rights abuses by government forces and other groups. In 2008 displaced women and girls were particularly exposed to rape and sexual violence, domestic violence and exploitation.

Displaced children are extremely vulnerable. In many countries, they were forced to work or they could not go to school. Displaced children were at risk of forcible recruitment in at least 13 countries where IDP camps had been infiltrated by armed groups.[35]

Torture of unaccompanied refugee minors

Unaccompanied refugee minors are children and youth who migrate to another country because their parents or caregivers have died, abandoned them, or simply gotten separated amid the chaos of war or civil unrest. Some of them are street children. The number of unaccompanied minors seeking asylum has increased dramatically in industrialized countries in recent years. During their displacement they are at high risk of violence and torture by police, border patrol forces, military or other violent groups.

Refugee minors who have entered another country can experience brutal detention. They are placed in custody or in detention centers pending a determination of their legal status. Frequently they are denied access to legal counsel, or education. They are also subject to punitive measures, such as handcuffing, shackling, solitary confinement. In some countries they are detained with violent young offenders or adults.[36] The real alternative is placing these children in foster care and community-based services.

Torture of children in armed conflict and the war against terrorism

The torture of children in the context of counterterrorism pre-dates the "War on Terror" launched by the United States government in 2001. There are many reports of the detention and torture of children in Colombia, Peru, Sudan, Kenya, and the Philippines. Children become victims much in the same ways of those children suffering through armed conflict.[37]

Human Rights Watch (HRW) reports that the U.S. military authority, operating the Multinational Forces in Iraq, has detained some 2,400 children since 2003. Adolescents between the ages of 13 and 17 have been detained in Iraq and accused of supporting insurgents and militias. Some of the children are as young as ten. Detention rates increased from 25 children in a month in 2006 to 100 children in 2007.[38]

The U.S. military keeps most children at Camp Cropper in Baghdad. Children have been interrogated for days and weeks by military units in the field before being sent to prison. They do not have legal support and they have limited contact with their families. The average length of detention is 130 days and some of them have been detained for more than a year without charges or trial. The United States, as of May 12, 2008, is holding 513 children as "imperative threats to security".[38]

A UN committee said it was concerned about reports of "cruel, inhuman or degrading treatment" of children held in Guantanamo and Iraq. Some of these children have been classified as "unlawful combatants," and have been charged with war crimes and subjected to prosecution by military tribunals without due account of their status as children."

The United States is holding three detainees at Guantanamo, in custody for more

than five years, who were initially detained as adolescents. Two of these young men, Omar Khadr and Mohammed Jawad, are both facing trials before a military commission. Mohhammmed El-Gharani, now 21, was detained when he was just 14 years old. He has tried to commit suicide at least seven times. There is clear evidence these boys have been tortured.

"Under international law, adults who recruit children for combat are to be prosecuted for that offense. But the children caught in combat are to be protected not prosecuted," said Diane Amann, a law professor at UC Davis University. The Geneva Convention and the Convention on the Rights of the Child hold that it is the responsibility of the state that captures juveniles in the battle fields to work to rehabilitate them towards integration into society.[39]

U.S. forces have not released statistics on the number of children that have been transferred to Iraqi custody.[38] Iraqi military forces have detained at least 220 children during military operations. The detained children are treated as adults. Local NGOs have documented evidence of torture perpetrated during interrogation.[40]

Torture of children by peacekeepers

A recent report by Save the Children describes the abuse of children in post conflict areas by peacekeepers that have been drafted to help them. The report documents cases of sexual abuse of children in Ivory Coast, DR Congo, Burundi, Liberia, Southern Sudan, Eritrea, and Haiti. Most of these abuses go unreported and unpunished, with children too scared to report them.[41]

The report identified different forms of sexual abuse such as trading sex for food, forced sex, child prostitution, and sexual slavery. The vulnerable children were orphans, children separated from their parents, children from poor families, children displaced from their home communities, and children who depend on humanitarian assistance for survival.

These abuses have been chronically under reported because children fear the loss of material assistance and support, and they fear the stigmatization, and the threat of retribution or retaliation. In some cases, there is a cultural acceptance to the abuse of children. Children do not know how to report the crimes, they feel powerless to report it, there is a lack of effective legal services, and the children have a lack of faith in the response.

In the cases that have been officially reported few victims received adequate response, treatment, or justice in the form of perpetrator punishment. The report made three key recommendations: an effective local mechanism of the reporting of abuses, a new global watchdog to monitor the situation, and efforts to tackle the root causes or drivers of abuse.[41]

Physical and psychological consequences

Psychological consequences of torture in children

The mental health consequences of torture to the individual are usually more persistent and protracted than the physical aftereffects.

The Center for Integrative and Development Studies of the University of Philippines has extensive experience in the study of the psychological consequences of torture in child survivors.[17]

During torture, children loose control of the situation and have no access to the internal or external resources of an adult. Adults or family can not protect them and they feel extremely vulnerable. They do not have the ability to act in this crisis situation,

and they become apathetic and indifferent when they loose faith in adults.

In a sample of 415 children, researchers found that child torture victims feel fear and anxiety within their immediate environment, especially when they are dealing with strangers. The symptoms increased when they were confronted with their own experiences.[17]

The children felt anxious if they were alone. They suffered from sleep problems and recurrent nightmares. They also suffered from feelings of helplessness and apathy. The loss of self-esteem due to their experience of extreme humiliation attacked their self respect and personal identity.

Sudden behavioral changes occurred and children became violent, overly dependent, withdrawn, neglectful of their routines, and tended to isolate themselves. They also had learning difficulties and showed poor performance when they returned to school. Their memory and concentration were affected and attention span was limited.

The detention and torture of a child breaks up the harmony of a family. The family is fearful that other relatives could be accused of a political crime and detained. They feel powerless.

Similar symptoms have been found in child victims of severe political repression in Latin America. Individual children responded in different ways. They experienced high levels of fear, anxiety, insecurity, and aggressiveness. They had difficulties expressing themselves corporally or emotionally. They complained of insomnia and nightmares and regressive behaviors such as bed-wetting. Argentine psychologists have described children with high intellectual abilities, but emotional immaturity.[28]

John Briere, Ph.D., has studied severely abused and neglected children. He believes these traumas interrupt normal child development, such as the acquisition of self capacities. Impaired self capacities lead to reliance on cognitive, emotional, and dissociation avoidance strategies that further preclude the development of self capacities. Consequently, these children suffer more psychological distress when they experience traumatic events.[42]

Physical consequences of the torture of children

Few child victims of torture received medical care, thus the documentation of physical consequences is scant. An exception has been the 133 cases of the torture of children in Honduras and Guatemala documented by Casa Alianza in order to prosecute the perpetrators. The findings were published in a book. All of those victims showed acute temporary injuries, such as bruises, hematomas, lacerations, cuts, burns, cigarette burns, and fractures of teeth or bones, that were documented with photographs.[9]

The most important physical consequence of torture is chronic long-lasting pain experienced in multiple sites. Survivors also experience diverse psychophysiologic symptoms.[7] PIDEE in Chile has documented frequent headaches and abdominal pain in child victims.[28]

Approaches to treatment

Child victims of torture is a group with immense unmet needs that has been abandoned by society. They look for medical care only in extreme circumstances. The information on treatment of children torture victims is scant or nonexistent.

The majority of child victims recover from their physical injuries and they are apparently functioning, but psychological symptoms are persistent. Of the 415 cases reported in the Philippines only six have undergone complete psychological treatment.[17]

The approach to treatment developed by

PIDEE in Chile and in other Latin American countries has been successful. Guatemalan rural health promoters help child survivors of torture and repression in Mayan communities. They base their psychosocial assistance on the cultural traditions of the indigenous populations, such as oral story telling, dramatization, use of masks, religious practices and natural plant resources. The health promoters use workshops organized as supplements to other development and health projects.[28]

John Briere, Ph.D., developed a model of treatment for children severely abused and neglected. He called the approach *self-trauma model*. The model is a synthesis of current dynamic, cognitive, and behavioral approaches that have been found helpful in the treatment of severe child abuse trauma. The model is based on the concept that symptoms in abused and neglected children are hyper developed adaptive mechanisms to maintain internal stability. The treatment is oriented toward helping the child survivors to do better what he or she is already attempting to do.[42]

It is necessary to study whether the symptoms of a child survivor of torture follow the same pattern of the abuse and neglected children of Briere's group.

Torturers and impunity

Torturers

Although torture has been practiced for millennia, knowledge about perpetrators of torture and how they are trained has been difficult to find. Manuals on techniques for interrogation and curricula for training intelligence officers have been classified until recently. Psychologically, perpetrators are usually "normal," but subjected to brainwashing or a dissociative process.[7]

The perpetrators of torture in children are the members of the same forces that torture adults generally the police, civil police, security guards trained by police, prison guards, and military forces. Rebel Forces are also perpetrators when they control and administer a territory. It has been documented that child soldiers also act as perpetrators of atrocities to other children and adults.

In situations of war, the principal perpetrators are the military and paramilitary forces (69%).[17]

Impunity

The lack of social and political power of the victims favors almost complete impunity for the perpetrators. Children do not file complaints or they do not report crimes committed by adults, especially if the perpetrator is a member of the police or another state agency. Reasons child survivors do not file complaints include:

- Fear of reprisals.
- Lack of impartiality in the investigation.
- The same state organization that committed the crime investigates the facts.

The Istanbul Protocol could be a useful instrument in bringing perpetrators of the torture of children to justice. The assessment of torture survivors has only recently been systematized. The Istanbul Protocol is a manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. It includes modules for medical, psychological, and legal professionals. The Protocol was approved as an International Instrument by the General Assembly of the United Nations resolution 55/89 on December 4, 2000.[43]

Use of the international human rights system to protect abuses and torture of children

Issuing worldwide urgent appeals

Since 1991, OMCT has been sending out

urgent appeals under the heading "Child Concern," requesting immediate and effective actions concerning specific cases of violence against a child. These requests are circulated to several thousand recipients around the world. After receiving information of a reliable source and double checking the information in the country, OMCT issues an urgent action appeal.

Use of the Human Rights Committee and Committee against Torture (CAT)

Philippines

The Philippines was scheduled to report to the UN Human Rights Committee in 2003. Philippines NGOs lead by PREDA prepared an alternative report of the juvenile Justice system in the country. PREDA and the other NGOs made a powerful presentation during the briefing session and in a press conference in Geneva. The Committee report cited several references to this alternative report and made requests for changes to the legal system.

Honduras

In 1996, the Supreme Court of Honduras implemented a rule that allowed judges to send under-age detainees to jails holding adults. This detention plan, called "Autoacordado," violated the Honduras Constitution and the CPC. Casa Alianza and other NGOs began a program to monitor jails and document violations of the human rights of detained children. They presented 300 Habeas Corpus cases that were rejected by the judiciary on "Autoacordado" resolution grounds. Casa Alianza and CEJIL presented the problem to the Inter American Commission on Human Rights. The Commission accepted the cases and forced the State to cancel the rule and compensate each child with US $20 per day of illegal imprisonment.[44]

Use of the Inter American Human Rights Court

Guatemala

In 1990, five street boys, aged 15-20 were kidnapped, tortured and murdered by the police in Guatemala. The bodies of four of them were found in a place called "Bosques de San Nicolas."

The boys' eyes had been enucleated, their ears, and tongues cut off.

Casa Alianza brought criminal charges against four policemen in a Guatemalan Court. After three years litigation, the policemen were acquitted. Casa Alianza and CEJIL presented the case to the Inter American Commission on Human Rights in Washington. The Inter American court of Human Rights in Costa Rica ordered the Guatemalan Court to reopen the criminal case against the accused. The Guatemalan government was ordered to pay US $500,000 to the families of the children, name a school after victims, and implement a national plan to benefit street children. This was the first case in the history of the Inter American court in which children were the victims.[18]

These are three land mark examples of human rights organizations effectively utilizing the International Human Rights Commissions and Courts. These cases also set an example for advancing the application of law at the domestic level in the fight against impunity and the process of obtaining reparations for the victims and their families.[44]

Strategies and effective programs for prevention

The majority of torture in children happens during peace times and the victims are the impoverished street children.

Planning prevention

Prevention is based on the identification of the risk factors. These are the most significant risk factors for children:

- A high proportion of poverty and extreme poverty.
- A high proportion of children in the families of the population or country under study.
- Violence at home and/or dysfunctional families.
- Failure of social support system to protect neglected, abandoned, and abused children.
- The use of the justice system against children in need instead of providing protection.
- Lack of training of law enforcement and juvenile system personnel on child development, needs of neglected children, and children's legal rights.

We can measure the magnitude of these risk factors in a social group, region or country. The highest levels of poverty and extreme poverty in the world are found in Sub-Saharan Africa, South Asia, East Asia, the Pacific, and Latin America according to the most recent study of the World Bank.[45]

In Latin America, Haiti, Honduras, Nicaragua, and Guatemala are the countries with the highest proportion of poverty and families with the highest proportion of children. In Honduras and Guatemala there is a higher level of awareness and a coalition of NGOs interested in the subject. Honduran groups are already studying the magnitude of the problem.

Similar situations can be found in South Asia in countries such as Bangladesh, Pakistan, India, and Sri Lanka.

The plight of street children and their deaths was a matter of public concern in many Latin American countries in the eighties. The first Latin American seminar on community alternatives for assistance to street children was held in Brazil in 1984.

Other countries have developed Programs to prevent the torture in children in conflict with the law.

Proposed actions In the community

- Organize a network of NGOs interested in the rights of children.
- Create a social support system to help children that have been neglected, abandoned or abused.
- Organize and empower street children as social actors, aware of their rights, to gain access to education and health services.
- Public opinion and media campaign to promote positive image of the needs of street children.
- Monitoring and reporting of abuses: research shows an effective and transparent data collection and publication is required. The Defense for Children International has studied this problem and has developed twelve indicators of violence against children deprived of liberty. These are minimum standards that every country should be able to produce and publish.[46]

Proposed actions in the justice system[47]

High level training of all personal working with children in the Juvenile Justice System

- Inter-sectorial training courses for those who are in direct contact with children (including judges, prosecutors, police officers, military personnel, prison staff, lawyers, and social workers).
- Detention as the last resort for criminal offenses by studying the possibility of alternative sanctions.
- Legal support: most of the abuses of a child happen at the time of arrest, during interrogation by officials, and while in police custody at the police station. The conditions of detention are generally bad and the children are often detained with adults.

- Support for detained children at police stations, in prisons and in courts by trained volunteers, social workers, paralegals, or lawyers to monitor their situation. These juvenile advocates are contacted upon the arrest of a child to help to find the child's parents. Some countries allow a lawyer to be present at the police station, and in other countries an attorney may be present as a silent witness, or only after 24 hours of police detention.
- Maintain a database on Juvenile Justice Indicators such as the number of cases received, accepted, and referred.

Ending impunity

- Police accountability through review board, Ombudsman, NGOs.
- Criminalization of violence, torture, or killing of children by the authorities.
- Creation of an effective complaint system.
- Independent and impartial investigation of any claims of torture.
- Criminal, civil, and administrative prosecution against individuals responsible for these human rights violations.

Legislative changes

Each government should adopt legislation to create an independent Juvenile Justice System (JJS). The JJS should be based on international treaties and international standards. Governments should also adopt legal requirements to implement and monitor the United Nations 15 Juvenile Justice Indicators. In addition, governments should adopt the independent inspections recommended by the Additional Protocol of CAT.

Strategies for social change: the example of Brazil

An example of a strategy on prevention is in operation now in Brazil. Many NGOs working with street children organized a national network called the National Street Children's Movement (MNMMR). These NGOs and advocacy groups were able to get the support of the press to create public awareness on the magnitude of the problem. They were also able to organize the street children by sectors in a city. The first "National Street Children Congress" was held in Brazil in 1986. These organizations began to discuss a long term strategy for social change to eradicate the root causes of the extreme poverty and other risk factors for street children.

Local, national and international recommendations

To IRCT Secretariat

Investigate possible sources of funding for an international program related to the torture of children oriented initially to study the magnitude of the problem, advocacy, preventive programs and research. These programs should be implemented in a geographical area with high prevalence of torture and killing of street children as in Central America and South Asia.

To donor governments and foundation

To support the effort of international organizations and local NGOs to investigate and rehabilitate child torture survivors.

To national networks and local centers

Each network and center should:

- Identify in each country and region which international treaties related to children have been signed and ratified: Convention On The Rights Of The Child.
- Identify if these international obligations have been codified in domestics laws.
- Identify children at high risk of being detained, maltreated and tortured.

- Identify and collaborate with others NGOs interested in the plight of tortured children.
- Monitoring: collect any existing information in your area to measure the magnitude of the problem, particularly reasons for detentions, torture by organization and regions of the country, age groups, and socio economic status of the victims.
- Determine whether the registration of age is carried out systematically during detention.
- Create awareness of the magnitude of the problem at the level of community and civil society.

How to measure the magnitude of the problem in a center or programme.
Quantitative indicators:

Analysis of child population enrolled in a rehabilitation program

A rehabilitation program upon admission of a survivor of torture should record the age and the age at the time of the torture to identify:

- Number of torture survivors admitted to the program below 18 year of age.
- Number of adults admitted to the program for treatment of torture suffered when they were children.

Children in conflict with the law

- Number of children in preventive detention.
- Number of children admitted with physical evidence of abuse after police investigation.
- Sexual abuse in detention.
- Number of children in adult prison.
- Number of children in adult cells.
- Number of children in solitary confinement.
- Child deaths in detention.

How to improve reporting

- Review check list of violence related issues.
- Review definition and use definition provided by UNSGVAC Study.
- Broaden the base of participation in reporting including representatives such as parents, classmates, teachers, associations, and other professionals with whom the child has contact.
- Develop permanent monitoring system in institutions.
- Support and develop child rights coalitions.
- Develop national advocacy campaigns among the public and the authorities on the urgency of the problem.

Conclusion

The highest risk groups and the highest prevalence of torture or murder of children are the street children and the children in conflict with the law.

The most significant risk factors are poverty, extreme poverty, high proportion of children in a family, and the failure of society to protect neglected, abandoned, and abused children.

The most important solution to improve torture and killing among children is a strategy for social change that combats the problem of extreme poverty and provides a positive prevention model program.

Annex 1

Organizations working to promote children rights

These organizations have been identified because their names are listed in scientific publications, United Nations, and NGO reports.

United Nations

Office of the United Nations High Commissioner for Human Rights (OHCHR)
United Nations Children's Fund (UNICEF)
United Nations Department of Peacekeeping Operations (DPKO)
United Nations Development Programme (UNDP)
United Nations Office on Drugs and Crime (UNODC)
United Nations World Health Organization (WHO)

International organizations

Advocacy and Child Protection, Consortium for Street Children, UK
Amnesty International (AI)
Casa Alianza in Latín América: Costa Rica, Guatemala. Honduras, Nicaragua, México.
Committee on the Rights of the Child, The Netherlands
Center for Justice and International Law (CEJIL)
Consortium for Street Children, UK
Defense for Children International (DCI)
Global initiative to end all corporal punishment of children, UK
Human Rights Watch (HRW)
International Association of Youth and Family Judges and Magistrates (IAYFJM)
International Federation of Red Cross and Red Crescents Societies
International Juvenile Justice Observatory (IJJO)
International Institute for Child Rights and Development (IICRD)
International Rehabilitation Council for Torture Victims (IRCT)
International Save the Children Alliance, Norway
Penal Reform International (PRI)
Save the Children, UK
Terre des hommes – aide à l'enfance (Tdh)
World Vision International
World Organization Against Torture (OMCT)

Coalition of International Organizations related to Children Rights

Interagency Panel on Juvenile Justice (IPJJ)
Office of the United Nations High Commissioner for Human Rights (OHCHR)
United Nations Children's Fund (UNICEF)
United Nations Department of Peacekeeping Operations (DPKO)
United Nations Development Programme (UNDP)
United Nations Office on Drugs and Crime (UNODC)
Committee on the Rights of the Child;
Defense for Children International (DCI)
International Association of Youth and Family Judges and Magistrates (IAYFJM)
International Juvenile Justice Observatory (IJJO)
Penal Reform International (PRI); Save the Children UK
Terre des hommes – aide à l'enfance (Tdh); and
World Organization Against Torture (OMCT)

National organizations

Argentina

Center of Legal and Social Studies on Childhood and Youth

Cambodia

Bar Association of Cambodia

Costa Rica
Defense for Children International, Costa Rica

Egypt
Association for Human Rights Legal Aid (AHRLA)

Honduras
Center for Investigation and Promotion of Human Rights in Honduras (CIPRODE)
Committee for the Defense of Human Rights in Honduras (CODEH)
Coordinator of Institutions for the Right of the Child (COINPRODEH)
Centro de Prevención Tratamiento y Rehabilitación para las Victimas de la tortura y sus familiares (CPTRT)

India
National Judicial Academy

Kenya
Child Rights Advisory Documentation and Legal Center (CRADLE)

Kyrgyzstan
Youth Human Rights Group

Malawi (Benin)
Eye of the Child in Blantyre
Malawi CARER
Center for Legal Assistance (CELA) in Liliongwe
Youth Watch Society, Mzuzur

Philippines
Ateneo Human Rights Center, Child Rights Unit
Free Legal Assistance Volunteers Association (FREELAVA)
Philippine Action for Youth Offenders (PAYO)
People's Recovery, Empowerment and Development Assistance Foundation Inc

South Africa
Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN)

Uganda
Defense for Children International-Uganda
Legal Aid Clinic

April 26, 2009

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School-based interventions for minors in war-exposed countries: a review of targeted and general programmes

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Abstract

Lately, there has been a call to develop and assess efficacious mental health interventions for minors who have witnessed organized violence. This review outlines what is currently known about targeted and general school-based interventions for children and adolescents in war exposed countries. Seven empirical outcome studies were identified from a PubMed and PsychINFO search; four targeted and three general programmes. Despite the paucity of published evidence, some promising findings were noted. School-based interventions implemented by locally trained paraprofessionals in organized violence settings appear to be a feasible and low cost sustainable alternative to individualized therapy for distressed children in low and middle income countries. However, the reported outcomes for treatment effectiveness were mixed and suggest that school-based group crisis interventions for traumatized war exposed minors may not be sufficient to reduce mental distress and may sometimes even increase it. Several limitations in the published literature were observed. Although studies reported changes in symptoms associated with interventions, most did not report on the degree of functional impairment. Further, there may be a need to develop interventions targeting other dimensions of organized violence than post-traumatic distress, for example, depression and maladaptive grief. At this point in time it is difficult to compare targeted versus general interventions. There may be risks associated with screening minors, and studies should weigh the cost benefit of targeted versus broader treatment approaches. Future research should aim to determine which therapeutic ingredients, which could be professional-specific, such as manualized cognitive-behavioural therapy, culture-specific, or a combination, significantly contribute to positive outcomes.

Keywords: school-based interventions, refugee, children, adolescents, organized violence, war, mental health

Introduction

Between 1990 and 2003 there was major armed conflict in 27 to 38% of the world's developing countries, affecting around 20 million children.[1] According to Walker et al. this exposure to violence accounts for 8 to 34% of negative outcomes in the children exposed to these atrocities.[1] Further, the authors found a 33% increase in post-traumatic stress disorder (PTSD) in children from more violent communities compared to children from less violent communities.

Contrary to the widespread perception that refugees flee to developed countries, the statistical evidence indicates that most of them remain in their region of origin or flee to neighboring countries. Today, developing

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countries host 82% of the world's refugee population.[2] In refugee minors exposed to war related stressors, exposure to trauma and violence is compounded by displacement and loss of their familiar environment, and the risk for developing mental health difficulties is increased for these children.[3] It is estimated that as many as 40% of young refugees may have psychiatric disorders, mainly PTSD, depression, and other anxiety-related symptoms.[4] However, data about the impairment associated with these symptoms is rarely available and multiple studies have underlined the discrepancy between high levels of reported symptoms and good social adjustment.[5, 6] Despite the multiple adversities they face, child and adolescent refugees have been found to be extremely resilient,[7] with family and community factors often playing a key protective role. However, the mental health needs of those who develop psychopathology are still largely unmet, especially in low and middle income countries.[8] According to Ehntholt, Smith, and Yule, psychological treatment opportunities for traumatized refugee children are nearly non-existent,[9] and randomized controlled trials are scarce.[10] Closing the gap between need and available services is complicated by the fact that there is a lack of clearly formulated mental health policy initiatives for children and adolescents. Although countries have a duty under various United Nations agreements to alleviate the effect of war on children's mental health, many do not live up to their responsibility. For instance, in the African region 35% of countries have limited local child relevant mental health policy and few have a dedicated child and adolescent mental health policy.[11] These findings are worrisome because, as argued in the literature, for relief efforts to be successful in addressing the needs of children in complex emergencies, coordinated interventions are critical.[12] In addition, most of the treatments for childhood PTSD are based on adaptations of interventions originally developed for adults.[13] As outlined by the World Health Organization's Atlas Project, few national programmes have been developed to highlight the mental health needs of children, and those that exist, have been almost exclusively developed in high-income countries.[14]

Lately, to address the gap between child and adolescent mental health needs and the availability of resources, there has been a call to develop and assess efficacious mental health interventions for minors who have witnessed organized violence.[13, 15] In the 2008 annual review issue of the Journal of Child Psychology and Psychiatry, Leckman and Leventhal outlined the need to develop preventative and efficacious interventions that can be implemented by non-specialist health care workers, such as school and community based programmes.[15] However, as outlined by Patel et al. the evidence base for low cost community based interventions for children in low and middle income countries, especially in the midst of an emergency, is lacking.[16] Recently, the first systematic review on evidence and treatment approaches for children in war in low and middle income countries by Jordans et al. found a moderate effect size for treatment efficacy.[17] Although they did find some high effect sizes, these were largely the results of within-group change rather than an effect of treatment, and the authors concluded that there is a general lack of empirical evidence for interventions.

As well, there is a scarcity of research documenting the effect of specific therapy techniques for war affected children, and most of the available evidence pertaining to the treatment of PTSDs has resulted from studies done in non-warfare settings.[13] In

a review paper on the psychosocial aspects of children exposed to war, Barenbaum, Ruchkin, and Schwab-Stone, claim that it is more important from a public health perspective to address the needs of large groups of traumatized children exposed to violence in their country of origin, rather than later when they are in exile.[13] However, this is also more difficult. As the authors argue, assessing traumatized children during war or social turmoil is complicated by limited economic and treatment resources. Thus, mental heath interventions may take the back seat to other relief operations, even though the psychological needs of children should be built into emergency and rebuilding initiatives.[18]

Although the evidence base for mental health prevention and intervention for war exposed children is still in its embryonic stage, recent years have brought increased attention to the importance of implementing mental health services aimed at reducing or preventing the harmful impact of armed conflict on children.[19] Several promising treatments, such as cognitive-behavioural therapy, narrative exposure therapy, and creative expression therapy have emerged.[10]

To date, no meta-analyses exist that directly measure the effect of school-based interventions for refugee children compared to other types of interventions. A systematic review by Silverman et al. found that group school-based cognitive behavioural therapy was "probably efficacious" in reducing symptoms of psychopathology; however, these results were not based on studies of children exposed to organized violence per se.[20] To address this gap in the literature, this review, although not systematic, will outline what is currently known about the effect of different types of school-based treatment interventions, in particular for children who have experienced organized violence. The paper will focus on general and targeted interventions implemented in war exposed countries.

The value of school-based interventions for refugee children and adolescents

Despite their high exposure to adversity, immigrant and refugee families tend to underutilize mental health services for multiple reasons (stigma, cultural inappropriateness, alternate help-seeking behaviours).[21,22] Mainstream Western mental health approaches have often not been effective with these populations.[7] For instance, in an epidemiological study of Somali and Oromo adult refugees, of whom 25-69% had been tortured, less than 1% of the participants requested or accepted referral to mental health services, even though they scored high on measures of psychological problems. [23] The same trend has been observed in a behavioural problem screening study of recently settled Bosnian refugee families in Massachusetts. Although the families reported behavioural symptoms for 77% of children, only one family expressed interest in psychosocial services of any kind.[24] Furthermore, in low income countries the mental health needs of psychologically distressed children are sometimes not met because their families have difficulty accessing mental health care. In 2003, a World Health Organization conference on Caring for Children with Mental Disorders identified lack of transportation and available resources as the most significant barriers to care.[14] Thus, in both developed and developing countries, several researchers have outlined the value of school-based interventions as a non-stigmatizing and easy access alternative to mental health care clinics for these children.[4, 22]

School-based interventions are considered to be a viable public health initiative in complex emergencies, because they are

able to reach most children and target larger groups of children than clinic-based referrals.[19] Because many victims of complex emergencies are reluctant to seek help, mental health professionals should take a proactive stance to outreach efforts and implement programmes in the children's natural settings, such as schools where their teachers may take the role of empathetic and responsible mediators.[25]

School intervention and prevention programmes do not just address PTSD symptoms in children affected by organized violence but are also directed to the wider social problems caused by war.[26] The initial goal of these interventions is to create an emotionally safe and stable environment. For instance, The STROP model developed by Swedish paediatrician Lars Gustafsson highlights the value of school and kindergarten as a safe place in the middle of an otherwise chaotic environment.[27] As outlined by the RCT Field Manual on Rehabilitation the first line of therapy for traumatized children and adolescents needs to focus on establishing safety, stability, and trust to support healthy coping strategies.[27] This may be attained by joyful group activities organized by familiar adults in school settings, such as creative expression and physical exercise. Further, as Tol et al. have argued, implementing feasible and cost effective school-based interventions run by locally trained paraprofessionals in complex emergencies is valuable because they address the global disruption of children's environment caused by war, reach large groups of children, and respond to the lack of specialized mental health interventionists.[19]

In a similar vein, Barenbaum, Ruchkin, & Shwab-Stone have argued that war relief programmes for children should emphasize simple, low cost, group-based non-specific therapeutic interventions.[13] Although not directly discussing mental health school-based interventions, Betancourt and Khan have outlined how educational institutions may work to improve the social and mental health outcomes of refugee minors during complex emergencies.[28] As argued by the authors, going to school may instil hope for the future and improve social networks. In addition, schools may serve a protective function because they improve the monitoring of children and their physical and mental health may be screened in a more systematic manner. Thus, mental health interventions in schools may facilitate the screening and treatment of refugee children whose mental health and functional impairment require further attention.

Offering interventions in schools is in line with the World Health Organization's policy on delivering mental health care through community resources rather than through isolated clinics.[18] However, although numerous small scale projects have been implemented in developing countries, they remain largely unknown because they are rarely evaluated or published.[22] When international mental health consultants are involved in projects in war affected communities, they must work with and train local personnel to ensure that interventions are sustainable.[18] For school-based interventions, this may be managed by training local teachers in basic mental health techniques so they can organize group interventions for their students with minimal aid from foreign consultants.

Although the value of school-based interventions has been outlined, researchers have also warned against pushing assessment and research procedures ahead of the promotion of social cohesion and functioning in war relief efforts.[13] Pure research should not compromise the effectiveness of other interventions, and must aim to be integrative and

culturally sensitive. Successful intervention programmes should not pathologize children, but must be based on the community's cultural norms and beliefs; incorporating cultural practices is essential.[28] Although researchers have pointed out that Western medicalization of children exposed to armed conflict may be culturally insensitive and fail to contextualize their distress,[29] it has still been emphasized that if traumatized children are not diagnosed, they may not get the attention they require.[10] As outlined by Barenbaum, Ruchkin, & Shwab-Stone the optimal approach to understanding and treating war exposed children might draw on principles of *both* cultural specificity and cross cultural universality.[13]

In the next few sections, this paper will describe the design of and results of school-based interventions for children and adolescents implemented in war exposed countries. In this review, a targeted intervention (also known as indicated) implies that the children were screened for psychopathology before being assigned to an intervention. Thus, these individuals reported a higher level of symptoms than their peers. In contrast, a general (also known as universal) school-based intervention means that the children and adolescents were not selected for inclusion in the study based on their level of symptomatology, although this may have been measured at baseline for evaluative purposes.

Targeted school-based interventions in war exposed countries

Targeted group-based school interventions have been designed because meeting the needs of traumatized children in complex emergencies by offering individual therapy is unrealistic. As argued by Yule individual therapy may also be undesirable because not all children are so severely distressed that they require individual therapy.[18] Further, group based treatments provide a source of peer support, which may further help alleviate distress in children exposed to armed violence.[30] The value of targeted interventions versus general interventions has also been indicated by Barenbaum, Ruchkin, & Schwab-Stone who have argued that screening for traumatic symptoms and psychosocial impairment before implementing therapeutic interventions may be beneficial because it separates those in urgent need from those less in need.[13]

PubMed and PsychINFO were searched to identify published empirical outcome studies evaluating targeted school-based interventions for children exposed to violence in developing countries; four were identified (see Table 1 for an overview).

In the first cluster randomized trial on a school-based intervention for children exposed to violence in a low income setting, Tol et al. implemented a manualized, five week school-based group intervention for children (mean age 9.9 years) exposed to political violence in Indonesia.[19] The children were screened for exposure to violence, for symptoms of posttraumatic stress and anxiety, and functional impairment prior to the intervention. Eighty percent of the children screened were included in the study. The intervention consisted of 15 sessions with groups of around 15 children led by locally trained paraprofessionals, and included trauma processing activities, cooperative play, and creative-expressive elements. The authors concluded that the intervention reduced posttraumatic stress symptoms for girls and helped maintain hope for boys, but did not reduce traumatic-stress related symptoms, depressive symptoms, anxiety symptoms, or functional impairment for either sex.

In addition to accumulating much needed empirical evidence about the ef-

Table 1. *Reviewed studies (n = 7)*

Authors, (year), country	Type of intervention	Sample size	Methodology	Intervention, (duration/ sessions)	Outcomes
Tol et al. (2008) Indonesia	Targeted	495	Cluster randomized trial	Manualized group based intervention (5 sessions, 5 weeks)	Reduced PTSD symptoms,helped maintain hope, but did not reduce traumatic stress-related symptoms, depressive symptoms, anxiety symptoms, functional impairment
Layne et al. (2008) Bosnia	Targeted	127	Randomized controlled trial	Trauma/grief focused psychotherapy (17 sessions, school year)	Reduced depression, PTSD symp toms, and maladaptive grief
Layne et al. (2001) Bosnia	Targeted	87	Non-controlled design	Trauma/grief focused psychotherapy (20 weekly sessions)	Reduced PTSD, depression, and grief symptoms; changes associated with psychosocial functioning
Thabet et al. (2005) Gaza	Targeted	111	Quasi-experimental	Group crisis intervention (7 sessions)	Did not reduce PTSD and depression symptoms
Gupta & Zimmer (2008) Sierra Leone	General	306	Non-controlled design	Trauma healing, recreational activities (8 sessions, 4 weeks)	Reduction of intrusion and arousal symptoms, but increased avoidance symptoms; increased optimism concentration, reduced nightmares
Woodside et al. (1999) Croatia	General	250	Non-controlled design	Psycho-educative, expressive groups (4 months of weekly sessions)	Reduced PTSD symptoms, ethnic bias, increased girl selfesteem and quality of social connections
Gordon et al. (2004) Kosovo	General	139	Non-controlled design	Mind-body experiential psycho-educative groups(6 weekly sessions)	Reduced PTSD symptoms

ficacy of school-based interventions, one of the major strengths of this intervention lies in the researchers' efforts to work with the local community. The interventionists were selected from local target communities based on a selection procedure assessing social skills through role play. In general, they had no formal mental health training, and received a two week training programme before the start of the intervention. As mentioned by Yule, training local paraprofessionals ensures greater sustainability of mental health initiatives than if foreign consultants run the intervention.[18] As well, as evidence of further community involvement, the instruments were administered by locally trained individuals, and not by the researchers themselves.

Layne et al. have published the findings of a randomized controlled trial on the ef-

fectiveness of a school-based group psychotherapy programme implemented by locally trained and supervised school counsellors for war exposed adolescents attending 10 secondary schools in central Bosnia during the 2000-2001 school year.[31] Of the 1,279 students who completed the risk screening survey prior to the initiation of the programme, 159 students met inclusion criteria and were randomized to the treatment or comparison condition. All these students reported severe symptoms of posttraumatic stress disorder, depression, or maladaptive grief, as well as significant impairment in school or relationships at baseline.

This study is unique in that it compared two experimental conditions; one was an active-treatment comparison condition consisting of an integrative mental health programme composed of psychoeducation and coping skills; the other a treatment condition composed of both the psychoeducation and coping skills programme as well as a 17 session specialized trauma and grief focused intervention for severely traumatized and traumatically bereaved youth. The results showed significant pre- to post-treatment and post-treatment to four month follow-up reduction in depression and posttraumatic stress symptoms in both conditions. Reduction in maladaptive grief was only found in the treatment condition. These findings suggest that psychoeducation and skills training, as well as more specialized mental health intervention, efficiently reduce mental health symptoms for minors exposed to organized violence. However, there are limitations to this study. The authors fail to mention if the PTSD and depression scores were below the clinical cut-off range post-treatment. Further, they did not measure reductions in maladaptive functioning, although one of the inclusion criteria in the study was evidence of significant functional impairment.

This intervention, in the same vein as Tol et al. aimed to be sustainable. First of all, the Federal Ministry in Bosnia made the implementation of the treatment programme a job requirement for the counsellors. Second, the Ministry contracted local mental health professionals to provide supervision.

Layne et al have also conducted an earlier study (open trial) on the effect of trauma and grief focused psychotherapy, implemented in 10 secondary schools for traumatized Bosnian adolescents during the 1999-2000 school year.[32] Inclusion criteria were history of clinically significant trauma exposure, report of moderate to severe symptoms of post-traumatic stress, and evidence of functional impairment. The authors do not mention the exact number of students who participated in the classroom-based screening before the intervention. The final sample included 55 students. As in their later study, the authors concluded that the intervention significantly reduced posttraumatic stress, depression, and grief symptoms. In contrast to their other study, this evaluation included a measure of psychosocial functioning at post-test. It was found that reductions in psychological distress were associated with higher levels of psychosocial adaptation. The fact that the researchers included psychosocial impairment as an inclusion criterion adds strength to the study.

The findings must be interpreted with caution, as the study did not include a control group or random assignment to treatment. Also, in a qualitative evaluation of the trauma-grief focused psychotherapy for war exposed Bosnian adolescents previously mentioned, the most negative outcome reported by students and teachers was that the intervention had a damaging impact on interpersonal relationships.[33] Fifty percent of the students' negative comments were related to stigmatization; at the initiation of

the intervention many felt stigmatized by teachers, peers, and even family members. These comments from the focus group participants show the potential harmful impact of selecting students based on indices of psychopathology and then separating them from their school mates to participate in a targeted intervention. One potential way to avoid the risk of stigmatization for programme participants may be to invite non-selected children to other non-therapeutic group activities.[19]

Thabet, Vostanis, and Karim have evaluated the short-term impact of a quasi-experimental group crisis intervention delivered in school for 47 children aged 9-15 years from five refugee camps in the Gaza Strip.[34] This intervention took place during ongoing conflict and the children were selected if they reported moderate to severe symptoms of post-traumatic stress disorder on the Child Post Traumatic Stress Reaction Index (CPTSD-RI). The authors do not mention the exact number of students initially screened. The group crisis intervention was led by a child psychiatrist, a psychologist, and a social worker. During the seven weekly sessions, the children were encouraged to describe their direct experience of trauma by using free drawing, talking about their traumatic experiences and feelings, writing about traumatic events, storytelling, games, and role play related to the conflict. This treatment was compared to a teacher led intervention conducted over four sessions, in which the teacher informed the children (n = 22) about the impact of trauma and tried to normalize the children's responses to organized violence. The teacher received four training sessions delivered by the principal investigator on what trauma entails, its consequences, and how to deal with it. The two interventions above were compared to a no-intervention group (n = 42). Neither intervention significantly reduced the children's post-traumatic and depressive symptoms from baseline to three months after the end of the intervention. In fact, depressive symptoms increased in both intervention groups, but not in the control group.

In conclusion, these four studies show that it is possible to implement sustainable and low cost targeted school-based interventions run by locally trained non-specialist interventionists for refugee children. However, because the number of children screened and subsequently involved in the interventions varies enormously (from around 80% in one study to around 10% in another, to missing information in two), it is difficult to compare the studies in a meaningful way. Although promising, the results are mixed and suggest that school-based group crisis interventions for traumatized war exposed minors may not be sufficient to reduce mental distress and may sometimes even increase it.

Several communalities were observed. For instance, all four studies applied significant exposure to traumatic events and symptoms of post-traumatic distress and depression as inclusion criteria. Tol and Layne et al. also applied functional impairment as an inclusion criteria.[19, 31, 32] Previously, researchers have been criticised for not considering the degree of impairment associated with symptoms of mental distress in war exposed children,[13] which is a substantial problem considering that impairment in social or occupational functioning is an essential diagnostic feature for mood and anxiety related disorders. Beyond similarities, there still seems to be a lack of consensus among researchers on what constitutes the most effective treatment modality. For instance, the proposed interventions varied in length from seven to 20 sessions, employed different methods of assessment and, although all studies included trauma-processing activi-

ties, other activities varied across studies. One programme offered only trauma-focused work with mostly negative results. It is thus difficult to evaluate how much of the observed benefits stem from trauma-focused activities and how much stem from other social and experience oriented activities included in the interventions. As well, all the students in these studies were above the age of nine. Thus, there is still a lack of evidence for targeted school-based interventions for primary school age children exposed to violence who may need programmes with more non-verbal content. Finally, only Tol et al.[19] reported results split by sex, which is in line with other studies of school-based interventions in refugee receiving countries.[35] It follows that upcoming empirical investigations should examine the effect of gender, which may indicate a need for gender-specific activities.

General school-based interventions in war exposed countries

General school-based interventions have been suggested as an alternative to targeted interventions on several grounds. First of all, in organized violence contexts all children are exposed to a certain level of social turmoil and, at least, indirect trauma. Thus, general interventions in schools may prevent further traumatization by establishing a safe and protective environment from which all children can benefit.[36] It has been found that most of the mental health needs of children affected by social turmoil can be addressed by restoring basic needs, security, and human rights.[36] Thus, intervention programmes should be broad, comprehensive, and not isolated from other activities, such as education and play, which improve the normalization and quality of life for all children affected by war. As argued by Kos and Derviskadic-Jovanovic expensive mental health programmes implemented in war settings for children with diagnosable PTSD are targeting just a small number of children and thus fail to take into account the broader social consequences of war.[36] As the authors point out, general programmes may be preferable because these also help children who may not have a diagnosable disorder but who still suffer from sadness and grief.

Although the rationale for screening for symptomatology in targeted interventions has been pointed out earlier, several potential disadvantages also need to be mentioned. Screening may possibly have adverse effects, such as secondary distress from asking questions about trauma.[37] Further, as outlined by Offord et al. screening is costly and may not capture those individuals at highest risk of developing a mental health disorder because they refuse to participate in the screening procedure.[38] Also, screening may result in false positives or negatives, and the difference between individuals meeting the threshold for inclusion in a targeted intervention and those scoring just below it may be minimal. Finally, the risk for a disorder may fluctuate over time, and unless screening is repeated, it will not capture the possible instability of symptoms over time. Thus, the benefits of screening children in targeted interventions may potentially be outweighed by the potential harm of excluding children who do not meet the exact inclusion criteria at the initiation of the intervention. It follows that in a context of organized violence it may be questionable to help a small number of children through targeted interventions when many more can be helped by broader interventions.[36]

General interventions may prevent a mental health decline in children not currently showing symptoms, and may work to increase their academic functioning and self-

esteem.[30, 35] Encouraging children to talk about their stressful experiences before they are ready may traumatize them further,[27] and creative expression, which is often used in general interventions, encourages children to express themselves non-verbally. Second, in asylum-receiving countries it has been found that refugee and immigrant families often feel threatened by targeted interventions offered through the schools because they are perceived as a risk for further marginalization and potential stigmatization.[38] As indicated by the qualitative evaluation in Bosnia previously mentioned, increased stigmatization may also be a risk in war settings. As well, immigrant families exposed to violence may not recognize their children's mental health distress as caused by violence exposure,[39] or may have a culturally different perception of disturbance.[40] Further, in the study previously mentioned by Layne et al.[31] it was found that the general psychoeducational and skills based comparison treatment significantly reduced symptoms, and that the more intensive treatment only incrementally outperformed the general treatment in terms of symptom reduction from pre- to post-test. These results suggest that specialized trauma-focused group therapy may be no more effective than a more general psychoeducational approach for refugee minors experiencing mental distress, with the latter being beneficial for all children irrespective of their level of symptomatology.

PubMed and PsychINFO were searched to identify published empirical outcome studies evaluating general school-based interventions for children exposed to violence in developing countries; three were identified (see Table 1 for an overview).

Gupta and Zimmer have reported the results of an eight session psychosocial intervention for 306 war affected children displaced by war in Sierra Leone.[41] The minors (aged 8-18) were randomly selected from a school registration list and were interviewed about their war experiences and reactions to violence by locally trained female research assistants at their camps before and after participating in the programme. The four week intervention, implemented by locally trained camp teachers, combined structured trauma healing activities with recreational activities and basic education in an effort to reduce the children's emotional distress and posttraumatic stress reactions. Overall, it was found that 96% of the participants reported a significant reduction in concentration problems, sleep disturbances, nightmares, and intrusion symptoms after participating in the intervention. The activities were also associated with a significant decrease in arousal symptoms, a slight increase in avoidance symptoms, as well as increased optimism for the future. Although these results must be interpreted with caution due to the lack of a control group, the findings are promising. The increase in avoidance is intriguing and should be investigated further. Increased avoidance may represent a healthy need for the children to distance themselves from a clearly overwhelming experience in a precarious safety context. This intervention was the first to address both educational needs and mental distress, and indicates that a short term general intervention implemented in a volatile environment may efficiently reduce symptoms of post-traumatic distress.

Woodside, Santa Barbara, and Benner[42] have reported the results of a four-month school-based pilot project involving 250 fourth and fifth grade non-refugee Croatian children affected by war. The project, involving three experimental classes and three control classes, was designed to promote trauma healing, non-violent conflict resolution, and reconciliation, and was presented weekly by

locally trained teachers. It was found that the intervention significantly reduced post-traumatic stress and ethnic bias. These results were maintained at one year follow-up. The intervention had a more positive effect on girls, whose self-esteem was enhanced by programme participation, than on boys. Although the positive changes observed were small, this intervention offers hope that ethnic bias may be reduced by psychological trauma healing, which in turn may improve inter-community relations and community climate. This programme was also well accepted by students and teachers, who commented that the quality of social connections improved in the classroom. Finally, this programme initiative shows sustainable large scale school-based interventions can be implemented in middle income countries. After completion of the pilot project, the programme was subsequently implemented for 1,260 children in 35 schools in Eastern Slavonia by 65 locally trained teachers.

Gordon et al. have reported the results of a six week one group pre-test post-test study evaluating whether mind-body experiential and psycho-educative techniques reduce symptoms of post-traumatic stress symptoms for war traumatized adolescents in Suhareka, Kosovo.[43] This pilot intervention, implemented four months after the end of the NATO bombing in Kosovo, included 139 voluntary high school students in three separate groups. No inclusion or exclusion criteria based on exposure or standardized screening were applied because, as argued by the authors, all students living in the Suhareka war zone had been directly exposed to atrocities. The intervention was implemented by local teachers trained by faculty from the Center for Mind–Body Medicine in Washington. After receiving six weekly sessions, the programme participants reported a significant decrease in post-traumatic stress symptoms as measured by the Post-traumatic Stress Reaction Index questionnaire at the end of the last group. Clinical significance ranged from moderate for group 1 (Cohen's d = 0.60) to large for groups 2 and 3 (Cohen's d = 0.80). Thirty of the participants from group 1 were also tested 15 months after the end of the intervention. While 17% reported severe post-traumatic stress symptoms at pre-test, none reported it at the 15 month follow-up. Although this study is limited by the lack of a control group, these results show promise for implementing mind-body skills training for traumatized adolescents, especially because the results were maintained longitudinally.

Discussion

Developing and implementing school-based interventions in low and middle income settings appears to be a promising avenue to address the mental health needs of children exposed to war and organized violence. However, this review of published programmes also supports the conclusion drawn by Jordans et al.[17] that there is a paucity of rigorous studies evaluating psychosocial interventions for minors exposed to organized violence.

Despite the scarcity of well-established evidence for school-based interventions, several promising findings were noted. Firstly, all the studies discussed aimed to be sustainable and culturally sensitive by training local non-specialist teachers or paraprofessionals to implement the interventions. This community-based approach holds promise for the future because it implies that large-scale interventions, both in the midst of an emergency and after, may be efficiently implemented for minors affected by armed conflict. As well, there seems to be a move towards applying more rigorous methods of programme evaluation. The two most

recent studies on targeted interventions by Tol et al.[19] and Layne et al.[31] were both randomized controlled trials. In addition, these two studies also included repeated measures (baseline, pre-test, and six and four month follow-up, respectively). Although these well-controlled studies offer evidence of efficacy, it may not always be ethical or justifiable to conduct rigorous research in organized violence conflicts due to the potential harm for children not included or placed on a waiting list. Thus, in complex emergencies, less controlled studies should not be discarded if they can reach larger groups of children faster.

Despite these promising findings, several limitations must be addressed. Although all studies, except for Thabet, Vostanis, and Karim,[34] reported reductions in post-traumatic stress symptoms, results for other measures of mental distress were more varied. These results indicate that there is a need to develop interventions targeting other dimensions of the distressing experience of organized violence, for example depression and maladaptive grief. Past research has demonstrated that screening for symptomatology often fails to separate grief reactions from depression and PTSD, which implies that traumatic grief may need to be assessed and treated separately from other stress-related symptoms.[13] Further, the clinical significance of findings was rarely mentioned. Only two studies (Tol et al,[19] Layne et al.[32]) measured functional impairment, which is relevant for planning and implementing interventions. As previously mentioned, there may not always be a relation between symptomatology and impairment. For instance, even though Sack et al. have found that PTSD symptoms are high and persistent in war traumatized Khmer youth, this need not be associated with major functional impairment.[6] In the same vein, Mollica et al. have reported a lack of an association between cumulative trauma and social functioning for Cambodian adolescent refugees.[5] These results underline the resilience of young refugees, and as pointed out by Kos and Derviskadic-Jovanovic claims about the high levels of psychological distress in children and adolescents who have experienced social turmoil may have been over-exaggerated by clinical findings of symptomatology excluding indices of impairment.[36] It may be that the high levels of reported symptoms of distress are normal responses to a volatile environment and not an indication of dysfunction per se. Thus, future studies of war exposed children face the challenge of unpacking normal reactions to distress from pathological ones, and determining if changes in behaviour, such as avoidance, represent disorder related impairment or adapted responses to the environment.[13]

Although psycho-education and trauma healing were common to all the studies, other treatment modalities varied. There also seems to be a lack of consensus about assessment; some use interviews, while others use questionnaires. While interventions claimed to be culturally adapted, they generally failed to mention in any detail how this was achieved, replicating the finding by Jordans et al.[17] Future research should try to distinguish what the active therapeutic ingredients of the interventions are: 1) the professional-specific aspect, such as manualized CBT, 2) the culturally-specific component (whether ritual, spiritual, artistic, and so on), or 3) the re-establishment of a safe and familiar environment where the children can discuss their experience and normalize their distress. If the latter is the case, non-specific school-based programmes organized around natural social interaction should possibly be preferred to specialized interventions.

Conclusion

While results are promising, they are still not convincing or conclusive. There is an urgent need for future studies to assess which factors of school-based interventions, both targeted and general, are most significantly related to positive outcomes. At this point in time it is impossible to conclude if trauma-processing activities are more effective than, for example, creative expressive elements, if Western-based cognitive behavioural therapy is more effective than traditional healing activities, or if longer interventions are superior to shorter ones. Even though interventions may report positive outcomes, there is currently no way to determine which ingredient or activity was the most important. In order for intervention efforts to be as efficient as possible, research must document how and why a specific treatment modality is better than another, both during ongoing conflict and thereafter.

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Torture against children in rebel captivity in Northern Uganda: physical and psychological effects and implications for clinical practice

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Abstract

Background: Although torture in adults is well documented, studies that document its use against children, especially during war, are rare. This study documented the use of torture against children and its physical and psychological consequences during the war in Northern Uganda.

Methodology: Changes to the skin were examined by medical assistants, photographs taken, and allegations of torture verified in an interview and the case histories filed upon admission to the rehabilitation centres. The sample included 183 children aged 12 to 18 (mean age 14.8, SD 2.9) of which 60 were physically examined in two rehabilitation centres. The impact of torture was assessed using the Impact of Event Scale – Revised (IES-R) in a multiple regression model.

Results: Medical examinations showed visible evidence of physical trauma. Torture methods included burns, beatings, carrying heavy objects, gunshots, cuts with bayonets and machetes, long distance treks, etc. resulting into scars and keloids in different parts of the body. The scars were consistent with injuries inflicted on purpose. The children scored highly on the subscales of IES-R indicating severe symptoms of posttraumatic stress. The experience of torture explained between 26 to 37 per cent of the variance in symptoms of posttraumatic stress.

Conclusions: The physical trauma is consistent with histories and reports filed upon admission to the rehabilitation centres indicating that the children were indeed tortured. As a result of the torture, the children were psychologically distressed. The challenge for clinicians is to employ a holistic approach of treating survivors of torture by recognising not only the physical complaints but stress symptoms as well. This is because the mental states of debilitation, dependency, dread and disorientation that is induced in victims may have long-lasting consequences just like the physical and psychological consequences.

Keywords: torture, children, war experiences, posttraumatic stress, Northern Uganda

Introduction

Torture is widely practised in more than 80 countries globally.[1] In Africa, torture is practised in several countries with poor human rights records to suppress dissent and freedoms and to silence political opponents. Government institutions such as the police, the army, and security organisations have been widely used as agents of torture.[2] The use of torture is associated with lasting physical and mental health consequences for survivors.[3-5] Torture has been documented mainly in adults,[6] although various forms of torture is meted out to children as well,[7, 8] especially during war. Documenting cases of torture and the mental health conse-

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quences in children is crucial to understand the medical and long-term consequences on child development, provide rare insights into their experiences during war, and possibly serve as evidence for prosecution of perpetrators. This study documents the use of torture against children and its psychological consequences during the war in Northern Uganda.

Mental health problems associated with exposure to war situations

The World Health Organization (WHO) estimates that one-third of total disability and health burden is as a result of mental disorder due to the prevalence of war trauma and violence.[9, 10] Childhood and adolescent psychological trauma appear to be a crucial aetiological factor in the development of a number of disorders both in childhood and in adulthood.[11] Experiences of various forms of torture associated with war such as sexual abuse, killings, beating, participation in battles and raids and being forced to kill, carry dead or wounded combatants or carry heavy loads or trekking long distances may be associated with symptoms of posttraumatic stress disorder (PTSD), behavioural and emotional problems and deficit in interpersonal relationships.[4, 5, 11-14]

The use of child soldiers in Uganda

After the removal from power of former Ugandan dictator Idi Amin in 1979, Uganda experienced two particularly violent wars in which children were used. First, the National Resistance Army (NRA) guerrilla war against government forces from 1981 to 1986[15] where an estimated 3,000 children were used as child soldiers, commonly referred to as Kadogos (meaning small one in the Kiswahili language).[16, 17] Secondly, the Lord's Resistance Army (LRA) war against government forces from about 1988 to date,[18] in which an estimated 30,000 children have been forcefully abducted and recruited by the LRA.[19, 20] Child fighters constituted about 30 per cent of NRA fighters[16, 17] and more than 85 per cent of LRA fighters.[21] In both the NRA and LRA conflicts, children were used as fighters, spies, porters, "wives", human shields, and camp followers.[16, 17, 22-26] This study will focus on the use of torture against children in LRA captivity.

Initially, the LRA targeted only government troops, but it began to engage civilians in from 1991 to 1992 when civilian militias were mobilized against it.[18] This led to the abduction and forced recruitment of young boys and girls and their physical and psychological torture in rebel captivity. In captivity, the abductees lived in constant terror of sudden attacks from government soldiers, threat of death, diseases, and extreme deprivations and hardships such as lack of water, food, clothing, and above all, sexual abuse and torture by rebel commanders. The children and adolescents are forced to kill, mutilate, torture, raid, burn villages, loot and commit other atrocities against each other and against their own communities[21, 27] in a strategy aimed at deterring them from escaping and severing the bond between the abductees and their communities: "burning the bridge".[22] Despite these measures, many of the abducted children have escaped from rebel captivity, others were rescued during battles with government forces, and the rebels released some, especially the child mothers. After their escape or release, the children are temporarily housed and rehabilitated at reception centres run by non-governmental organisations (NGOs). These children are rehabilitated at several centres in Northern Uganda before reuniting with their parents or reintegrating back into their communities.

The current study

This study will focus on children formerly abducted by the LRA at two rehabilitation centres: Gulu Save the Children's Organisation (GUSCO) and World Vision Children of War Rehabilitation Centre (WVC), both in northern Uganda. The aim of this study is twofold: 1) to document the use of torture against children in LRA captivity and 2) to assess the impact of the torture on their mental health.

This article will examine torture within the framework of the torture model postulated by Suedfeld.[3] In his contextual analysis of torture, Suedfeld[3] identified four key elements crucial to the diagnosis of torture: *debilitation, dependency, dread, and disorientation. Debilitation* is the intentional physical and mental means perpetrators of torture use to "break the spirit" of their victims when victims are unable to meet their own needs such as sleep deprivation, starvation, beatings, etc. *Dependency* is when victims are not allowed to be close to one another for fear of "negative influence" e.g. victims are not allowed to talk to one another, thus making them psychologically dependent on their captors. Dread is a state of mind brought about when victims are kept in constant "fear and anxiety" for example, that they could die or something bad could happen to them anytime. Lastly, *disorientation* is aimed at making events "unpredictable and incomprehensible" to deny the victim a sense of control and ability to cope.[3, 28] The experiences of formerly abducted children in LRA rebel captivity meet all these key elements of the torture model postulated by Suedfeld,[3] 1990 (summarised in Figure 1).

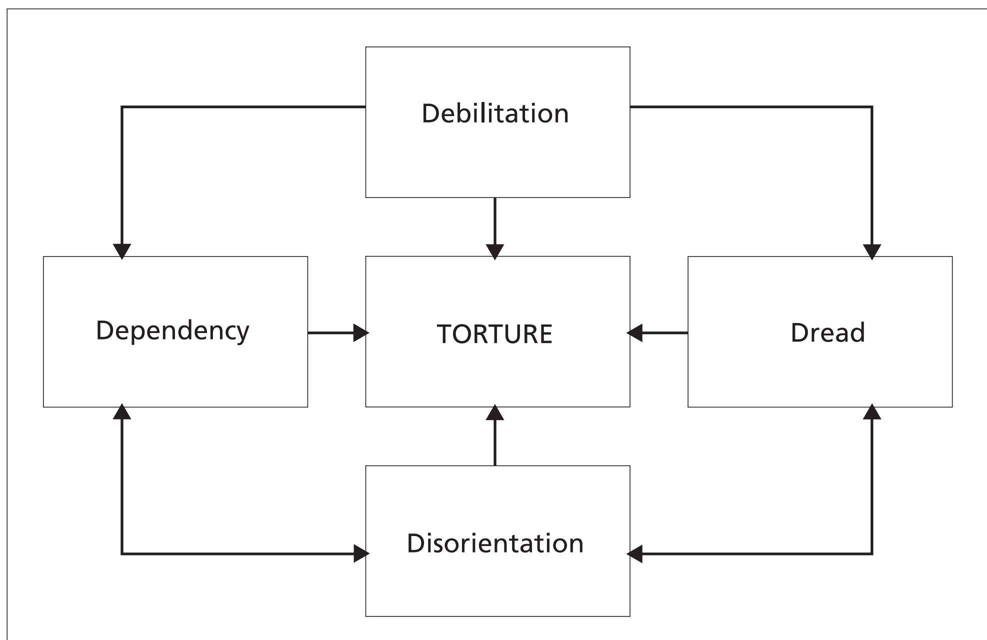


Figure 1. *Torture model showing mental states induced in victims of torture postulated by Suedfeld.*

Methodology

Sample

Participants were children who were abducted, lived in rebel captivity, and experienced war situations ranging from one month to ten years (M = 7.8 months, SD = 2.01) and were rescued or escaped within the previous three months (n = 101, 55%) and in the previous three weeks (n = 82, 45%). Children being rehabilitated at two rehabilitation centres: Gulu Save the Children's Organisation (GUSCO) and World Vision Children of War Rehabilitation Centre (WVC) were invited to participate in the study. All the participants were given identity numbers which were entered into the computer where a simple random sample was computer generated to select the required number of adolescents from the two centres. Participants who were above 18 were excluded from the study because the focus of the study was mainly on the children. Finally, a total of 183 children aged 12 to 18 (mean age 14.8, SD 2.9) were included in the data, of which 136 (74%) were boys and 47 (26%) were girls. Of these, 86 (47%) from GUSCO and 97 (53%) from WVC.

Documentation of torture

We assessed both physical and psychological impact of torture. First, 60 participants were randomly selected from the original sample of 183. Of the sample of 183, a simple random sample of 33% (n=60) was computer generated to select the number to be physically examined for evidence of alleged torture. Next, the participants' case histories, compiled by the centre administrators and counsellors, were examined to corroborate evidence of alleged torture in rebel captivity to find out whether they were consistent or not. Consistent here means that the alleged torture and changes to the skin agree with the information in the participants' history taken upon admission to the rehabilitation centres. Upon admission to the rehabilitation centres, all the participants were physically examined, and their experiences, injuries, etc. before and after abduction were recorded. Similarly, parents or guardians were separately interviewed about the child's experiences, injuries, scars, etc. before abduction.

Assessment of impact of torture on the mental health of adolescents

The mental health consequences of torture and associated events were assessed by the Impact of Event Scale – Revised (IES-R) in all the 183 participants. The IES-R scale was developed by Daniel S. Weiss and Charles R. Marmar[29] to parallel the DSM-IV criteria for PTSD. IES-R has 22 items and respondents are asked to rate each item in the IES-R on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit) and 4 (extremely) of what they have experienced in the past seven days concerning their experience of torture. Weiss and Marmar[29] reported that the internal consistency of the three subscales were very high, with intrusion (7 items) alphas ranging from 0.87 to 0.92, avoidance (8 items) alphas ranging from 0.84 to 0.86, and hyper-arousal (7 items) alphas ranging from 0.79 to 0.90. The correlation co-efficient for the test-retest reliability ranged from 0.71 to 0.94.

Analyses

To assess physical torture, changes to the skin where alleged tortures were inflicted were examined by medical assistants to assess the nature, description, parts of the body, where (geographical location) the torture allegedly took place, and whether the alleged torture was consistent with information in the participants' files. Female medical assistants examined both boys and

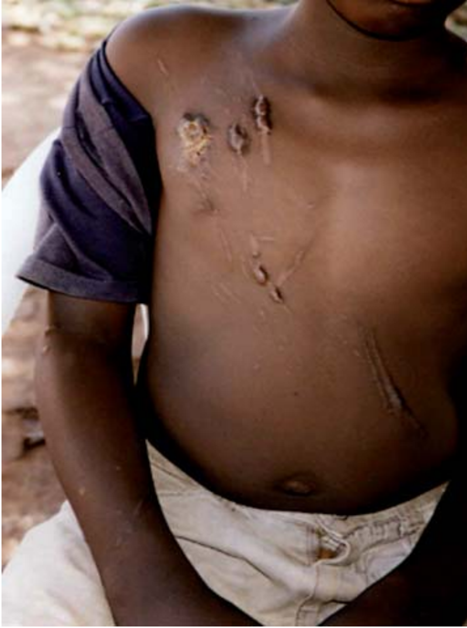


Figure 2. *13 year old formerly abducted boy. Examinee no. 3*

1. Area of the body	Alleged torture involving flogging with wires three months before examination.
2. Nature of torture	Lesions above the right breast, on the chest and on the abdomen. Apparent problems in healing and development of secondary infections and keloids in some parts.
3. Description of torture	Lesions consistent with external infliction.
4. Conclusion	Consistent with the history of torture.
5. Place of torture	LRA camp in Southern Sudan.

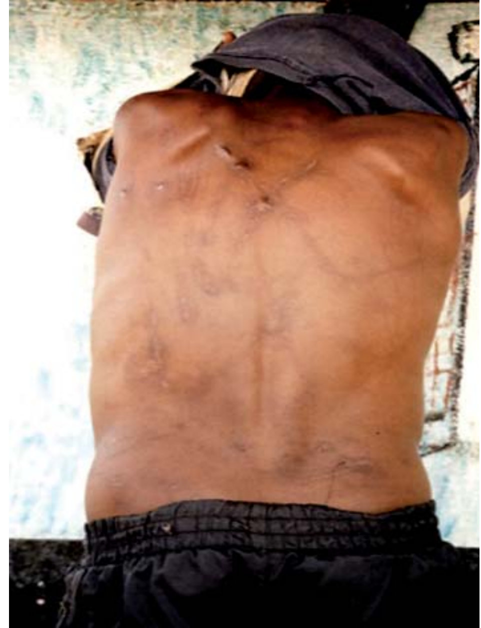
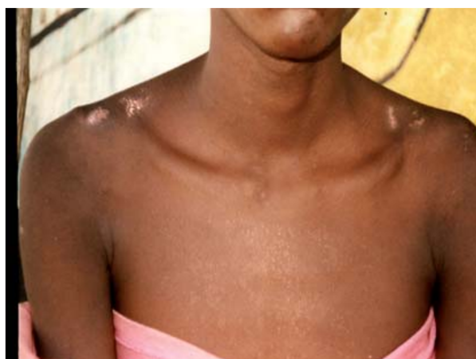


Figure 3. *12 year old formerly abducted boy. Examinee no. 5*

1. Area of the body	Alleged torture involving flogging with sticks and wires all over the back two months before examination.
2. Nature of torture	Random lines of scars all over the back.
3. Description of torture	Lesions consistent with external infliction.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	No knowledge of location.

Figure 4. *16 year old formerly abducted boy. Examinee no. 6*

1. Area of the body	Alleged torture involving flogging with sticks and wires and stabbing under the right armpit (three weeks previously) with a bayonet. Torched with burning flame in the back (4 months previously).
2. Nature of torture	Lines of scars all over the back.
3. Description of torture	Lesions consistent with external infliction by blunt and sharp object and first degree burns.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	Near Juba, the capital of Southern Sudan.



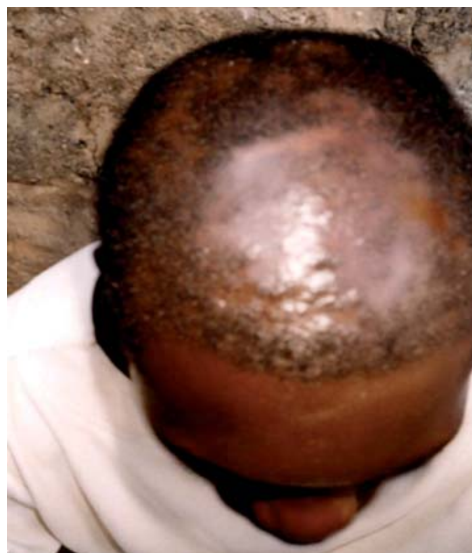


Figure 6. *15 year old formerly abducted boy. Examinee no. 17*

1. Area of the body	Carrying heavy munitions and foodstuff on the head over long distances.
2. Nature of torture	Scars all over the scalp/top of the head.
3. Description of torture	Scars consistent with external infliction of heavy objects.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	LRA camps in Southern Sudan (movement from one camp to the other).

Figure 5. *14 year old formerly abducted girl. Examinee no. 14*

1. Area of the body	Alleged torture involving carrying sick or wounded rebel soldiers over long distances supported by poles on the shoulders.
2. Nature of torture	Recent lesions/fresh scars on the shoulders.
3. Description of torture	Lesions consistent with external infliction.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	From Northern Uganda to Southern Sudan.

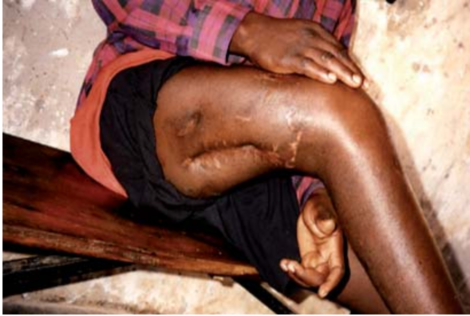


Figure 8. *17 year old formerly abducted boy. Examinee no. 29*

1. Area of the body	Injured during a battle: multiple gunshot wounds and incision to extract a bomb shrapnel from his right thigh.
2. Nature of torture	Multiple scars on the right thigh.
3. Description of torture	Lesions consistent with gun-shot wounds and deep cut by a bomb shrapnel.
4. Conclusion	Consistent with the history of participation in battle.
5. Place or torture	First gunshot wounds in Southern Sudan and major injury in Northern Uganda.

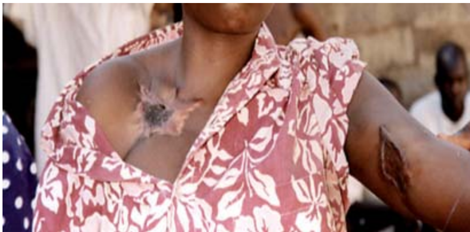


Figure 9. *14 year old formerly abducted girl. Examinee no. 37*

1. Area of the body	Gunshot wounds sustained during a battle.
2. Nature of torture	Keloids/scars on the left up-per arm and a shattered collar bone. A bullet tore through the upper left arm.
3. Description of torture	Lesions/keloids consistent with external infliction of gunshot wounds.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	Battlefield in Northern Uganda.

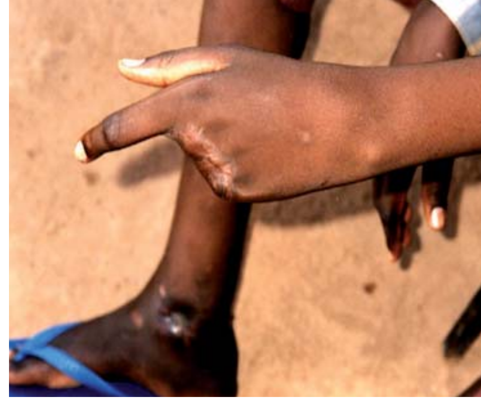


Figure 10. *16 year old formerly abducted boy. Examinee no. 39*

1. Area of the body	Injured during a battle: multiple gunshot wounds on the ankle and fingers which was later repaired in a hospital.
2. Nature of torture	Loss of three fingers on the right hand and scars on the left ankle.
3. Description of torture	Lesions consistent with gun-shot wounds and subsequent repair in a hospital.
4. Conclusion	Consistent with the history of participation in battle.
5. Place or torture	LRA camp in Northern Uganda.

Figure 11. *16 year old formerly abducted girl. Examinee no. 42*

1. Area of the body	Send to battle field and sustained gunshot wounds which shattered her jawbone.
2. Nature of torture	Keloids/scars on the jaw shattered by bullet and an operation to repair the shattered jaw.
3. Description of torture	Lesions consistent with external infliction of gunshot wounds which festered and developed into fibroblast scars.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	Battle in Northern Uganda.

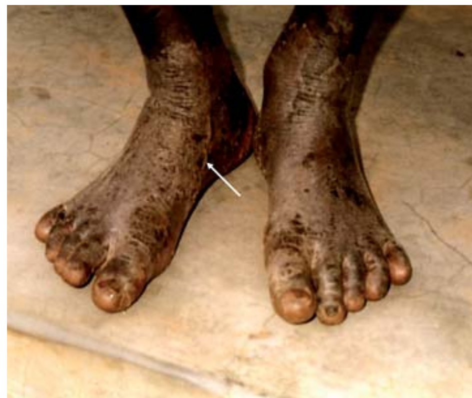


Figure 12. *13 year old formerly abducted boy. Examinee no. 43*

1. Area of the body	Walking over long distances three weeks before examination.
2. Nature of torture	Scaly feet apparently healing with fresh cuts indicated by a white arrow.
3. Description of torture	Scales and cut consistent with rough terrain traversed by victim.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	Movement from Northern Uganda to LRA hideouts in Southern Sudan.

Figure 13. *15 year old formerly abducted boy. Examinee no. 45*

1. Area of the body	Walking over long distances two weeks previously.
2. Nature of torture	Scaly feet symptomatic of long distance travelling barefooted. Open wounds at the sides of the feet resulting from injuries sustained during long treks.
3. Description of torture	Scales and cut consistent with rough terrain traversed by victim.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	No knowledge of where he moved.

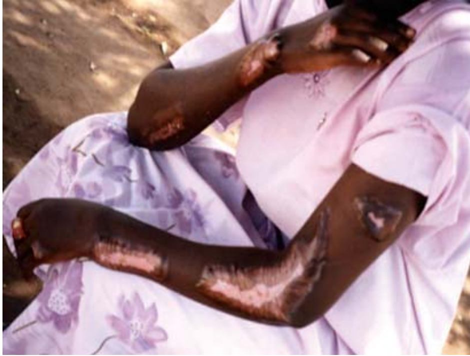


Figure 14. *17 year old former formerly abducted girl. Examinee no. 13*

1. Type of torture	Alleged torture involving tying of hands around the body and dragging on a mountanous terrain two month before examination.
2. Nature of torture	Recent lesions/keloids on both arms.
3. Description of torture	Rocky/rough surface.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	Imatong hills in Southern Sudan.

Figure 16. *18 year old former formerly abducted child mother. Examinee no. 53*

1. Type of torture	Sexual enslavement.
2. Nature of torture	Sexually abused and gave birth to three children fathered by a rebel commander-
3. Description of torture	Sexual abuse
4. Conclusion	Consistent with the history of torture.
5. Place or torture	She gave birth to three children while in rebel captivity having been in captivity for eight years in various places in Northern Uganda and Southern Sudan

Figure 15. *15 year old former formerly abducted child mother. Examinee no. 51*

1. Type of torture	Sexual enslavement.
2. Nature of torture	Sexually abused and gave birth to a child fathered by a rebel soldier
3. Description of torture	Sexual abuse.
4. Conclusion	Consistent with the history of torture.
5. Place or torture	She gave birth to her baby in a sickbay in one of the hideouts of the rebels in Southern Sudan.

girls but female participants were examined only by female medical assistants. Later, any changes to the skin in a participant were corroborated in an interview with the participants and an analysis of the case histories filed upon admission to the rehabilitation centres. Pictures of changes to the skin were taken with assent from the children and consent from parents/and or centre managers.

To assess the mental health consequences of torture on participants, scores on IES-R were computed for avoidance, intrusions, and hyper-arousal subscales in addition to the IES-R total score. Next, we assessed the amount of variance in mental health problems (avoidance, intrusions, and hyper-arousal subscales in addition to the IES-R total score) that can be explained by experience of torture.

Results

Physical impact of torture

Participants were subjected to several forms of physical torture. The most common of which was beating with sticks and/or wires (Figures 2-4), carrying heavy luggage for a long period of time over long distances (Figures 5-7), injuries in battles (Figures 8-11), trekking over long distances (Figures 12–14), and tying and dragging over rocky surface (Figure 15). These alleged experiences left clearly visible scars and/or *keloids on the skin* and were consistent with history of torture and records at both rehabilitation centres. The participants did not have these scars/keloids before abduction according to their parents/guardians. Out of the 47 girls in this study, 11 (23%) had children fathered by rebel soldiers (Figures 16 and 17). According to the parents/guardians, the girls were not pregnant at the time of abduction to the best of their knowledge.

Psychological impact of torture

All the subscales of the IES-R were significantly correlated: avoidance and intrusion ($r(183) = 0.54$, $p < 0.001$], avoidance and arousal ($r(183) = 0.56$, $p < 0.001$), and intrusion and arousal ($r(183) = 0.65$, $p < 0.001$). The adolescents' IES-R scores (avoidance, intrusion, and arousal) are presented in Table 1.

Many of the adolescents in the sample reported that they often tried to stay away from situations or events that reminded them of their experiences such as: "I was aware that I still had a lot of feelings about it, but I didn't deal with them", (M = 2.69, SD 0.61, range = 0-4), "I avoided letting myself get upset when I thought about it or was reminded of it" (M = 2.65, SD 0.71, range = 0-4), and "I tried not to think about it" (M = 2.63, SD 0.59, range = 0-4) to mention but a few. Most reported arousal symptoms were: "Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart" (M = 2.79, SD 0.66, range = 0-4), "I felt irritable and angry" (M = 2.65, SD 0.56, range = 0-4), I felt watchful or on guard" (M = 2.65, SD 0.68, range = 0-4), and "I had trouble concentrating" (M = 2.61, SD 0.63, range = 0-4). Despite efforts to keep them off their minds, intrusive images and thoughts such as: "Any reminder brought back feelings about it" (M = 2.94, SD 0.38, range = 0-4), "I had dreams about it" (M = 2.70, SD 0.61, range = 0-4) and "Pictures about it popped into my mind" (M = 2.89, SD 0.64, range = 0-4) were reported by the adolescents.

Mental states induced by torture

In line with the model of torture outlined by Suedfeld,[3] the torture methods used in LRA rebel captivity were closely related to the key elements crucial to the diagnosis of torture:

Table 1. *Average IES-R mean scores.*

	Mean	SD	Min.	Max.	Range
Avoidance	19.99	3.03	10	29	0–32
Intrusion	18.65	2.18	10	26	0–28
Arousal	18.72	2.49	5	26	0–28
IES-R total	57.36	6.55	25	81	0–88

Table 2. *Experience of rituals in LRA captivity (n=183)*

Rituals	n (%)
Prayers	181 (99)
Anointment with oil (sheanut oil)	178 (97)
Anointment with blood	37 (20)
Carrying head or body parts of dead people	13 (7)
Drinking blood and/or blood in food	11 (6)
Dressing in clothes removed from dead bodies	9 (5)

debilitation, dependency, dread and disorientation. The rebel commanders flogged the abductees, summarily executing abductees who tried to escape, and force the abductees to beat and kill each other, all intended to break the spirit of the abductees and make them resigned to their fates. In this way, the rebel commanders intended to debilitate the abductees. To make the abductees totally dependent on them, the rebel commanders would ban communication among the newly abducted children and forced them to participate in raiding their own villages and killing and mutilating their relatives. This was meant to sever the bond between the children and their communities and make them forever in the rebel ranks and dependent on the rebel organisation. Further, the abductees were kept in constant fear of being killed any time by being accused of thinking of escaping, participating in battles, or dying of starvation or thirst. This made the abductees constantly fearful, anxious and full of dread. Finally, to disorient and deny the abductees any sense of control and ability to cope, the rebel commanders engaged in senseless and wanton killing, constant movement from one location to another to avoid detection by government troops and forcing the abductees to engage in grotesque acts of killing and mutilations of villagers in their areas of operations. During military parades, the children were asked to turn their backs to the rebel leaders who would be addressing them. This was intended to hide the identity of rebel leaders and create an aura of mysticism, a wall of fear, and awe for the rebel leaders. On another occasion, the children revealed in an interview that a notorious rebel commander suddenly appeared and accused two boys seated next to each other of thinking of escaping. He told them that he could read their minds and could also see it from their faces. The rebel commander ordered the others to beat them to death.

In addition, the abductees were forced to participate in several rituals meant to control them psychologically and bind them to the rebel group (Table 2). A former abductee narrated one of the rituals he underwent while in captivity:

"Sheanut butter mixed with soil was smeared on our bodies. The ceremony was meant to give us spiritual strength to fight. I believe the sheanut butter gave us that courage. It was also protecting us because very few at that time got injured. If you followed the rules, nothing happened to you."

Most former abductees reported that the LRA leader could read their inner-most thoughts, can prophesy whatever will happen to them, and is endowed with supernatural powers as one of them said in an interview:

"Even now as we talk, he is listening to

Table 3. *Regression analyses of gender, other war experiences, and torture on PTSD symptoms.*

		Avoidance	Intrusion	Arousal	IES-R Total
		β	β	β	β
Step 1	Gender	0.21 **a	0.23 **a	0.20 **a	0.24 **a
Step 2	Other traumatic experiences	0.38 ***	0.33 ***	0.37 ***	0.39 ***
Step 3	Experience of torture	0.54 ***	0.51 ***	0.57 ***	0.61 ***
Total % of variance explained (R2)		48.0%	42.2%	50.2%	58.1%

a) Greater likelihood for boys than girls
*) $p < 0.05$, **) $p < 0.01$, ***) $p < 0.001$

us, he knows what is going to happen next, and can tell you what you thinking about…"

The experience of torture and other traumatic life events

To investigate the relationship between the experience of torture and other traumatic life events on the one hand and subscales of the IES-R on the other, multiple regression analyses were performed in three steps (Table 3). Gender was entered into the regression analyses in step 1 to adjust for any possible confounding by gender. Significant effects were produced for gender on all the subscales of IES-R but interaction terms did not reach significance. This could be because of the relatively small number of girls in the study. The experience of other traumatic experiences (not related to captivity or abduction) was entered in step 2, helping to explain an additional 14.4% of the variance for avoidance, 10.9% for intrusion, 13.7% for arousal, and 15.2% for total IES-R. Adolescents with higher scores on IES-R subscales experienced more torture. The experience of torture was entered in the last step explaining additional 29.2% of the variance for avoidance, 26% of the variance for intrusion, 32.5% of the variance for arousal, and 37% of the variance for the total IES-R score. The findings indicate that adolescents who experienced more torture scored higher on IES-R subscales.

Discussion

In this study, it was demonstrated that the children were subjected to torture in captivity by the LRA. Incidents of physical torture were more common among boys than girls. Many of the children were flogged with sticks and wires, others were injured during battles, and some were bruised or developed wounds as a result of long distance treks or carrying heavy weights. Sexual abuse was reported only by female participants. Although reported by girls only, sexual abuse could have happened to boys as well. Societal attitudes and the sexist and traditional beliefs that men, even as children, are invulnerable to sexual victimization often leave boys confused, ashamed, humiliated, and in denial of sexual abuse. Girls did not only endure physical, psychological and sexual abuse but had children fathered by rebel soldiers. Upon abduction, the rebel commanders first allocated the girls considered of age among themselves and others were distributed to trusted and loyal rebels soldiers as "wives". Although a few said they were treated well by their "husbands", most were ill-treated. They were told that the children will constitute the new "New Acholi ethnic group". Sexual abuse was therefore used as a deliberate strategy by rebel soldiers to further their ambitions and philosophy.

Comparison with previous studies is limited because no previous studies have been conducted to document the use of torture against children during war. Previous information on torture in rebel captivity were based on anecdotal reports by humanitarian,[30] human rights organisations,[6] and surveys based on reports by opinion leaders, government officials,[31-33] among others. For example, in Sierra Leone, 94 per cent of families surveyed during the war had experienced torture and sexual assaults including rape and sexual slavery[31] and in Nepal, children as young as 10 were used as porters, spies, informants, bomb planters by Maoists rebel groups.[32, 33] Nepalese military and police are reported to have tortured children whose parents were suspected of being Maoists rebels to extract information from them.[32, 33] In the Democratic Republic of Congo, gross abuses were committed by both rebel and government troops: rape of women and young girls, sexually explicit torture against women such as cutting or shooting of women in their genitalia.[6, 34]

Physical abuse

The main goals of torture methods used were as follows: First to break the bond among the children and make them totally dependent on their rebel commanders. Rebel commanders forced the children to abuse each other to create an atmosphere of suspicion and mistrust to keep them in the rebel ranks consistent with the torture model postulated by Suedfeld[3] This involved inducing the four states of mind: debilitation, dependency, dread and disorientation. Second, to break the bonds between the children and their communities by making them commit atrocities against their own people. Third, to create a totally new identity that would characterise the rebel organisation's notion of a "New Acholi ethnic group".

Another aspect to the conflict is that the LRA employs a mixture of traditional rituals, pseudo-Christian mysticism, and cult-like means to control its followers.[35] A former Catholic altar boy, the LRA leader Joseph Kony has said he aims to create a Ugandan government based on the Biblical Ten Commandments.[35] In addition to the ordeal of abduction, the abductees undergo elaborate rituals aimed at cleansing and preparing them to become new members of the rebel group. For example, immediately upon abduction, the children are anointed with oil or blood[22, 23] the blood and oil is smeared on their forehead, back of their hands and on their backs. Some of the children are caned as a form of "combat hardening". Others are made to carry body parts of those who are killed or sleep near dead bodies to instil courage in them.[22, 23] After these rituals, they are declared members of the "New Acholi ethnic group". All these rituals were designed to create not only a new identity but also fear. The rituals bound them to the organisation and any breach of the terms of the rituals would result in bad luck or even death.

Many of the children bear large scars/keloids on their bodies, constantly reminding them of the torture they underwent while in rebel captivity. The scars are a result of beatings, burns, bullet wounds, walking long distances, carrying heavy loads, carrying the wounded or sick commanders, carrying big guns, ammunitions and food items. Our findings agree with reports on war affected children in Rwanda and Sierra Leone after the genocide and civil war respectively.[36, 37]

In Northern Uganda, abducted girls faced multiple traumas. Many endured abduction, witnessed atrocities, participated in

combats, lost loved ones, and were tortured and sexually abused. Even worse, many of the girls who had children fathered by rebel commanders bear new care-giving burdens and endure discrimination and stigmatisation from the community. They are often shunned by men and referred to as "widows" or "mothers of Kony's children". Thus, they are humiliated, ashamed, and bitter about their situations.

PTS symptomatology

The majority of the children had very high scores on the IES-R scales often associated with PTSD in many western societies. This is consistent with previous studies in Sierra Leone and Rwanda[36, 37] and other parts of the world[4] where the adolescents surveyed showed clinically significant PTSD symptoms and reactions. The children reported high avoidance activities, intrusive thoughts and images besides hyper-arousal symptoms. Like in the Sierra Leone and Rwanda study, several limitations need to be considered. Without a thorough and sufficient diagnosis of PTSD, it is not possible to specify that all the clinically significant cases meet the criteria for PTSD. Preferably, measures developed and authenticated for this particular culture could have been used. However, such measures are not available in many African countries including Uganda. Despite criticism of using measures developed in the West and cultural differences in registering trauma[38, 39] recent studies show that massive trauma transcends cultural and social barriers.[40]

This study has a number of strengths. First, to the best of my knowledge, this study is the first attempt to empirically document torture against children in rebel captivity in African hot spots. Second, evidence of torture was corroborated by parents/guardians interview-based reports, thus making the evidence of torture credible. Third, corroboration with reports of interviews with parents and physical examination might have reduced the influence of informant bias. The limitation for this study is the cross-sectional design and reliance on self-reports on mental health outcomes. Physical examination was performed on only 60 of the 183 participants for logistic reasons and time constrains. However, many with torture-induced skin lesions could easily be found in the rehabilitation centres.

Conclusion

The experience of physical trauma by the children is consistent with histories and reports filed upon admission to the rehabilitation centres. Scars/keloids were clearly visible in different parts of their bodies as a result of burns, beatings, carrying heavy objects, gunshots, cuts with bayonets and machetes, long distance treks, etc. The alleged tortures were corroborated by reports from interviews with the children and their parents/guardian upon admission at the rehabilitation centres. The children showed high degrees of psychological distress partly explained by their experiences of torture. The impact of debilitation, dependency, dread and disorientation the perpetrators induce in victims may be just as long-lasting as the physical consequences of the torture. The challenge for clinicians is to employ a holistic approach to handle survivors of torture by treating not only the physical complaints but also the psychological symptoms. Psychological symptoms may present as somatic complaints. Future studies could benefit from longitudinal multidisciplinary studies aimed at assessing the physical, psychological and other impacts of torture on the long-term development of the children.

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Legal consequences for torture in children cases: The Gomez Paquiyauri Brothers *vs* Peru *case*

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Abstract
The Gomez Paquiyauri Brothers case, before the Inter-American Court of Human Rights, was the first international case concerning the protection of children in the context of armed conflict where an international court stated the law concerning the duties of States towards children even in the context of war, and provided for reparations. As such it represents a landmark decision. The case arose from the illegal detention, torture and extra-judicial execution of two minors, Emilio and Rafael Gomez Paquiyauri, at the hands of Peruvian Police in 1991, under the Fujimori Administration at a time when the internal war in Peru was at its peak. Unlike most cases coming to the jurisdiction of the Inter-American Court, the case had been subject to domestic criminal investigations that had led to the convictions of two low ranking policemen. Yet a more subtle pattern of impunity lied at the root of the case. Torture had been denied by the State, and the prosecutions of low ranking policemen had intended to cover up the responsibility of those who ordered a policy of torture and executions (including the existence of secret codes for the torture and elimination of suspects of "terrorism") during the years of the internal armed conflict in Peru. The joint work of legal and medical expertise in the litigation of the case permitted the establishment of the facts and the law, obtaining an award of 740,500 dollars for the victims and a number of measures of reparation including guarantees of non-repetition and satisfaction, such as the naming of a school after the victims.

Keywords: torture, children, impunity, evidence, forensic expertise, legal consequences, reparation

1. Establishing the facts of the case

Emilio (14) and Rafael (17) Gómez Paquiyauri, left their home on the morning of 21 June 1991 never to be back again. On their way to pick up lunch from their mother's centre of work they were stopped and taken away by Peruvian Police, in the context of an encircling operation against subversive suspects unleashed by an early morning bomb attack against Navy personnel in El Callao, Lima, Peru. 1991 had been a year in which the violence of the internal armed conflict in Peru, developing since 1980, gained particular momentum and there existed a state of emergency. The fate of the minors in the hands of the police was made public in a press conference, presenting them as "terrorists" who had been killed in an "armed confrontation". A police report recorded in a local Police Station had fabricated details of the alleged "armed confrontation" and even produced "confiscated weapons".

The manner of how the cover-up story of the State for the killing of both minors was unveiled had a uniqueness of its own:

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Peruvian TV cameras covering the events have captured the moment of their detention. The images showed them walking and being suddenly stopped by the police. The cameras clearly captured the face of Emilio Gomez, just as he was introduced in the boot of the police car. An hour after their arrest, the Gomez Paquiyauri brothers were left dead in a morgue with labels on their bodies stating that they were unidentified. This footage constituted key evidence that at the moment of their arrest both minors had been defenceless and that they had indeed been executed following their arrest and not, as the police had accounted, been killed in an "armed confrontation". As the father of another victim, tortured and killed in similar circumstances the same day, denounced the crimes on national television, a scandal unfolded (see Box). This forced the State organs to 'investigate' the events. However, only two lower ranking non-commissioned police were found to be criminally responsible for the killings and were released after serving just a short time of their sentences. Torture had not been an issue at all in the investigations. No reparation had been given to the relatives of the victims.

The Inter-American Commission on Human Rights submitted a complaint before the Inter-American Court of Human Rights on the basis that an officer who was portrayed as sole intellectual author[a] had not been detained and prosecuted, and on

a) The national criminal investigations in the case only reached the immediate superior of the actual non-commissioned officers that were in the police car that took the Gomez Paquiyauri brothers on detention. During the proceedings before the Inter-American Court though, counsel for the victims proved that this had not been the making of a single officer but rather, he in his place had received orders from those who directed the operation. It was also proved that the pre-established secret codes to eliminate detainees were part of a modus operandi designed as an anti-subversive State policy.

Box

Fredy Rodriguez Pighi (27), a medical student who was in the area by coincidence on the way to his girlfriend's house, was also detained in the same operation. His detention was also recorded by TV cameras. The detainee had no visible wounds or signs of blood from haemorrhaging and no weapon was found on him. He appeared in the images face down on the ground, spread out in the outside garden of a building, his head covered with a coat, and his body stood upon by police officers. He was taken to the boot of a police car. The vehicle left for an unknown destination and 45 minutes later the corpse of Rodriguez Pighi was left at a local hospital with multiples bullet wounds from firearms. As in the Gomez case, the police reported that he had "died in armed confrontation with the police". The autopsy report in his case showed that the victim had died from wounds perforating the head and wounds perforating the right hemithorax caused by projectiles. The shots had been fired at short range, as the wounds presented a blackish and scorched halo in the entry holes of the projectiles. The doctors who received the body noted on examination of it that the blood was "fresh, shining and warm", which indicated that he had died between five and ten minutes before his arrival at hospital. It was also established that he had been hit by the bullet "whilst he was lying face down on a hard surface", which had prevented the complete exit of the projectiles both from the skin and from the clothes. The father of Rodriguez Pighi, himself a medical doctor, denounced this crime in a Television program which prompted that the Minister of Defence address the issue. It was because of this denunciation that a criminal investigation about the three deaths by different police patrols during that operation was initiated.[1]

the basis that the family had not received any reparation for the wrongs done to them. As counsel for the victims I took a different view of the key legal issues at stake in the case. I considered that the State was internationally accountable first and foremost for the illegal arrest, treatment given to the minors prior to their executions, and for their extrajudicial executions. My starting point though was to understand and establish the facts fully. I wanted to understand the context in which these executions were carried out. Were these the deeds of just some bad apples in the police or was the State responsible for a more serious type of conduct such as a policy behind these executions? I wanted to establish as fully as possible what had happened with the minors in the time that they had been retained in the hands of the police.

The mere fact of having pushed the minors alive into the narrow space of the boot of a police car was sufficient to establish a violation of Article 5 (right to humane treatment) of the American Convention. Yet, from the perspective of counsel for the victims there was a twofold public interest in a proper investigation of the facts. On the one hand, it was the right to truth of the victims: facts had to be established so that the relatives of the victims could *know* and have the facts acknowledged. On the other hand, it was the need to have the facts acknowledged *for what they were*, if one was to prevent this type of recurrent behaviour from happening again: "no, this is not casual, incidental ill-treatment; this is torture". The type of treatment afforded to the Gomez Paquiyauri children was too common in police practice in Peru (stepping on top of the detainees, blindfolding them, shoving detainees into the boots of the police cars[b]) to the point that it was regarded as *normal*.

The contention on the part of Peru that the treatment meted out to the minors (including bundling them alive into the trunk of a car "because there were no handcuffs available") "constituted some mistreatment but not torture", resulted in a very careful examination on the part of the Court as to whether or not this treatment constituted torture. In its demand the Commission had already argued that in the case of children, the threshold for treatment considered to be torture (vis a vis inhuman or degrading treatment) was lower: the severity of the infliction of pain had to be seen in relation to the young age of the victim. His/her psychological and physical vulnerability had to be taken into account.

For the representative of the victims though, the facts constituting torture in the case comprised a wider set of events. Given the particular cruelty with which the minors had been assassinated and the state in which the corpses had been later found (relatives and media described that they had been urinated on) it was hard to believe for an experienced counsel, that in the 50 minutes that both minors had been in the hands of the police, their integrity had been duly respected. My task in this respect was first of all to identify the array of practices constituting severe psychological and physical intentional suffering, which the Peruvian authorities had inflicted on the children prior to assassinating them, so as to present the case of the victims in a proper manner.

b) The practice of bundling detainees in the boot of the police car was first examined by the Court in another Peruvian case: Case of Castillo Paez v Perú. Judgment of 3 November 1997, Series C No 34 at para. 66. In the said case, the Court held that this treatment constituted inhumane treatment.

The challenges in establishing the facts

I had only 10 days plus a possible extension of my deadline to a few more days to put together my case. Legal cases have procedural rules with tight deadlines and it is in that context that a legal counsel has to produce evidence, expert witnesses, reports, and sound pleadings to represent a case of a victim of torture. I carried out my investigations at the same time that I worked with the documentary basis already on record in the case. The Commission had submitted hundreds of pages related to the national prosecution of the case. A key task of someone representing the victims of human rights is to bring their perspective fully before the Court. I took testimonies of all members of the family that experienced the events in different ways as witnesses. It was important to inform the Court about the impact that these events had had on their lives. The credibility of these accounts was reinforced by all possible documentary evidence in their hands and by testimonies of independent witnesses that could further corroborate the manner of how the events had unfolded. I obtained footage of the events and watched again and again the moment of detention. Assisted by an experienced photographer I obtained pictures of the footage to be able to observe details of each of the moments. The minors were forced to kneel down, they were beaten and forced face down onto the ground. A police officer stood on their backs, their faces were covered with a coat depriving them of sensory perception (which is used to disorientate the person). In this condition, they were taken to the boot of a police car where they were both shut inside and taken to a destination, which was unknown to them at that moment. From a careful reading of the different versions the policemen that had been prosecuted in the case had given, I drew a picture of what had happened after their detentions. They had been taken to a wasteland area known as "Pampa de los Perros" (Dog's Land) following an order from above, where they were beaten with rifle butts, interrogated and later executed. The fact that their assailants had urinated on them showed the degree of lack of respect for any human dignity in the treatment of their remains.

The autopsy reports did not record any signs of torture or mistreatment, only the cause of death by bullet wounds. In other words, the medical account of the events had completely overlooked the torture of both minors. Moreover, at the time of the events, despite being a Party to the Inter-American Convention to Prevent and Punish Torture,[c] and the United Nations Convention Against Torture (ratified on 7 July 1988), Peru had not typified torture as a crime within its domestic legal system. This lack of criminalisation was per se a violation of the American Convention. Despite this, the investigation of the violence both minors had endured prior to their deaths could have well be done under less specific provisions of the criminal code such as bodily and mental harm.

The pictures taken by the relatives of the victims of the faces of the two boys and hands of one of them, as they found them in the morgue, served as a basis for my reassessing the information provided in the

c) Peru became a party to the Inter-American Convention to Prevent and Punish Torture on the 27 of February 1990, prior to the Gomez Paquiyauri's case. Article 6 of said instrument establishes: […] The State Parties shall ensure that all acts of torture and attempts to commit torture are offenses under their criminal law and shall make such acts punishable by severe penalties that take into account their serious nature. The State Parties likewise shall take effective measure to prevent and punish other cruel, inhuman, or degrading treatment or punishment within their jurisdiction.

autopsies. One of the thumbs of the older boy was almost severed from the hand. The colour of the skin next to it was black as though it had been burnt. What could have been the cause of this? Had it been caused by burning with a naked flame? What type of violence is required to take off a thumb in the manner shown in the picture? Investigating acts of torture requires the representative to go beyond stereotypical ideas of torture that identify it as a practice that takes place in a "chamber" and with methods such as giving electric shocks, burning with cigarettes or using other quasi-medieval types of instruments. Can someone be "tortured" by gunshots?

2. The Istanbul Protocol

Nowadays, the legal representative concerned with these types of cases has at hand the accumulated knowledge of professionals from different fields of expertise who have been working for the rehabilitation of survivors of torture for several decades, and *he or she should use it.* The Istanbul Protocol: *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* expressly recognises gunshots as a possible form of torture.[2]

3. Working with experts

I felt I was on the right track. Yet establishing the truth required working with other experts in the field. In particular, I urgently needed to discuss the case with Forensic Pathologists and with medical experts working in the field of rehabilitation for torture.
As I observed the disfigured faces of the Gomez Paquiyauri brothers in the pictures, I needed to establish whether what I saw corresponded to the damage the bullet wounds causing their deaths only: I needed to know whether it was possible (upon observation of the material), to see any evidence of additional harm consistent with violence by third persons. Legal knowledge did not suffice. I needed medical knowledge. I urgently also needed to get expertise from the medical and psychological point of view to establish what would have been for a child to experience what both minors experienced prior to their deaths. Logically, we can imagine. But we needed to conceptualise and to scientifically explain for example, why would being shot in the boot of a car cause on a child a different type of psychological harm than on an adult. Two relatives of the victims were themselves children when confronted with the images of their siblings dead. The type of reactions (the 8 year brother suddenly felt pain in his legs, had recurrent nightmares etc.) both had, needed to be subjected to a psychological expert examination. I considered that the relatives had also been victimised by these facts: witnessing torture inflicted on another person has been, after all, identified as a form of torture in itself in the Istanbul Protocol.

Gathering expert views as written evidence and as oral evidence: the role of each type of evidence

i. Written evidence

As counsel for the victims in this case I sought out three independent views of forensic pathologists with wide experience in investigating torture. In putting questions before them I worked with the hypothesis that this was the case of a defenceless minor, who was immobilised in the hands of his captors, and who being in that state, had received gunshots in the hands. Such a wound had not caused his death, nor was it intended to do so. Such a wound had only been inflicted for the purpose of causing suffering in the context of a possible interrogation. In ad-

dition, a second question was: were the injuries and bruises shown in the faces of the brothers, the consequence of bullet wounds only, or was there any evidence in the pictures consistent with the violent acts of third persons that were not the cause of death? An important lesson for those intending to represent victims in international cases is to remember that although prima facie, a brief autopsy report that does not register any information about torture seems to deny evidence of torture in a case, rather than being proof that torture did not take place, may well be evidence of the contrary. The first issue addressed by the forensic pathologists I approached therefore was whether or not the autopsy reports satisfied international standards in the investigation of alleged extrajudicial executions and torture. It was important, therefore, to establish *what information was lacking* in those reports.

The independent Medical and Legal Report from the Department of Forensic Pathology of the Basque Institute of Legal Medicine, sought by counsel for the victims and prepared by Dr. Rafael Alcaraz and Dr. Benito Morentín, noted that a number of tests that should have been conducted in compliance with the autopsy protocols had not been carried out. In this report, the experts Dr. Rafael Alcaraz and Dr. Benito Morentín, noted in respect of the autopsy protocols regarding Emilio and Rafael Gómez Paquiyauri that they were conducted in a superficial manner (succinct or brief). It contains no tests or photographic material and that the findings referred exclusively to the injuries caused by a firearm.[3]

The report provided by these forensic pathologists was complemented by other expert views concerning psychological and physical torture in the case based on interviews with the family, their affidavits, photographs of the moment of the detention, and video footage of the police operation and the detention of the minors. Expert views of Dr. Edith Montgomery, specialist on Research related to Children and Torture from the Rehabilitation Centre for Torture Victims based in Copenhagen, as well as expert affidavits from Dr. Bent Sorensen (former Expert of the UN Committee Against Torture) and Dr. Inge Genefke, leading medical expert on torture and its effects, all submitted by counsel for the victims, added further evidence of the commission of torture in the case.

The following are some of the aspects to take into account (from the perspective of the legal representative) when working with experts:

– Contacting experts with relevant experience: If one is trying to ascertain effects of *falanga* beatings, then find an expert with experience on this type of torture. In this case I needed experts with as much experience as possible on Forensic Pathology (extrajudicial executions and torture) and Medical Experts with good experience working in the field of children as victims of torture.
– If possible find an expert that can assess the evidence in the native language. Although use of interpreters and translations are common in the representations of cases, highly technical medical reports or autopsy protocols may not contain easy language to translate and important information can be lost in the translation. In this case the Forensic Experts I contacted could examine all evidence in the native language.
– An informal discussion of the case with the expert can provide a starting point to quickly asses whether the expert can address the question the legal representative is posing or not. The expert will immediately let you know what he/she

needs to see. He/she may reassure you on some lines of argumentation or may challenge an hypothesis you took for certain. Identifying clearly the expertise that is required, providing a succinct background of the case with clear questions to the expert is a sine qua non on this first contact.

– Once an Expert has agreed to work on a case, the legal representative must provide all necessary material for the Expert to have a sound understanding of all issues relevant to his expertise. This includes providing the position of the other parties in the case or relevant evidence that other parties may have submitted. It is important that in the expert report, all the material that was made available to him/her is mentioned. It is also important that counsel for the victims clearly guides the expert as to the format the written report must have. Different courts have different styles in their working practice. In my experience a good report will always have a good structure. It will indicate what specific points it will address and it will state what it needs to state under each question or aspect addressed.

ii. Corroborating expert views and assisting to present highly technical language into a narrative accessible to non-experts: oral evidence

The written expert reports I obtained were extremely important to support my line of argumentation. Why did I consider it necessary to bring additional expertise directly before the Court, in Costa Rica? A hearing has the purpose of putting before a court the key aspects of a controversy. One can present thousands of pieces of evidence during the written proceedings yet the key points can be lost in the midst of this evidence. It is crucial to convey during the hearing the crux of the legal issues the court will have to decide upon and to assist the court with the answers to these legal questions. Bringing experts before the court is crucial in that sense, not only to centre the case on the key aspects that are subject to a judgment, but to assist the court in establishing facts. Oral evidence of an expert allows the judge to ask questions, gives the opportunity to the other party to ask questions and in this manner it serves the purpose to enlighten the subject and to corroborate earlier expert reports submitted. I was very privileged to work with very experienced experts during the hearing in the Gomez Paquiyauri case, Dr. Inge Genefke and Dr. Hans Petter Hougen. I wish to make the following comments about their participation as experts in the case. Besides assisting to establish that the treatment both Gomez Paquiyauri brothers underwent amounted to torture, Dr. Genefke's role was extremely important to explain in which way the relatives of the children were secondary victims of torture. She interviewed each of the relatives and studied all the material (including videos, photographic material etc) very carefully. She brought with her an experience of many decades of treating survivors of torture including her experience as having being part of a Panel of Experts sitting on the United Nations Compensation Commission (UNCC) for violations of international law including torture, in the context of the Iraqi invasion of Kuwait. Among other things, this panel acknowledged that damage occasioned during periods of armed conflict usually has serious psychological and physical dimensions and that being forced to witness the torture of others, particularly a child, spouse or parent, is torture in itself.[d]

Not only was her expert knowledge in matters relevant to the substantive issues of the case of great value, but her practical knowledge rehabilitating survivors of tor-

ture was invaluable concerning procedural aspects during the hearing. For example, she pointed out to me that it was important to have medical support at hand for the relatives during the actual hearing. As the Tribunal does not have a Victim Support Unit and victims do not have resources to bring additional privately gathered support, this was an important lesson I learnt as representative. Indeed, Dr. Genefke was right. The mother of the victims had a break down during her cross-examination and I was glad Dr. Genefke had foreseen this possibility and was allowed to assist the victim as an emergency measure. For my next cases in the future I made sure I had, additional to my expert witnesses, professional psychological support for the victims available during the hearing in case the proceedings themselves brought up a need for professional help.

In what concerns the expertise of Dr. Hougen I regard that his input as expert was of particular importance because of the following reasons:

i) he explained in language accessible to the court a very difficult set of forensic findings based on the examination of the evidence and aided by the graphic material he examined, projected on a screen, which made a big difference from just reading a written report
ii) his style was clear and to the point
iii) he answered the questions of the Court in an equally clear manner clarifying any point that remained obscure
iv) he absolved new questions I put before him based on evidence I had not had in my possession at the time of my original pleadings (assessing evidence consistent with blows with gun butts in the clothing of the victims)
v) he was very consistent as expert witness, using the right degree of assertiveness in his way to answer questions put forward by the representative of State in the case.

I believe that an important point in working with expert witnesses in these type of oral proceedings is to familiarise as much as possible the expert with the procedure itself he/she will participate in (explaining what will happen exactly, what are the rules, how many judges will be present, and the formalities about their presentation) as well as ensuring the expert is clear about the time he/she has to present the information and the manner (whether it will be through guided questions or through his/her own sole presentation).

iii. The facts as they emerged

Based on the joint effort of experts and legal counsel to establish the facts of the case, the following picture emerged.

The deprivation of the freedom of both minors took place under circumstances of extreme violence: their apprehension by force and their summary execution by the impact of bullets when they were in a state of complete defencelessness. The Inter-American Court of Human Rights stated in the Villagrán and Others Case that it is reasonable to infer the extreme aggressiveness of the treatment received by persons placed in that situation. In the cas d'espèce it had been likewise demonstrated that in the space of about 50 minutes comprising the interval between their arrest and their summary execution Emilio and Rafael were isolated

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d) United Nations Compensation Commission, Expert Report on Mental Pain and Anguish (Prepared for the United Nations Compensation Commission, 14, March 1993, Report of the Panel of Experts Appointed to Assist the United Nations Compensation Commission in Matters Concerning Compensation for Mental Pain and Anguish, reproduced in, ILR 109, 42-447, p. 440.

from the rest of the world in the hands of their captors.

As this Court had asserted on previous occasions "isolation from the outside world produces in any person moral suffering and psychological apprehension, placing that person in a position of particular vulnerability and increasing the danger of being treated with aggressive and arbitrary behaviour […]" that connection the Court recognised the severe effects that lack of the ability to communicate has on all persons deprived of their freedom.[4] The lack of communication per se of Emilio and Rafael was a source of severe anxiety and extreme psychological and moral suffering for both of them. It is reasonable to infer that both were therefore aware that their lives under those circumstances were in grave danger.[5]

It was submitted by counsel of the victims that in the case of minors the denial of communication per se constitutes torture. It was demonstrated that the minors were arrested, made to kneel and a police officer forced them to the ground. He would then stand on them and jump on them. Their faces were then covered so that they were disorientated from their surroundings whilst this violence would continue, perpetrated by a large group of police officers surrounding them. Thus, they were to be dragged by the hair to the boot of a vehicle where they were both to be shut in without ventilation and in cramped surroundings for about 15 minutes. Thereupon the boot was to be opened so that they could be beaten with the butts of rifles by the police officers who victimised them. They had been taken to a desolate location, Pampa de los Perros (Dogs' Land). During the space of time when they were taken out of the boot and executed, they were interrogated at the same time as they were tortured. As the opinion of the expert Dr. Montgomery asserted:

Torture methods can be divided into physical and psychological methods, but in practice it is usually a combination of both. Torture methods that threaten destruction of the body and its functions, or death, are assumed to provoke a maximum degree of fear and horror, and thus to be the most traumatic. In the case of children the threshold of what may be considered torture or serious infliction of pain is lower than as an adult due to children's more vulnerable condition and their limited ability to make sense of what is happening to them. […]

The pictures of Emilio and Rafael testify to the physical maltreatment and torture they had suffered prior to their death. In addition to the physical pain inflicted on them, they have been confronted with severe threats to their life and integrity and must have gone through a period with a maximum degree of fear and horror prior to their death. What they have been exposed to must be considered physical as well as psychological torture.[6]

The expert opinion of the Department of Forensic Pathology of the Basque Institute of Legal Medicine showed that the corpses of the victims had traumatic corporal lesions that did not appear to be reflected in the autopsy report and that were not the effect of the bullet wounds that caused their deaths. Moreover, in the same expert statement it was established that there were serious deficiencies regarding the autopsy protocols of both minors with no account of why they did not take notice of the injuries occasioned in the victims by the blows with gun butts and possible fractures of bones and bruising caused by other acts of aggression such as the fact that fully grown police officers had been standing on the backs of both of them. Thus, from observation of the photograph of Emilio's face, the experts have noticed grazes in the middle part of the face that were consistent with the use of violence by a third party. In the case of Rafael it was noted that the ecchymosis of

the upper lid of the right eye was consistent with a direct traumatism independent of the gunshot wounds since in that area there can be detected a certain amount of inflammation on the orbital edge of the exterior of the eye. Likewise, the experts noted in the case of Rafael a series of lesions in the area of the nose, in the area of the right malar and in the area between the lower lip and the chin, as well as in the area of the chin itself, which from their location in different parts would indicate that they had not been caused by the mere falling of the body as a result of death but by the violence of third parties.

Furthermore, special mention needs to be made of the lesions on Rafael's hands. The savage nature of these suggested severe, terrible suffering, which Rafael experienced before his death and which it is reasonable to assume that his little brother had to witness. The said lesions were caused by gunshots from a distance of one centimetre, which demonstrates also the degree of defencelessness as regards the victim and the degree of violence as regards the agent of the State. From the photograph of the hands it could be appreciated that there could have been two or three shots, one of which would have destroyed the thumb (Figure 1). The said shots were fired when the youth was still alive, in a situation of defencelessness and completely unable to move. The expert examination conducted also indicates that these injuries to the hands were independent of the bullet wounds that caused his death. In that connection it was ruled out that these wounds could have been caused by the same bullet that hit the victim in the head (assuming he had been executed with his hands on the nape of his neck). This is because it would have been impossible for two or three bullet wounds to appear in the hands since, upon the impact of the first bullet, the hand would have fallen away.

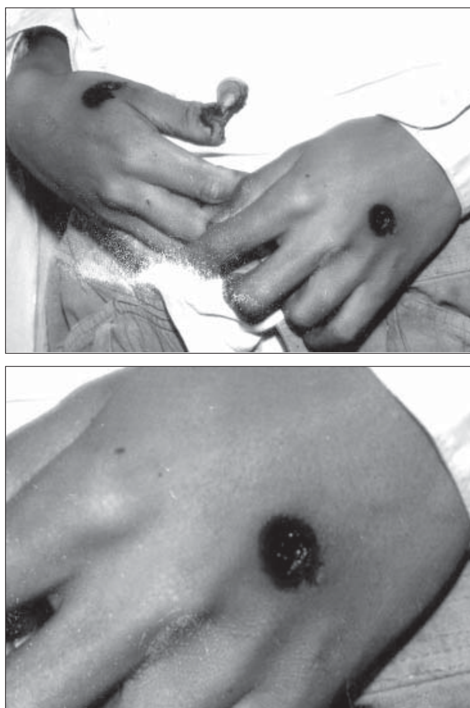

Figure 1. *Detail of the hands of one of the Gomez Paquiyauri Brothers.*

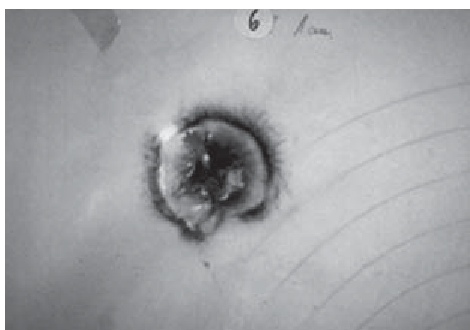

Figure 2. *Shows an example of how a gun shot at a distance of 1 cm with a 9mm caliber pistol using armoured ammunition, looks like. See the similarity. [Taken from the Expert Report of Dr. Benito Moretín and Dr. Rafael Alcaraz , Department of Forensic Pathology of the Basque Institute of Legal Medicine, in the case.]*

Even if it were assumed that there were several killers who fired at the same time, the experience of more than 20 years of carrying out autopsy protocols in cases of this type of violent death on the part of one of the most prominent experts in this field in Spain, Dr. Rafael Alcaraz, indicated that even in the case of simultaneous shots, the bullets would not have been able to impact exactly at the same time with the hand falling away as soon as the first bullet was hitting it.

Therefore, such dramatic lesions that could be observed on Rafael's hands served no other purpose than to cause him severe suffering imposed with intent, in the context of the interrogation to which he was submitted prior to his death. The mouths of the boys were full of earth and their trousers full of holes as if they had been beaten with rifle butts as the video records showed. And the police had urinated on them, as it had been established from the testimonies of all witnesses involved.

4. The holding of the Inter-American Court concerning Torture

The Court handed its judgment on July 8, 2004.[7] In what concerns the prohibition of torture the most important points the Court held were:

Direct victims

i) Cases in which the victims of human rights are children are especially grave, as their rights are reflected not only in the American Convention, but also in numerous international instruments, broadly accepted by the international community – notably in the United Nations' Convention on the Rights of the Child that "establish the duty of the State to adopt special protection and assistance measures in favour of children under their jurisdiction." In the case in question these violations gave rise to Aggravate State responsibility.

ii) The fact that the alleged victims were children requires applying the highest standard in determining the seriousness of actions that violate their right to humane treatment.

iii) The Court held that the treatment given to the Gomez Paquiyauri brothers amounted to torture. The treatment consisted of an array of events including: "during their detention and before their death, [the victims] received physical and psychological maltreatment that consisted of: being thrown on the ground, kicked, a policemen stood on their backs and other policemen covered their head. They were also beaten with shotgun butts and subsequently murdered by gunshots to the head, thorax and other parts of the body, with evidence of more injuries and bullet wounds than would have sufficed to cause their death, if that had been the only intention of the agents of the Peruvian National Police".

iv) In situations of massive human rights violations, the systematic use of torture has as its aim the intimidation of entire populations[7]

v) Torture is "strictly forbidden by international law"; a prohibition that is today "absolute and non-derogable". Not even in the most extreme situation such as war, threat of war, the "fight against terrorism", state of siege or states of emergency, political instability, or any other emergency or national calamity is torture permissible.[7]

vi) An international juridical system of absolute prohibition of all forms of torture, both physical and psychological, has been established, and it is today part of the sphere of international jus cogens.[7]

Relatives
Following the principle already enunciated in the Villagrán Morales et al in respect of the recognition of relatives of victims, as victims in their own right in specific cases, the Court also recognised in the Gómez Paquiyauri Brothers case that the immediate relatives of the two victimised children had been victims of inhuman and degrading treatment in their own right under the circumstances of the case.

Impunity
As a legal counsel in the case I had succeeded to demonstrate that the victimisation of the Gomez Paquiyauri brothers had not been a case of "an excess" by two bad policemen. They had been tortured and murdered in the context of a round-up operation directed by the highest echelons of the police. The policemen who victimised the minors were following orders. When one of the policemen involved was asked why he did not report the deaths, he said, "out of loyalty to my superiors" and that these officers had offered him many things including the fact that the case would pass to the military jurisdiction "and that there it was completely different". Different patrol cars that victimised detainees at different times the same day had followed the same modus operandi. The orders received came directly from the headquarters. The order not to take the victims to detention but to Dog's Land, to be executed came by police radio using a pre-established secret code (DX hundred nine) to carry out the executions of detainees. Orders would be followed up. Superiors would ask over the radio whether the order had been carried out or not with the code "twenty one twelve". The operator would reply "twenty one". The reply in code meant "yes".

Proof that torture and the elimination of detainees within the framework of this operation was part of the Police plan to combat what they considered to be terrorist attacks, was demonstrated by the fact that all those detained under this operation were executed in similar circumstances by personnel of different patrol-cars in different places, their bodies then left in a hospital as if "unidentified" (marked NN), arguing similar alibis, that they had died in an armed confrontation with the police.

Proof also that these arbitrary detentions, torture and summary executions were carried out following superior orders as part of the operation was noted by the Peruvian court itself that investigated the Gomez Paquiyauri's and Rodriguez Pighi's assassi nations, which affirmed:

> [...] the conclusion is reached that the criminal actions carried out by the two police units are closely related; it is proved that the matter relates to a decision taken beforehand [...], to execute that day subversives who were arrested, as reprisals against terrorist actions, which had broken out again; and this is explained by the help they received in order to produce fake alibis, in the reports they presented, even accompanying weapons of war. It also explains the radio communications received in code by the operators of both police vehicles, [...] it explains the rapidity with which they operated and why in the La Perla police station no one asked for an account of or even at least noticed the disappearance of the detainees [...]

The participation of the superior officers was corroborated further by the facts, evidence that might have compromised them, such as the tapes where all the orders given via the Patrol Radio from the headquarters, disappeared that day. In addition, the codes that the police used were changed straight away. This could not have been the work of a subordinate or a middle-ranking official. Moreover, the statements of the non-com-

missioned officers denouncing the high command was consistent with the fact that a dispute over jurisdiction was raised for the case to be heard in the military jurisdiction. Again, this was instigated at the highest levels of the police force.

It was therefore established that the Peruvian police effectively operated under the criteria in the context of Peru's internal armed conflict, that the best subversive was a dead one. The directive that the security forces applied was to eliminate the alleged subversive and not allow him to get into the hands of the judicial authorities.

As counsel for the victims I had been able to trace one of the low ranking policemen that had been prosecuted for the crimes committed against the minors. The Inter-American Commission had presented this witness before the Court and cross-examination of this participant of the events had given a further source of evidence and information in order to establish the facts. The facts of the case constituted indeed "a typical schema of impunity", in accordance with which,

> when events of this nature are unearthed and there is a lot of public and judicial pressure, amongst other factors, military or police institutions "hand over" in some way lower ranking officers, with the promise of offering them legal counsel, safety in the prison environment, help for their families, measures to obtain benefits for them in prison and, possibly a return to the force once they have been released. In exchange for all this, the lower ranking officers promise not to denounce their superior officers who, as in this case, usually remain immune from punishment.[e]

This was fully accepted by the Court, who stressed the duty of the state to use all the legal means at its disposal to combat this type of situation, since impunity fosters chronic recidivism of human rights violations and total defencelessness of victims and their relatives.

5. Legal consequences: the Implementation of the Court's ruling

Among the legal consequences that the Court established was a compensation award of $ 740,500 dollars in total for the relatives of the victims. Whilst the Court awarded $240,500 for pecuniary damages, it was the award for moral damages ($5,000) that reflected more evidently the Court's view of the gravity of the violations committed by the State of Peru in the said case. The Court also ordered the acknowledgment of responsibility by the State of Peru before the relatives of the victims in a public ceremony, the publication of proven facts of the judgment in a newspaper of national circulation, the investigation of the events and prosecution of all the perpetrators of the crimes (including the intellectual authors), and the naming of a school after the victims in the locality where they lived. Up to the point that this author continued with the representation of victims in this case, the State of Peru had complied with the publication of the relevant part of the said judgment, with the ceremony acknowledging the truth, with the payment of the full amount ordered by the Court to the victims and with the naming of a school after the name of the victims.

e) Demanda de la Comisión Inter-Americana de Derechos Humanos ante la Corte Inter-Americana de Derechos Humanos en el Caso de Emilio Moisés Gómez Paquiyauri y Rafael Samuel Gómez Paquiyauri (11.016) contra la República del Perú, 5 de febrero de 2002, at para. 75. On file with the author. Translation by Barry Cheetham and revised by the author.

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The political and cultural background for using child soldiers

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The political and cultural background

In 2006 the Democratic Republic of Congo (DRC) held its first multiparty elections in 40 years, marking the end of a difficult three year transition period that followed nearly a decade of war. Two successive wars, the first from 1996 to 1997 and the second from 1998 to 2005, left DRC devastated and at least five million of its citizen dead, some due to disease and starvation but many as a result of torture and ill-treatment.

Cultural factors play an important role in the origins of conflict in DRC. In contrast with the past, when conflicts were ascribed mainly to political or economic motives, conflicts today are localized and have ethnic, civil and/or religious causes. They stem from longstanding intergroup rivalries that often lead to political instability. A second characteristic is the increased intensity of the violence and the seemingly irrational behaviour typical of people involved in ethnic and civil conflicts in the DRC. For example, civilians are increasingly the specific targets of armed conflicts as evidenced by the rising number of civilian casualties in proportion to the total. Women and children in particular are now more likely to suffer casualties. Families and communities are now more likely to disintegrate and lose their cohesion. While young children play no part in negotiations or even the conduct of war, they are subjected to severe injuries, visible and invisible. They experience destitution, abandonment, neglect, abuse, exploitation, and long-term emotional and psychological effects.

Of all the weapons of modern warfare, the landmine is one of the most lethal to children. Mines are not only a common cause of mortality, injury and disability, but also the cause of widespread social and economic disruption and psychosocial distress in child soldiers. Land mines threaten not only individual survival, but the survival and continuity of whole communities. They are forced to leave their lands and seek work in urban areas, increasing the number of displaced persons. In most cases there are no maps indicating where mines are laid. In some parts of DRC, child soldiers are mutilated for life because of the thousands of mines strewn over the countryside and are abandoned to their fate and forced to eke out an existence as best they can.[1] Anti-personnel mines often look like brightly coloured toys, but when mines are picked up or stepped on, they maim and kill indiscriminately. In some places

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troops send child soldiers on ahead, thereby testing the route. A third characteristic of conflict today in DRC is the significant involvement of children and young persons as participants in the conflict.

The problem of using children in war situations

There are increasing numbers of child soldiers in DRC. Furthermore, most of today's conflicts can be categorized as complex emergencies. What this means is that two or more of the following elements are a part of the event: civil strife, armed conflict, migration of the population, internally or across neighbouring borders, collapse of the economy, scarcity of food and water, and famine. In reality, most of these conditions exist as a part of the majority of today's conflicts in the DRC. The Impact on Child soldiers by organized violence at its best interrupts a child's healthy growth and development, at its worst it debilitates children physically and/or emotionally. The physical impact of organized violence on children, in terms of mortality, disease, injury, disability and malnutrition is dramatic. In most conflicts more child soldiers in DRC die as a result of malnutrition and disease, an indirect consequence of the violence, than the violence itself. This is directly related to the fact that during times of war health systems collapse and living conditions deteriorate.

There is a lack of clean water and waste disposal systems are nonexistent. As a result, the incidence of epidemic diseases generally increases during conflict, sometimes dramatically.[2] Moreover, diseases that in many regions may have been under control prior to the onset of fighting, such as malaria or small pox, may be reintroduced as a direct result of conflict. Preventable diseases such as cholera, dysentery, acute respiratory infection, and malaria are also common. Disabilities among child soldiers are common in many conflict zones in the DRC. These result from injury, lack of immunization services, Vitamin A and iodine deficiency. Simple eye and ear infections can lead to blindness and deafness due to a shortage of basic drugs. Amputations are common in conflict zones, and lack of emergency care contributes to the large number of deformities. Disabled child soldiers face bleak prospects, rehabilitative services are entirely absent in most conflict areas and the demand for artificial limbs far outweighs supply.

Situations in war time described by child soldiers

Human Rights Watch estimates that at least 5,000 civilians died from the violence in the area of Ituri between July 2002 and March 2003, in addition to the 50,000 civilians the United Nations estimates died there since 1999.[3] In April 2003, in Drodro and its surroundings, militias allegedly massacred at least 300 civilians, both Lendu and Hema, with machetes, knives and guns. Torture and killing have also been attributed to the Congolese army or to government-backed militias, who are alleged to have committed massacres in Ituri, Kivu, North Katanga and Maniema. In 2002, at least 68 persons were killed and 3,500 houses were burnt down at Ankoro by the government armed forces.[4]

Elsewhere in North Katanga, Mai-Mai militias supported by the government are responsible for acts of cannibalism as well as looting and burning houses, and constantly harassing civilians. Torture and other forms of brutality have characterized the armed conflict on both sides. On the government side, military, police and security services are reported to torture detainees. Common methods include being whipped, beaten with belts or metal tubes, burnt by cigarettes

or otherwise assaulted. On the rebel side, women and girls are particularly exposed to sexual violence including mass rape, mutilation of sexual organs and sexual slavery. Women are abused by both sides, either by members of the Congolese armed forces and police who are alleged to rape women working in the fields, or by rebels. Sexual violence has become a particular feature of the conflict. A peace accord in 2003 ended a vicious civil war that claimed the lives of more than three million people.[5] However, armed conflict has continued in pockets of the country, especially in the East. Severe poverty, insecurity, lack of basic social services and sexual violence all continue to take a heavy toll on child soldiers.

To date, very few human rights abuses have been documented, prosecuted or even investigated by the Congolese government. In government held territory, the judiciary remains under-funded, inefficient and corrupted. Lawyers are often denied access to their clients and are given no time to prepare their defense. They are often threatened and sometimes kidnapped and tortured. Corruption remains pervasive in the court and lawyers often provide illusory observations regarding the situation of child soldiers in the DRC. In the rebel held territory, the judicial system hardly functions. Most courts simply do not operate and the judges fled to government controlled territory during the war.[6] The trial of a group of rebel officers belonging to the Movement for Liberation of Congo (MLC), who are accused by the United Nations of atrocities against civilians and the group of cannibalism, whose trial was to open in February 2003 in northern town of Gbadolite in the DRC but the lawyers said they had found no evidence to support these allegations and no-one has been charged with cannibalism.

Socio-cultural factors – socialization practices and beliefs. Strength of affective ties between child soldiers, their family and community

Cultures in DRC have different ways of socializing children and have different attitudes and beliefs about what constitutes appropriate behaviour.

These attitudes and beliefs contribute to former child soldiers' ability to cope with stress and violence. Some cultures in the DRC rely more on faith than on problem solving in facing adversity. Some cultures are more concerned with punishment and guilt while others discipline and reconciliation. Some cultures expect children to be more dependent on others for help in adversity rather than becoming autonomous and more self-reliant. The parents in some regions in the DRC maintain a close relationship with their demobilized child soldiers, while others 'cut off' their relationship. The resilient child soldiers manage this rejection; but non-resilient child soldiers withdraw, submit and are depressed. Former child soldiers feared they could be 'caught' by international workers and thus denied themselves the support that might have been provided.

The degree to which the culture is disrupted

There is a sense of continuity and security that child soldiers are able to maintain if familiar structures and practices are maintained, even though the setting may have changed. But when armed groups officers force changes in rites and ceremonies, when they prohibit practices that once brought the community together and introduce alternative schemes, whether they are in the form of schooling or religious practice or ways of earning a living, then child soldiers were left without familiar supports and were more traumatized. When child soldiers are separated from their families and found refuge in an armed group where customs and foods

are different, then there is greater disruption and trauma.

DRC has a population of 65 million. War and armed conflict had been going on for the past 10 years. During that time more than 2 million people have been killed; 4 million people have become refugees and one million have been displaced internally.[7]

Most of the schools and hospitals have been destroyed. While there are groups/organisations attempting to meet the needs of former child soldiers, the war continues.[8] During this stage, trauma is still in force but structures are being instituted to address needs.

During the second half of 2008, SAVE CONGO and a series of local NGOs in DRC came together to discuss how best to respond to the trauma of former child soldiers affected by war and violence. The Convention on the Rights of the Child (CRC) provides an affirmation by the international community that all rights for all children must be universally recognized and protected including in DRC.[9] The CRC is a powerful document that should be used for advocacy and as a legal framework for specific interventions aimed at the protection of children's rights. With the approval of the CRC, followed by the Declaration and Plan of Action from the Summit on Children, there is affirmation of a commitment to provide for children in war. These declarations are the result of an understanding of the importance of early experiences in relation to children's later development.

All the principles and provisions of the Convention are relevant in times of war when all the rights of children are at risk. Articles that are especially important during wartime include § 22, § 37, § 38, and § 39, which relate to survival, family support, education, and health care and adequate nutrition.[10] While the CRC and the Declaration and Plan of Action are genuine landmarks that can and should be used to advocate for attention to children who are affected by organized violence, at this point these principles and other international laws are being ignored in the DRC. Clearly what is lacking in the DRC are the mechanisms and the will for enforcement. Enforcement requires systematized monitoring, but it also requires a determination to prosecute offenders and rehabilitate torture victims including former child soldiers. In December 1993, the General Assembly passed a resolution by consensus calling on the Secretary General to appoint an Expert Committee to carry out a study on the impact of armed conflict on children. The resolution was a clear recognition by the international community of the catastrophic conditions to which children have been and continue to be exposed, both as targets and as perpetrators of the atrocities of war.[11] Further, it called international attention to the ever-increasing number of conflicts involving and adversely affecting civilian populations. In keeping with the principles of the CRC, the humanistic value of the child assumes a central pervasive position in the conceptual framework for the survival, protection and development of the child in an emergency situation.[12] In the 1980s, the concept of children as conflict-free zones – Children as Zones of Peace – was first put forward. The notion was that children, who are neither the proponents nor the perpetrators of war, should have their rights protected. They should neither be the victims of war nor called upon to wage war.[13]

In the horror of war it is vital that children be protected from harm and provided with the services essential to ensure their survival and well-being. Thus children, as zones of peace, can be an organizing factor in the development of interventions.[14]

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Child soldiers as zones of violence in The Democratic Republic of Congo: three cases on medico-legal evidence of torture

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Abstract

This article sets medico-legal light on torture of three former child soldiers by comparing torture methods, consequences of torture and medical observations.

It is focused on these child soldiers as representatives of the many abuses of children as soldiers in armed groups.

The three persons were child soldiers during 12 years in The Democratic Republic of Congo (DRC) as members of three different armed groups. They were exposed to armed conflict events, experienced torture, and participated in atrocities, sexual abuse and traditional rituals during their role in armed conflict. They were psychologically distressed with unhealthy physical and mental states.

The principles for working with child soldiers are described. The model addresses basic items: The confluence of the dimensions of the items will determine the specifics of medico–legal evidence of torture in child soldiers, taking into consideration inputs that are required at the macro, community and individual levels. A primary goal is to prevent violence from occurring in child soldiers. Thus, much more deliberate effort is made to address the underlying causes of recruitment of children in armed groups in DRC and to invest more resources in conflict resolution before there is an outbreak of violence. Peace education tends to be introduced too late and does little to alleviate the use of children in armed conflict in DRC.[a]

Keysword: violence, torture, child soldiers, armed conflict experiences, physical and mental states, medico-legal documentation, Democratic Republic of the Congo (DRC)

Funding: This study was supported by the Third Millenium Foundation. The organization had no influence on data collection, manuscript preparation or study design.

Case stories

In Article 1 of the United Nations Convention on the Rights of the Child, "child" is defined as "every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier". The definition of violence is that of article 19 of the convention: "all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual

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a) The three former child soldiers participating in this study are in accordance with the ethical standards of the regional committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 1983.

abuse". It also draws on the definition in the 2002 World Report on violence and health: the intentional use of physical force or power, threatened or actual, against a child, by an individual or group that either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity.[1]

All parties to the armed conflict in DRC recruited and used children. Widespread human rights abuses have been committed by armed groups in the DRC in recent years. All parties to the conflict have been responsible for violations. Among the worst violations are killings of civilians, forced recruitment of child soldiers, destruction of villages, internal displacement, cannibalism, rape and torture.

This study engages directly and consistently three children who participated in armed groups. The three persons, aged 13 to 15 before being recruited, are two boys and one girl who were child soldiers during 1996 to 1997 and 1998 to 2008 in The Democratic Republic of Congo DRC as members of three different armed groups: the Congolese government army, the Movement for the Liberation of Congo (MLC) and the Mai-Mai militia. They were exposed to armed conflict events, experienced torture, and participated in atrocities, sexual abuse and traditional rituals during their role in armed conflict. They were psychologically distressed with unhealthy physical and mental states.

The study builds on the background of the armed conflict in DRC involving the Congolese government army, MLC and the Mai-Mai militia, and describes both the torture and the ill-treatment methods, that the three children experienced, as corresponding to effects and impact of armed conflict on children in general.

Medical evaluation

In order to produce valid documentation of torture inflicted on child soldiers, medical doctors and psychologists from SAVE CONGO examined the three child soldiers in December 2008, comparing methods of torture and ill-treatment, physical and psychological complaints and observations. The examinations were conducted in accordance with the standards principles for examinations of evidence of torture as declared in the Istanbul Protocol. All three former child soldiers described in this article have given their written permission to publish their torture and ill-treatment history and medical reports.

The three children in DRC were physically and psychologically well functioning before the wars. At the time of their recruitment they were trained to kill the enemy, rape women, and commit harassment, intimidation, and destruction of property.

Information on the health situation of the children was obtained by anamnesis, physical examination and tests, made by physicians working with SAVE CONGO together with consultants (psychiatrists, physiatrists and ophthalmologists) of the University Clinic. The three child soldiers were in good health prior to their recruitment in armed groups.

After examinations, a child soldier had been diagnosed with visual and auditory problems, memory impairment and irritability. The two other child soldiers had been diagnosed with sleeping disorders, headaches, oro-dental problems, musculoskeletal system disorder and disability.

Methods of torture

The three child soldiers were recruited individually by armed groups' officers. "When they came to my village, they asked my older brother whether he was ready to join

Table 1. *Common observations of trauma on child soldiers (observations from the Save Congo Program).*

Physical signs	Character	Behaviour
Strange appearance, ill-health, thinness, too small for their age, pot-bellied stomach, scabies on their head, dirtiness, red eyes, deafness, ugliness, young body but old face	Aggressive, untidy, disobedient, sad, mentally retarded, impolite, full of hatred, mysterious, disrespectful, quick-tempered, unruly, liar, hypocrite, provocative, courageous, jealous, too fearful, stubborn, incomprehensible, solitary, too clever, weak, naughty, violent, fearless, quiet, rude, curious, incredulous, selfish, insensitive, wants to be superior, creative and full of initiative, ungrateful	Steal, never look people in the eyes, transform themselves or their toys, do not sleep at night or sleep badly, eat a lot, practice sexual abandon, do not hear or do not listen to what is being said to them, talk to themselves, don't study, go out even when they are ill

the militia. He was just 17 and he said no; they shot him in the head. Then they asked me if I was ready to sign, so what could I do, I didn't want to die," as said by the first former child soldier recruited in 1996. The second child soldier recruited in 1998 said "They gave me a uniform and told me that now I was a new girl in the army. They even gave me a new name: 'Mimi'. They said that they would come back and kill my parents if I didn't do as they said. So I was frequently raped by officers".

During daily examinations, the last former child soldier recruited in 2000 confirmed that "Being new, I couldn't perform the very difficult exercises properly and so I was beaten every morning. Two of my friends in the camp died because of the beatings. The soldiers buried them in the latrines. I am still thinking of them". The three children confessed to having participated in the killing, rape and cannibalism of thousands of civilians in ethnically targeted violence in Eastern DRC, particularly in Kivu and Ituri.

All of them were exposed to torture. The girl was exposed to rape, sexual harassment and insulting. The two boys were subjected to systematic beatings and to various forms of ill-treatment including being forced to perform excessive physical activities, to obey nonsensical orders and to wear uniform clothing.

The three former child soldiers suffered severe trauma resulting in physical and psychological problems. The observation states it as different problems and different degrees, but they are not impacted in the same way nor to the same degree.

Common factors of trauma

The common factors that affect the degree of trauma in child soldiers include:

- the nature, duration and intensity of the event
- the child's age and personal characteristics
- socio-cultural factors as socialization practices and beliefs
- strength of affective ties between the children, their family and community
- the degree to which the culture is disrupted
- the actions of the armed groups' officers and the reactions of the child soldiers.

After-effects to torture and traumatic experiences

The nature, duration and intensity of the event

Because of the nature, intensity and duration of the armed conflicts during 1996 to

1997 and 1998 to 2008, these children were severely traumatized and experienced nightmares, difficulty in concentrating, depression and a sense of hopelessness about the future. Children living in families and communities without a history of violence react quite differently from the three former child soldiers whose whole life has been dominated by violence.

Age and personal characteristics as mediators

The age and characteristics of the three former child soldiers have a mediating effect on how well they survive and thrive. Also important is the children's previous experience with violence, their degree of resilience, and their knowledge, skills and abilities. In response to organized violence, they demonstrate regressive behaviour. They showed evidence of anxiety, fear, restlessness, irritability, and dependent and demanding behaviour. This may be explained by the fact that their "cognitive immaturity is an obstacle to finding ways to avoid the impact of traumatic events." Evidence of their trauma is seen in their lack of ability to concentrate, memory problems, learning difficulties, lack of spontaneity, passiveness, depression and/or aggression, and demanding behaviour. But age alone does not determine their reaction. To overcome adversity, children draw upon three sources of resilience – I Am, I Have, and I Can.

Variable factors of trauma

Variable factors in the way the three child soldiers react to violence as the result of how those around them act and react.
In the psychological examinations, psychiatrists from SAVE CONGO found that the three former child soldiers divide into two groups. The boys were pupils of war/armed conflict and the girl a victim of war. All three came from the same population groups, yet because of experiences immediately after the violence they had different responses and were engaged in opposite kinds of activities. As a victim of war the girl remained in her village immediately after it was attacked. Subsequently

Table 2. *Sources of resilience in child soldiers (categories used in the Save Congo Program).*

The "I Am" category describes who the three former child soldiers are in terms of their internal sense of self and how they present themselves to the world	I AM: – a person people like and love; – willing to be responsible for what I did; – glad to do nice things for others and show my concern; – respectful of myself and others; – sure things will be all right
The "I Have" category represents the external supports that provide children with security and feelings of safety	I HAVE: – people around me that I trust and who love me, no matter what; – people who set limits for me so I know when to stop before there is danger or trouble; – people who show me how to do things right by the way they do things; – people who want me to learn to do things on my own; – people who help me when I am sick, in danger or need to learn
The "I Can" refers to the ways in which the three former child soldiers relate to the world. This dimension includes the child's social and interpersonal skills	I CAN: – talk to others about things that frighten me or bother me; – find ways to solve problems that I face; – control myself when I feel like doing something not right or dangerous; – figure out when it is a good time to talk to someone or to take action; – find someone to help me when I need it

she showed little sign of aggression and expressed few wishes for revenge. She did not identify with the armed group officer, but rather, saw herself as working toward peace.

In terms of the affect, this child was characterized as evidencing an overwhelming sadness. She also suffered anxiety, depression and grief. She was able to express her horrors of war and also was able to work through her sadness and grief after loss of significant group members. The two male child soldiers became ultimately "adopted" by "dads" in the army. Through their relationship with older men they were "socialized to violence and aggression and taught the power of the barrel of a gun. They had been taught that they could solve conflicts through brutality." They were aggressively sought out to become fighters. One of the main strategies of the armed groups' officers was to "burn the bridges" between child soldiers and their families. One way of doing this was to force these child soldiers to be part of a group that attacked and looted their village and possibly killed their own family members. They were highly traumatized as a result.

Alleged physical torture methods
- Beating (3)
- Blindfolding (1)
- Cell isolation (3)
- Pressurized/cold water (3)
- Restricting food and water (3)
- Forcing to wait on cold water (2)
- Sexual harassment (1)
- Rape (1)
- Forcing to perform extensive physical activity (3)
- Continuously hitting on one part of the body (3)
- Medical intervention without consent by force (3)
- Pulling out hair (3)
- Wounding with a gun (3)
- Other positional torture methods (3)

Alleged psychological methods
- Insulting (3)
- Death threat (3)
- Humiliation (3)
- Forcing to witness torture of others (3)
- Application of chemical substances (3)
- Torturing in the presence of others (3)
- Asking to act as an informer (3)

Medical complaints

All of the three former child soldiers had physical and psychological complaints. In total, 403 complaints had been diagnosed. The most common among psychological complaints are those related to sleeping disorders and these are experienced by all of them. The most common physical complaint is headache. The most common 10 physical and psychological complaints are presented below.

Ten most common physical complaints
- Headache
- Visual impairment
- Low back pain
- Discoloration of the skin
- Fatigue, weakness
- Indigestion
- Prickle
- Low back pain together with pain in legs
- Back pain
- Stomach ache
- Other

Ten most common psychological complaints
- Sleeping disorders
- Nightmares
- Anxiety
- Concentration difficulties
- No enjoyment of life

- Feelings of detachment from others
- Flashbacks
- Irritability
- Urge to weep
- Amnesia
- Other

Findings of the physical examinations

The total number of physical findings amount to 275. It appears that findings in connection with the musculoskeletal system (30.5%), neurological system (25.3%) and oro-dental findings (18.2%) are the most common.

Psychiatric symptoms and findings

All three former child soldiers had an interview with a psychiatrist from SAVE CONGO. The interviews with these demobilized child soldiers revealed psychiatric symptoms and findings. Regarding the distribution of these symptoms and findings, it appears that all three child soldiers had anxiety, difficulties in falling or staying asleep, concentration difficulties, memory impairment and irritability, intense physiological reactions to stimuli associated with the trauma, feelings of detachment from others, increase/decrease in sleep duration, weakness/fatigue, markedly diminished interest and participation in significant events, sense of foreshortened future, hypervigilance, depressive affect, exaggerated startle response, efforts to avoid activities, places or people that arouse recollection of the trauma, flashback experiences and acting as if the traumatic event were recurring, responses of intense fear to the traumatic events experienced or witnessed, change in appetite/weight, efforts to avoid thoughts, feelings or conversations associated with the trauma, diminished psychomotor activity, decrease in sexual interest, depressive mood, suicidal thoughts or attempt, obsession, dysphoria, dysphoric mood, compulsion and delusion.

Table 3. *Physical findings.*

Systems	Number of findings
Musculoskeletal	48
Neurological	41
Oro-dental	36
Ear, nose and throat	33
Cardiovascular	32
Endocrinological	27
Auditory disabilities	20
Visual disabilities	18
Respiratory	12
Urogenital	5
Ophtalmological	3
Digestive	1
Total	275

Discussion and conclusion

The in-depth medico-legal examinations of the three former child soldiers by anamnesis, physical examination and other tests made by physicians working with SAVE CONGO together with consultants (psychiatrists, physiatrists and ophthalmologists) of the University Clinic in DRC have demonstrated that all three demobilized are victims of torture as defined in the United Nations Convention against Torture (CAT).

Of foremost concern for child soldiers during and following armed conflicts is that something has happened to their family members/parents and/or significant caregivers.[2] To the extent that it is possible to keep families together, it will help lessen the trauma. Unnecessary separation and other dramatic changes should be avoided.

If separation occurs, then an attempt should be made to reunite the former child soldiers with close relatives as soon as possible. It is also important to realize that several relatives may have had a father or mother role in the child's life and as such they can be important to the child until reunification with the primary caregiver or biological parents can be completed.[3] If possible, unac-

companied former child soldiers should be linked to an older youth or adult with whom they can become acquainted and who they can rely on for support and protection. Demobilized child soldiers should feel safe and protected because they have been confronted with losing their lives and are more traumatized than children who were a reasonable distance from the violence. Situations that put children in direct confrontation, even if it is not more dangerous than the situation they have already faced, should be avoided.

In addition to knowing something about the nature of the violence, it was important to find how former child soldiers are likely to react. The ways in which this study was implemented – the goals, activities and resources available – depended on the evolution or progression of the trauma in the three former child soldiers. The interventions developed while violence is occurring are not necessarily the same as those that should be undertaken when they were living in armed groups and/or when they are being demobilized. We have defined three stages in relation to trauma: Intensity, Transition, and Rehabilitation/Reconstruction. Intensity is when the violence is actually occurring.

One of the characteristics of this stage (which can last from a few hours to several years) is that there is a breakdown of all systems.[4] During the intensity phase there are few assistance agencies or mechanisms in place to address the situation. The activities that do exist in relation to the three former child soldiers are likely to focus on basic survival – providing food, water, shelter – and trying to ensure that they are with parents and/or other family members.

Medical documentation of alleged exposure to torture and ill-treatment is based on the reporting of the degree of consistency between torture and ill-treatment history, symptoms as explained by the former child soldiers and findings of physical and psychological examinations. In this presentation of three former child soldiers alleging exposure to torture and ill-treatment during armed conflicts in 1996 to 1997 and 1998 to 2008 in DRC, there was a high degree of reliability between the allegations of physical and psychological ill-treatment. Also there was a high degree of consistency between allegations of violence and the findings at medical examinations of these former child soldiers. Before their recruitment in armed groups all the three were physically and psychologically well functioning. Psychological symptoms were all typical reactions to stress and torture is directed towards the musculoskeletal system.

Organisations committed to child soldiers' protection must aim to achieve the highest level of protection for children with whom they come into contact and work towards achieving the standards outlined in this document in the CRC.[5] We affirm our belief in the right of all former child soldiers to be protected from all forms of abuse, neglect, exploitation and violence, as set out in the UN Convention on the Rights of the Child 1989. We recognise that all organisations coming into contact with children have a fundamental duty of care towards them, and we acknowledge our responsibilities to keep children safe in both relief and development interventions.

Services at SAVE CONGO recognize and support the family as well as a range of non-traditional family units, and support the many and varied relationships that provide support, comfort, and protection to former child soldiers. Key relationships vary depending on the ages and circumstances of the child. Parents are the primary support system for demobilized child soldiers. However, at times of disruption, war, and violence parents are not always available;

children seek others adult who can provide them with nurturing, guidance, and direction. They may find this in a member of the extended family or perhaps in a person from the same community or armed group. Key relationships can also be found among peers. These relationships should be recognized and supported. If children are exposed to violence over a long period of time and there appears to be no likelihood of it stopping, child soldiers are likely to be worn down by the constancy. They lose hope. On the other hand, even if the violence they experience is intense, if it comes to an end rapidly, and if there are people and services on hand to address the issue with them, the trauma is likely to be less severe. In sum, there are a numerous diverse variables that affect how child soldiers are impacted as a result of organized violence, including the fact that the justice system in the DRC violates ethical standards and are involved in the participation of torture and ill-treatment of child soldiers in DRC.

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Children, torture and psychological consequences

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Abstract

Torture is a strategic means of limiting, controlling, and repressing basic human rights of individuals and communities that is often covert and denied by authorities. Deliberate infliction of pain and suffering or intimidation or coercion on children to obtain a confession or information, for punishment of real or perceived offences on the basis of discrimination about race, ethnic or political affiliation, is practiced in many places around the world. Impact of torture on children may vary depending on the child's coping strategies, cultural and social circumstances. We at Refugee Therapy Centre provide psychotherapy and associated treatments to people who have been tortured, giving priority to children. While our main objective is provision of clinical services, our focus is also to influence policy and practice by searching for evidence and demonstrating solutions to improve the lives, homes and communities of children disadvantaged by torture and the services that support them. We seek to provide some remedies to children of refugees who are suffering the consequence of trauma that they experienced and demonstrate good practice. In this paper I will give a brief introduction of our work at the RTC. I then discuss and reflect on children and torture. I will present a vignette and some examples of clinical intervention.

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Keywords: children, torture, trauma, refugees, psychotherapy, associated treatment

Introduction

The Refugee Therapy Centre was established in 1999 in response to the growing need for a therapeutic service which respected, and worked with, the cultural and linguistic needs of refugees and asylum seekers who suffered torture and other forms of human rights violation. We offer psychotherapy, counselling and associated treatments. We offer individual, couple, family and group therapy based on an assessment of need.

The majority of the Centre's therapists has a refugee or immigrant background and brings with them a wealth of linguistic, cultural and shared experiences. Patients have the choice of receiving therapeutic support in English or in their own language. We are aware and respect the fact that some people prefer not to see a therapist from their own cultural background because of feelings of mistrust, guilt, shame or embarrassment about what has happened to them, and also due to feeling rejected by their own country or the intensity of feelings of pain when talking in their own language.

Based on evaluation and feedback we have developed:

- Bi-lingual Support Workers: providing a more active style of support which suits

people coping with practical issues related to the processes of resettlement.

- Mentoring: providing weekly, one-to-one language support to clients in the process of adapting to their new environment, to help people improve their English and to help newly-arrived children and young people with their school work.

Our priorities are always refugees and asylum seekers. Children are supposed to play, to laugh, to look forward to their future and have hope; and above all to be a child. They are not supposed to be abused for food, chained to a wall or be in any way tortured. Children need care and protection. It is not acceptable to simply watch the way children are treated around the world; we have a social responsibility to say loudly and repeatedly torturing children is wrong.

Children and torture – overview

Amnesty International[1] reported that child torture remains widespread in the world including Afghanistan, Algeria, Angola, Brazil, Burundi, China, Colombia, Democratic Republic of the Congo, Ecuador, Eritrea, Ethiopia, Georgia, Honduras, Iran, Iraq, Israel/occupied territories, Lebanon, Mexico, Moldova, Mongolia, Nepal, Paraguay, Saudi Arabia, Serbia, Sri Lanka, South Africa, Sudan, Swaziland and many others. We need to act to put a stop to this and save children from torture.

The largest group of tortured children are amongst refugees. There are high numbers of unaccompanied children, mainly from Latin America, Africa and the Middle-East. Amongst them, child soldiers, those affected by armed conflict street violence, living in extreme poverty, abandonment and child labour.[2, 3]

The UN Secretary General's report on children and Armed Conflict in Sudan has highlighted that in 2007 and 2008 internally displaced children in Darfur faced the highest risk of rape and sexual violence.[4] One third of the 34 reported incidents which the UN verified were perpetrated against internally displaced children or occurred within the vicinity of an IDP camp. Girls were reported to be particularly at risk. One example of evidence was a 15-year-old girl who was raped in January 2008 while collecting firewood with a group of women on the outskirts of their camp in Western Darfur. The report raises concerns over the abduction of children in Darfur.

In general, the extent of these types of abuse and cases of sexual violence go unreported because of the social stigmas attached to rape; therefore although some cases are confirmed as the result of investigations by the UN, the extent of the problem goes beyond this. Lack of research is one of the main factors which conceal such tortures and atrocities that children suffer. Recognition and exposure of torture and abuse should become priority for the IRCT, indeed all other organisations respecting and working towards implementation of human rights. Monitoring of violation of children's rights should be encouraged and commissioned to be carried out by the local, regional and international humanitarian and rehabilitation organisations. As clinicians, we must also affirm a commitment to protect people's rights, indeed rights of children.

Torture and rape

Many refugee children suffer appalling violence and have been tortured as part of collective punishments for whole communities, or as a means of extracting information from parents.[5] Some children throughout the world are exposed to physical, mental and emotional abuse and torture and suffer immeasurable pain. In some countries children are tortured as a form of punishment for their parents,

whilst in others children are as likely as adults to be captured, imprisoned and subject to torture. In some Asian, Latin American and African countries such as Congo or Rwanda, for the first time in history children have been imprisoned and are facing trial for genocide.[6] Child imprisonment and ill treatment is therefore an increasing concern.

Sexual violence is particularly common in these ethnic conflicts. In Afghanistan, Rwanda or the Balkans, girls suffered the added trauma of sexual abuse and rape, which can be the most intrusive memory that these girls carry into their adult lives.[5] In fighting in Bosnia and Herzegovina and Croatia, and indeed in Rwanda it has been deliberate policy to rape teenage girls and force them to bear "the enemy's child".[5] Moreover, in Rwanda rape has been systematically used as a weapon of ethnic cleansing to destroy community ties. In some raids, virtually every adolescent girl who survived an attack by the militia was subsequently raped.[7] Many of those who became pregnant were then ostracized by their own families and community; some abandoned their babies, some committed suicide, and some kept their enemy's child, at the expense of losing relationships with all other family members.

Many tortured children have lived in circumstances that most of us could never imagine. There are disturbing incidents, such as the one in the Renamo camps in Mozambique, where young boys, who themselves had been traumatized by violence, frequently inflicted sexual violence on young girls. Children should not be chained to a wall and be raped as these girls were. Even girls who are not forcibly raped may still be obliged to trade sexual favours for food, shelter or physical protection for themselves, their baby or younger siblings. The rise of sexually transmitted diseases, and particularly of HIV/AIDS, is therefore inevitable. One of the common factors contributing to the high rates of AIDS in Uganda is that some girls had to trade sex for security during the country's civil war.[8] Many of these girls suffer the consequence of such a torture to the end of their life, whenever that would be, given the lack of treatment.

Psychological impact

The Mental health of refugee children can be affected by experiences of loss, separation, stress and the psychological impact of an uncertain life.

The psychological impact of life in the host country i.e. UK, can be positive and negative. Positive because of the safety, food, shelter, education and new opportunities offered by UK life; and negative because of the stress of asylum application, social rejection (prejudice, racism and xenophobia lack of appropriate care, limitation in language and cultural environment and bullying).

Some consequences of psychological trauma would then include: Post-traumatic Stress (PTS), traumatic grief, psychosomatic illnesses, anger outbursts, academic difficulties, sleep disturbances, regressive symptoms i.e. bedwetting and chewing nails. The person experiences a traumatic event in which both of the following were present:

1. The person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror.

Possible measures for children's services and specifically rehabilitation centres

Children, most at risk of exposure to torture, include refugee and displaced children, child soldiers, children affected by armed conflict, street children, children in extreme poverty,

abandoned or unaccompanied children and children subjected to child labour. It therefore is possible to establish that there is need for study to identify gaps and to develop appropriate preventions in order to protect children at risk.

IRCT is contributing to the human rights of children and young people. It has been recognised that it is of great importance to meet the increased demand for appropriate campaigns, rehabilitation and prevention services with a wider competency based workforce. The organization need to recognise that alongside the development of expanded services there remains the need for solid core of skilled listening and highly specialised practitioners who are able to support, train and supervise others. Some long term measures to transform children's mental health and improve retention in mental health work could include:

- Secured Children's Centres and the Parent Child Project.
- Provision of supervision, consultation and training for workers to enhance early intervention.
- Tackling substantially recognised inequality by securing local government to commit to consider and accept lack of equality and address the need to enhance provision of services.

Increased knowledge of the situation leads to:

- Identification of status of ratification of relevant international treaties.
- Identification of implementation of international obligations.
- Identification of children at high risk to detention, ill-treatment and torture.
- Identification of perpetrators and reasons for torturing children in specific regions.
- Socio-economic circumstances that children are tortured.

Issues related to refugee children

We are far from a world without human rights abuses, impunity and torture. The experience of being the subject of torture is often a precursor to psychological distress and psychiatric illness for children. The pervading sense of not being wanted attacks the wellbeing and hope of a child. Especially those young people who live with endemic poverty, sadness, feeling lonely and uncertain, and helpless. Sometimes their relatives cannot help or they were psychologically not well enough to help, and some are simply cruel and abusive to the child themselves.

Refugee children suffer from war and other forms of persecution in their countries of origin. Yet refugee and migrant children continue to suffer human right abuses in countries of asylum especially if they are separated from parents and caregivers.

In the United States, Europe and some other western countries, the immigration services continue to detain a substantial proportion of children, "unaccompanied without parents."[9-11] In the States unaccompanied children are sometimes held in cells with juvenile offenders.[a]

Some refugee children that we work with in London feel that they receive inadequate support from social services, have problems

a) Provisions of the UN Convention relating to the Status of Refugees (Refugee Convention), the International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR), the Convention on the Rights of the Child (CRC), and the Convention Against Torture and Other Cruel, Inhuman or Degrading Forms of Treatment (CAT) all contain provision related to detention, including the use of detention generally, treatment of individuals in detention, the detention of children, the right to legal assistance for detained individuals, and judicial review of detention.

accessing health services and education and have serious concerns about being dispersed when they are 18; and many are subject to problems related to age disputes and detention.

The number of children and adolescents seeking asylum in the UK is rising and one in four people seeking asylum is a child. These vulnerable young people need protection and support. This now seems to be recognised as one of the main priorities of child services in the UK since the acceptance of the UN Convention on the Rights of the Child. But there are still serious shortcomings in the protection of refugee children. It seems that these shortcomings are largely down to lack of resources together with poor management and shortage of systematic research about key issues.

Defective conceptualization of refugees, in particular children, is due to inadequate empirical data and knowledge which leads to serious shortcomings in the protection of refugee children. Some reasons for this include: the influence of western psychological models which bring a lack of understanding across cultures and social contexts that these children come from. Effective policy requires sound theories and sound empirical data, not assumptions underlying western conventional practice. I maintain that the dominant idea of childhood as a universalized and (paradoxically) very individualized construct that is built on notions of vulnerability and incompetence has led to interventions that unintentionally undermine children's resilience and denigrate their capacity.

Many services for refugee children who endured massive trauma and atrocity are lead by stereotypical notions of social norms, values, dynamics and power structures. In order to avoid these stereotypes there is a need to contextualize projects and to give greater attention to ethnographic needs of children. This is to assure greater resiliency and sustainability and closer social and cultural adaptation for the people that we set our self to serve.

Refugee children have been exposed to stressors. They are exposed to stressors in their country of origin, flight to safety, during their asylum application and during the process of settlement and integration. Part of this is because children often leave their homes without any knowledge, sometimes without parents or personal belongings. They often do not have any cultural awareness of the environment to which they are fleeing and must overcome the hurdles of adapting to a new language and a new culture during which they live in deprived neighbourhoods with high levels of crime where they can suffer from acute discrimination.

The challenges are enormous. Children's traumatic experiences of war, torture, persecution and the flight from home countries can lead to a sense of constant fear. It is important to note that apart from the risks that all children and adolescents experience; refugee children who have been tortured have the added stress of having to live with distant relatives or foster families whilst taking on adult responsibilities. This can lead to problems with young refugee identities and education attainment which can lead to gaps in inter-generational understanding and disperse family cohesion possibly leading to delinquency, neglect and abuse which ultimately will add to community strain.

Many refugee children, although living in the west, find themselves in difficult situations that undermine their opportunities to grow up as happy, healthy, educated and responsible members of the community in which they live. Those that succeed are a tribute to the resilience, survival skills and hope demonstrated by their potential for adaptability.

The cultural issues incumbent on the refugee child can stem from a family's un-

derstanding of the therapeutic process. First there can be confusion over the parent's vs. an institution's assessment of a child's mental health. Following this, the family's demands and the cultural values are also threatened by the interview process. Language issues are also a problem. This is especially harmful when a child is used as an interpreter by parents, and professionals allow it. A child should not be used as an interpreter or intermediary between the professionals and the parents as this can distort a child's mental health.

Therapeutic intervention is justified by the child's suffering and impairment and is defined by what the child needs and not what the adults may project on the child. The therapist must remember that they know less than the child about the traumatic events and they must dare to ask frightening questions but avoid fascination. Moreover, the therapist must respect the child's pace but should not avoid painful subjects. However, during therapy it is important that the therapist remains aware of the fact that the child may be constructing a narrative in an attempt at describing the indescribable, that the relationship with the therapist may become the prototype for all relationships and that while neutrality is impossible, an excess of empathy can be toxic for therapeutic intervention.

The fragility of the situation therefore begs the need for a suitable framework and from a clinical point of view there are two main questions to be addressed in order to create such a guide. 1) If therapy is primarily aimed at the gentle exposure of one's worst fears, then what purchase can it have on this most ungentle process of a tortured child? 2) What is needed by those who have come finally to rest in some refuge to heal the wounds of external trauma due to torture and their environmental impingement?

Presentations and discussions of four cases referred to the RTC

Here I will briefly refer to a vulnerable young boy that I call Erik, to demonstrate a defensive form of dissociation.

Erik

Erik, a twelve year old boy from Africa was referred to RTC for assessment and possible therapy. The referrer indicated that Erik was unable to concentrate, extremely withdrawan and did not relate to others. He witnessed his father and brothers shot by officials. He also witnessed his mother and sister being raped, beaten and killed. He was forced from the age of eight to serve in the rebels' camp; beaten regularly and deprived of food and hygiene.

Erik's defence strategy was typical of the autistic withdrawal. He did not talk in therapy for a few months, although at times he became tearful in the sessions. Intensification of sharing his pain was too great for this young boy, indeed became challenging for me in countertransference. I so desperately wanted to help him, and so desperately wanted to work towards strengthening his ego, for both of us to survive the torture he endured. I communicated with him verbally, but I have always doubted whether I was able to convey to him a clearly defined meaning related to his experience. Having said all of this, I was very aware that I didn't know much about him, and that I had to be very careful not to give him the wrong impression that I was intending to explain his truth. His ongoing silences continued with tears session after session with no words, apart from greeting politely on his arrival and his leaving which became a regular exchange from his side (that how much he could relate and cope with). With gentle encouragement, I intended to contain an unprecipitous meaning schematic with projectuality that required his contribution with the

hope to become actual. My intention was to establish a meaning, and not merely confirm, reject or add something. Although he was silent for a long time, I kept talking to him and about him to find words that had meaningful connotations to his experience; he could then express his feelings about them, which would be the beginning of him building some level of resilience to relate to another human being without fears. However, Erik's regular attendance and his tears were confirming that he started gaining some level of relation to me. I assumed that having me as a "listening other" in his ongoing silence was helpful to him as he started to make eye contact. He was looking at me when I was talking to him about our relationship. I could observe his affects in his gaze. I was thinking and talking to him about his lack of response which demonstrates his fear of relating and being let down. Hence, part of him unconsciously at some level related to me by his gaze and tears, and indeed by his coming to every session.

For a tortured refugee child such as Erik, the stress of associating with his memory was too much to bear, so, although longing for relationship, he needed to dissociate himself from the past memory of torture. This types of dissociation is a very concrete and bodily one, which the psychic pain and symbolic representations are denied. Consequently there was no room for him to symbolise his relations with me as his therapist. The defining factor was the experience of reality and representation of reality, and the pain related to it, or lack of it. This is due to the fact that humanity has been denied for Erik as a refugee child who endured severe torture and the pain of losing his carers. As his own humanity has been denied the details of the sensation related to the traumatic experience and the images that could come to be a symbolic representation of the experience was blocked and denied to his conscious function, at least temporarily due to the fragmentation of his mind.

Erik's dissociation and consequent disintegration which occurred too frequently resulted in his total helplessness and hopelessness. He could not finish the disturbing memory of torture and trauma he endured, and he could not dissociate with the thought and memory of it either. As a result, his whole existing psychic structure was shattered by re-experiencing the trauma in a fragmented way which could go on for too long without finding direction. I hypothesise that regardless of intensity of the trauma, if Eric has not had a good enough object relation in his early developmental process, although he could dissociate, he will not be able to dissociate in a healthy manner and not be able to turn the attention to something else in positive way, i.e. coming to therapy regularly and cry without feeling under pressure that he has to talk.

Here, we can see that Erik's psyche in its defensive state may at times retreat into dissociation in general to deal with an unbearable situation. This happens because the child has broken confidence and reliance with the consistency and resilience of his core to deal with some of his experience or memory of it. It is as if his core self support systems, agency, continuity, cohesiveness, and affect were temporarily disconnected by dissociation during the actual trauma, when he was tortured and could not be reconnected without psychological disturbances. Despite this, there was an awareness that he has lost the familiar ground on which he stood before atrocities in his life. It has been a sad shift and move of his ordinary everyday life to horror which leads him into a kind of defence that restricts his ability to sublimate his experiences or to be creative. This is partly because memories experienced by him pose as thoughts, feelings, or images that do not reveal themselves as memories. They may at times come to mind, but seem

relatively meaningless. At other times they overwhelm his consciousness and lead him into a vividly remembered past. As he lost his resilience his memories could not emerge into consciousness clearly where there is enough psychic strength that can give him pause for thought.

A periodic, interrupted or broken up representation of a previous state of consciousness could lead him to an intense vivid moment of recollection, without him being able to form self-defining memories in which a previous state of consciousness may be reinstated, which is associated with awareness which unexpectedly place the consciousness in the past. They may cause feelings of revelation, recognition, confusion, and indeed trigger an intense sense of himself in the past. But, the important factor here is that this was not manageable for him. As he lost his resiliency due to being tortured he was not able to dissociate before getting to the state of fragmentation. He did not have the capacity to dissociate in this way which can lead to ego fragmentation. His feelings consequently lead to a state of disintegration, due to the fact that he could not dissociate himself from the memory of trauma and take his attention to another matter, neither was he able to stay with the memory and finish it.

In RTC we appreciate our role as a therapeutic service in the community or as an institution for people who have been institutionally persecuted. We realise that many refugee children come to us having lost their social network supports. Our clinical data from the last two years, April 2007-April 2009, shows:

- 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children and adolescents who have experienced trauma, 3 to 15% of girls and 1 to 6% of boys could easily be diagnosed with PTSD.
- 90% of sexually abused children presented with PTSD symptoms. 77% of children exposed to violence inflicted on their loved ones in their community also presented with symptoms of PTSD. 35% of refugee children who were exposed to community violence also presented with PTSD.
- These differences are shown to be related to the risk factors of the child and mainly associated with the severity of the traumatic event, parental reaction to the traumatic event and physical proximity to the traumatic event.

Considering that actual or threatened death, separation, loss of fundamental functions, irreversibility, universality and property of leaving things are main characteristics for PTSD.

Very young children (under 7) of refugees that we work with present with few PTSD symptoms, but present with generalized fears such as separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, disorganised attachment and over-dependency and preoccupation with words or symbols that may or may not be related to the trauma. Although young children of refugees do not present with major post-traumatic symptoms, they will display post-traumatic play in which they repeat themes of the trauma they have experienced in play or their drawing. In cases where help is not available, a child can lose an acquired developmental skill (such as toilet training, talking, walking) as a result of experiencing a traumatic event.

However, we observed that the developmental delay very much related to parents mental health or lack of it. This confirms the external vs internal traumas in the process of development. External events happen objectively and internal events happen subjectively.

Internal events are almost always triggered by an external event but the historical fact is negligible compared with the fantasy that it triggers, they are events that are synthesised by the psyche. Internal events can be distressing but don't have the traumatogenicity of external events with the building block being the signifier or representation.

Some events trigger emotions that a child enjoyed in the past which have been worked through and a link is made between the present event and the past i.e. a cuddle in earlier childhood by the loved one (mother or the primary carer).

The events which can not be linked with any previous positive experience can leave the child's psyche vulnerable and psychologically resourceless. Therefore child can not integrate the experience within the course of own internal world.

To capture the effect of torture on refugee children I am going to present the following case examples:

Aran

Aran was young, about seven, during the initial stages of ethnic cleansing in his country. The police in his village (from the majority ethnic group) had a station next to the village football pitch. Shooting the ball while the children were playing became a favourite pastime, with beatings of any child who protested.

When Aran was about ten, he and other children from their ethnic group were forbidden to go to school. His elder brother (intelligent and politically aware) had been warned not to attend any meetings. On his way to a meeting in defiance of this, he was shot dead and his body was kept in the street under guard in the midsummer heat for four days, after which the family were allowed to bring the body home. The stench was terrible, making the wake very difficult.

Meanwhile life was made increasingly difficult for the minority population. A curfew was imposed, young men were forced to fight in the army (most of whom were killed, so constant funerals), and sniper fire in the streets made it impossible to stand near windows or bring in supplies safely. Then the army arrived at their door.

Aran witnessed his sister and aunt being raped by at least fifteen soldiers. His older brother was rifle-butted in the face when he protested. The family had to leave the house, men and women were separated and the younger men removed.

The rest of the family escaped to a refugee camp in a neighbouring country where conditions were very bad with little food and extreme cold. Aran's uncle was very ill and could not help the family. Meanwhile Aran met other youngsters and decided to return with them to his village to dig up some valuable items the family had buried. The house was an unrecognisable burnt shell, though he found some money. Fighting prevented his return to the camp.

Aged fourteen, he joined the militia where he witnessed many further atrocities. At fifteen he came to this country in the back of a lorry.

When we first saw him at the Refugee Therapy Centre he was unable to sleep at night, suffering from frequent flashbacks and having suicidal thoughts and coming increasingly to the attention of the Youth Offending Team. Like many young people who have experienced violence, he would be very quick to act out aggressively, with little empathy for the person receiving it. During the two years he was in therapy here, he felt contained enough to talk about the events he had experienced, frequently gripping the sides of the chair with white knuckles.

As therapy progressed, his nightmare and flashbacks diminished and his sleeping improved, he stopped behaving aggressively

and did well at college. He was also able to contemplate the fact that he may never see his family again. Eventually he felt well enough to say that he could manage on his own, while assured that he would be welcomed back at any time if he felt he needed support.

Ivan

Ivan started attending the Refugee Therapy Centre at the age of fourteen, with a history of aggression and violence and an already lengthening criminal record of assaults and attacks in this country. He also could not sleep and suffered flashbacks. His level of communication was extremely poor.

Through therapy it became clear that, although he had arrived from a war zone using the usual refugee routes, he had been deeply traumatized by his family, in particular by a brutal father. From an early age he had virtually lived as a feral child, with food left out in the yard for him, and sleeping in the barn with animals or in a van.

Ivan never attended school and had to be educated alone in this country, due to continual conflicts with other children. Eighteen months after starting at the Refugee Therapy Centre he was able to attend college successfully, started a part-time job, developed empathy with others, and began to realise that no child should be treated as he had been. He also learned to handle difficult situations without resorting to violence, and has not been in trouble with the police again. He continued to do well and is now an articulate thoughtful young man with well-developed insight.

Misha

Misha started attending the Refugee Therapy Centre when he was ten, following a referral from his primary school teacher. He was presented as being deeply depressed and hard to engage. Through drawings we managed to get a picture of a pleasant early life in a lakeside African town which was suddenly interrupted by the arrival of militias at his school where some of the older boys were randomly selected, made to lie down in front of the others, after which their limbs were hacked off with machetes.

As the violence worsened his family fled, but Misha and his mother were captured by the militia. Whilst in captivity Misha was forced to shoot an older child and his mother was killed. Following a courageous rescue by his father, the remaining family eventually sought sanctuary in the United Kingdom.

Misha is starting to talk more, and is learning to cope with aggression at school, which he finds deeply traumatising. He is also learning to be more pro-active in searching out help from staff. Young people who have been traumatised by aggression and violence, though initially numb and unable to defend themselves, can frequently start acting aggressively at a later time. It is hoped that through therapy, discussing past events and associated feelings, and working on strategies for present-day difficulties, Misha will be able to further control unacceptable behaviour.

Conclusion

If children are to be helped to overcome highly stressful experiences they have endured, their views and perspectives need to be treated as a source of learning and strength, not weakness. We need to use children's negative experiences to create positive outcomes. It is important to acknowledge the painful, humiliating and profoundly debilitating experiences that many children suffer during periods of war, torture or other forms of political violence. It must also be recognised that the dominant discourse of vulnerability, sickness, crisis and loss has the potential for seriously undermining children's current wellbeing as well. The physiological experience of suffering undoubtedly has universal characteristics for

human beings that have a limited repertoire of responses to catastrophic experiences but different responses recur across cultures.

In assisting children who have been tortured, we, as campaigners and service providers need to have access to in-depth information about cultures, the nature of trauma endured, family dynamics and any special needs they may have. Most importantly, though often most overlooked, we must listen carefully to the child.

Our task as campaigners and service providers should drive us to include culturally and linguistically appropriate workers in the team; provide opportunity for children and adopt methods with philosophical and anthropological reorientation and adjustment to take into consideration the cultural and linguistic differences as well as different phases in children's lives. In addition to this, there is the situation whereby some children have considerably been impacted by torture or their time spent as child soldiers. It is also important for therapists to consider the role of words in treating trauma that comes from physical and bodily privation, and the indicators by which we can pick those whose resilience can carry them through.

We need to remember refugee children leave behind a home and become stateless and in many cases have lost their carer/s and everything familiar to them. They often have either been victims of or witness to violence, torture, rape and murder of loved ones. Some watched their homes being razed to ground and suffered pain and physical damage at the hands of perpetuators. They may have walked hundreds of miles seeking a passage to safety. Many may come with physical and psychological scars that run deep. And we know the wounds of the recent past re-stimulate the wounds from long past.

Effects on the family can be destructive. Often there must be an adjustment in the role division between refugee partners and parent-child relations which can lead to a gap in communication. Indeed, refugee parents may, more than a child, feel socially isolated and distant from their familiar environments which can have adverse impact on the relationship with the child, creating risk of identity confusion. This can limit flexibility of a child to adjust to a new environment.

The development of an effective policy requires sound theories and sound empirical data, not assumptions underlying western conventional practice. There are many shortcomings in the protection of refugee children who have suffered torture and who have had their basic human rights violated. Some of these shortcomings, in our experience, are:

- Lack of resources, which brings with it poor management.
- Shortage of systematic research about key issues.
- The influence of western psychological models which can result in a lack of understanding across cultures and social contexts, which affects policies results in refugee children living in questionable circumstances.
- Defective conceptualization of refugee children, due to inadequate empirical data and knowledge.

I maintain that the dominant idea of childhood as a universalized and (paradoxically) very individualized construct, that is built on notions of vulnerability and incompetence has led to interventions that, unintentionally, undermine refugee children.

We are at RTC constantly seeking to employ ideas in our interventions that respect differences. We are proud to move away from western psychosocial interventions at an individual level and to run projects based on the feedback we receive from the people that

we set ourselves to serve. We focus on social reconstruction, social reconciliation and healing. We work with families and communities in an effort to restore social structures and a sense of normality. Our service is not lead by stereotypical notions of social norms, values, dynamics and power structures. We focus on the need to contextualize projects and to give greater attention to ethnographic needs. This assures greater resilience and sustainability and closer social and cultural adaptation for the community that we set our self to serve. Our approach is sometimes criticised to be imprecision and lacking a firm, quantified data of impacts. This is mostly coming from people or services who do not have knowledge of our work and the outcome of our intervention. Contrary to this view, our very existence and our practice is based on evidence and assessments of need. Arguing for a view of children as at least potentially resourceful is not to sanction their exposure to adversity, nor to deny that some children may be rendered very vulnerable. This approach questions normative ideas about childhood weakness and considers whether a focus on children's vulnerabilities really is the most effective way of supporting self-esteem and self-efficacy in adverse environments. The practical value of an understanding of children as resourceful is that it builds on children's strengths, rather than emphasizing their ill-health, vulnerability, weakness and dependency. The physiological experience of torture undoubtedly has universal characteristics for children who have a limited repertoire of responses to catastrophic experiences and a number of responses recur across cultures.

In summary, it is important to develop strategies to prevent torture inflicted on children around the world. While we are working towards that, in our job which is assisting refugee children who survived torture and human right violations, we, as service providers need to have access to in-depth information about refugee children's cultural environment, the nature of trauma they have endured, family dynamics and their special needs.

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Physical forensic signs of sexual torture in children

A guideline for non specialized medical examiners

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Abstract

Proper forensic documentation of sexual torture in children is crucial. Informed consent for examination and documentation must be sought from the child/accompanying person and the examination conducted in a sensitive and respectful manner. Time should be given to the child to relate the history of torture and the examiner should start with open ended questions. The history of torture should be recorded verbatim as much as possible.

The words used to describe the anatomy and the forensic findings have to be precisely defined.

The child should be examined from head to toe and should be left partially clothed.

Penile, digital or object penetration of the vagina does not always lead to injuries even if the child is seen very soon after the abuse. Genital injuries heal rapidly and can leave no scars.

Penile, digital or object penetration of the anus does not always lead to injuries even if the child is seen very soon after the abuse.

Sexual torture cannot be disproved by the absence of injuries or scars.

Keywords: sexual torture, forensic examination, children, hymen injuries, anal injuries

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Primum non nocere: first do not harm. The principle of avoiding to do harm (non maleficence) is one of the principal precepts of medicine. It is better to do nothing than to do something that risks causing more harm than good. Physical forensic examination of sexually tortured children should be conducted with extreme care by experienced health care professionals in order to avoid retraumatization of the child. However, medical personnel not specialized in forensic medicine could, due to their work, be expected to carry on examinations on sexually abused and tortured children. This article is intended to be a guideline to carry out examinations in this situation

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Torture, in the context of human rights law, is the deliberate infliction of physical or psychological pain in custody or under the control of a state agent, or by a non state agent acting in an organized group (such as a rebel group), including organized violence which the state is either unwilling or unable to control.[1] Torture is used to discourage dissent and to demonstrate power. This is particularly true of sexual torture. The purpose of sexual torture is to humiliate the victim and intimidate others. Sexual torture encompasses any unwanted sexual activity as

well as deliberate infliction of physical pain to the genitals. Sexual tactics used by female interrogators towards male detainees have been described also as sexual torture, for example in Guantanamo,[2] as well as the severe sexual humiliations of detainees in places like Abu Graib.[3]

Despite all the complications children face before coming forward with complaints, many reports of sexual torture, from countries all over the world, have reached the international community in the past decade. Unfortunately, the children were able to prove their case in only a few instances.[4]

The knowledge of what physical signs can be expected in child victims of sexual assault and proper forensic documentation are crucial. Even if physical signs of sexual torture are rare in children and adults, it is essential to be able to document them properly.

In this article a child will be defined as "every human being below the age of 18 unless under the law applicable to the child, majority is attained earlier" according to the Convention on the Rights of the Child.[5]

It is essential that the examination is carried out in a sensitive way. The process should be carefully planned, conducted by someone with expertise and directed at healing.[6]

Respect/confidentiality/consent

The child and the person accompanying the child (if there is any) must be treated at all times with empathy. The examiner should keep in mind that the examination might be felt as extremely embarrassing and should do his best to put the child and the accompanying person at ease. If an interpreter is necessary, it should ideally be an authorized interpreter who is conscious that this kind of examination is very difficult and sensitive. In any case, the interpreter should be briefed before the examination to make sure he/she understands the situation and his/her role. Take into account the fact that the interpreter and the victim could have different cultural attitudes towards sexuality and sexual abuse than yours. The examination shouldn't be done in a rush and should be conducted in a place where no one can enter without the permission of the examiner.

The examiner should express himself/herself in a language understandable by lay people and when addressing the child should do so in a language appropriate to the age of the child.

The utmost respect should be demonstrated to the child and accompanying person, which means also that the decisions of the child and/or accompanying person should be respected. The child should never be forced to undergo an examination.

The forensic examiner must first introduce himself or herself and explain clearly what is the purpose of the examination, and what could be the possible advantages and the possible disadvantages of the examination. The issue of confidentiality should also be explained clearly. As a forensic examination is part of an investigation or might contribute later on to a court case, it is important that the accompanying person and the child (depending on its age) are informed of what use might be made of the notes, or of the eventual body diagrams or photographs taken during the examination.

It is essential that the child (depending on his age) and /or the accompanying person give his/her informed consent to the examination.

Valid consent is a consent that is freely given, without fear, duress, or fraud and is appropriately informed. The child/accompanying person needs to be competent to receive information about the examination and

able to weigh that information and come to a rational decision.

Note that acquiescence in circumstances where the person does not know what the intervention entails is not the same as consent.[7]

Taking the history

Interview of children about sexual assault is a task for highly specialized professionals and is usually videotaped in developed countries.

A history from the child should be taken through free recall without prompts or direct questions and with a non judgmental approach.[8] Time must be given to the child to express what has happened to him/her. Remember that children might not know their body well, especially the genitalia. Most prepubertal children don't know or have no clear idea about what is a sexual act; they can for instance mistake touching or attempted penetration with penetration. Younger children often describe ejaculate as pee. It can be very difficult for a child to describe exactly what happened. Sexually inexperienced teenagers might also be unsure if penetration happened.

Children can feel guilty or ashamed about the abuse, it is important that the examiner stresses that other children too have difficulties to talk about what happened to them.

It is important to remember that if the child is questioned repeatedly the examination's validity deteriorates.

Important points for interviewing children.

- Interview the child alone (if age permits) in a safe environment, comfortable for the child.
- Establish rapport with the child (ask name, age, name of siblings …).
- Show a diagram to the child and ask to identify body parts: hair, eyes, nose, private parts, anus …
- Use the words used by the child for the body parts (for example penis can be named as "pee pee" by a child).
- Start with open ended questions: did something happen to you?
- Avoid questions that contain the answer in the question.
- Avoid questions that can be answered by yes or no.
- Use more focused questions if needed: did someone touch your private parts?
- Where were you?
- Who did it?
- Did the assailant say anything?
- How did you feel? (it is important to record also the emotional feeling of the child, for instance: "dirty, ashamed …")
- How did your private parts feel? (it is important to know about bleeding, soreness …).
- How did it feel after: ask about dysuria, constipation, possible signs of sexually transmitted infections (ulcers, warts, discharge ...).
- Depending on assault: ask about the penis of the assailant: where did it go? Anything came out of it? Who cleaned it up? With what? How was the taste of the semen?
- How many times did it happen? Was it always the same assailant? Was a condom used, any lubricant (saliva, cream, gel …)? Was an object used?
- Any witness?
- What were you wearing?

Make sure that the child understands each question and can give consistent answers to similar questions posed in different ways.

Obtain menstrual history, obstetric history. For older children ask if they are sexually active, if they use tampons.[9]

Document thoroughly the history, verbatim (i.e. in precisely the same words than the speaker) as much as possible.

If another child or other children are involved, interview them *separately.*

Examination

The child should be examined from head to toe progressively. Ask the child or the accompanying person (depending on the age of the child) to undress the upper body, then once the upper body has been examined, the child can put its top back on and the examination can proceed with the lower body.

It is important to reassure the child and tell him/her that part of the examination is to make sure that he/she is alright "down below".

Record the stage of development of the child using the Tanner scale (a stage of puberty based on the growth of pubic hair in both sexes, the development of the genitalia in boys, and the development of the breasts in girls).

All injuries (recent or old) should be clearly recorded on a body diagram, and described by their localization, symmetry, shape, size, color and surface (e.g. scaly, crusty, ulcerating) as well as their demarcation and level in relation to the surrounding skin. Sexual torture is not only about penetration but is also about violence, kicking, burning etc. Photography is essential whenever possible.[10] If photographs are taken, remember to use a scale. If a colposcope is available and the examiner is competent in the use of a colposcope, it can be used to take pictures or videos of the external genitalia.

It is important that the examiner is clear about the definition of the terms he/she uses.

Definition of terms

- *Erythema:* abnormal redness of the skin resulting from dilation of blood vessels (as in sunburn or inflammation).
- *Oedema:* swelling from excessive accumulation of watery fluid in cells, tissues, or serous cavities.[11]
- *Bruise:* discoloration of the skin due to an extravasation of blood into the underlying tissues.
  To be noted: Ageing of the bruises: scientific evidence concludes that we cannot accurately age a bruise from clinical assessment or from a photograph. Any clinician who offers a definitive estimate of the age of a bruise in a child by assessment with the naked eye is doing so without adequate published evidence.[12]
- *Abrasion:* an abrasion is a superficial injury to the skin or mucous membranes. In lay terms an abrasion is known as a "scratch" or a "graze".
- *Laceration:* in a laceration the full thickness of the skin is penetrated. It is known as a "tear". A laceration is caused by blunt impact in opposition to incisions that are caused by sharp objects (see below). In general, lacerations will occur following application of force to skin overlying a firm base.[13] However, if the force is great, such as may occur from a fall from a great height, then any skin may tear. Overstretching of the genital and anal skin/mucosa may also produce a laceration.
  The characteristic features of a laceration are ragged wound edges, irregular, bruised and abraded wound margins, and tissue bridges within the wound bruising to the skin margins as well as some abrasion (nerves or blood vessels that have not been transected). Where the skin is hairy then hair may be present within the wound. Skin flaps may also have

been formed. It should be noted that genital and anal lacerations caused by overstretching usually do not have these characteristic features.

- *Incised wounds:* These are caused by sharp cutting instruments such as knives, glass and scissors. They differ from lacerations in that the edges are cleanly divided and bleeding is often profuse. The skin margins are usually unbruised and free of damage. Cut hairs may be visible. There are two types of incised wound:
  Slash wound – this is defined as an incised wound that is longer than it is deep. It may be deeper at its entry point and the wound edges may gape.
  Stab wound – this is defined as an incised wound that is deeper than it is wide. It may be extremely difficult for the examiner to determine how deep a stab wound is.[14]

The clinician should remember that *the examination of most children with substantial sexual abuse is normal.*

Abnormal examinations are more likely if bleeding or pain occurred during the assault. It is important to exclude other causes of bleeding like menstruation.

1. Hymenal and other female genital injuries

The positions used for examining a girl are: the supine position with separation technique and traction technique and the knee chest position.

- In the supine position the child is lying on her back with her knees bent, it could be described as doing the "frog" to children.
- In the supine separation technique, the labia are separated with the tips of the fingers in a lateral and downward position until the vestibule and hymen are exposed.
- The supine traction technique is useful if the edge of the hymen cannot be seen well in the supine separation technique. In the supine traction technique, the examiner grasps the lower portion of the labia majora between the thumb and index finger and gently but firmly pulls outward and slightly upward.
- The knee chest position: the child rests her head on her folded arms, her abdomen is sagging downward, and her knees are bent 15 to 20 cm apart with her buttocks in the air. It could be described as "doing the rabbit" to children. The examiner then presses a thumb outward on the leading edge of the gluteus maximus.15 Access to a good light source is essential.

Proper anatomical terms must be used to record the findings
See adult sexually active genitalia, Figure 1.

- Vulva – the external portion of the female genital organs. It includes labia majora, labia minora, vestibule, clitoris, urethral opening, vaginal opening, fossa navicularis and fourchette.

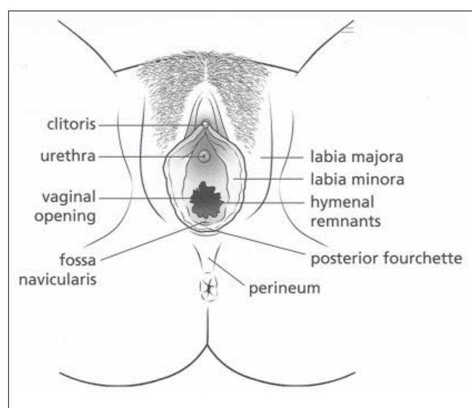

Figure 1. *Adult/sexually active external genetialia.*

- Labia Majorae – the two large, hair bearing, fleshy lips or folds of skin that form the outer boundaries of the vulva.
- Labia Minorae – the two thinner non-hair bearing folds of skin or small lips that lie inside the labia majorae and surround the vestibule.
- Clitoris – the small protrusion enclosed by the labia minorae, which is erectile and sensitive to stimulation.
- Vestibule – the cleft between the labia minora that contains the opening of the vagina and the urethra.
- Fossa Navicularis – the shallow depression in the vestibule between the vaginal orifice and the posterior vaginal fourchette.
- Fourchette (Posterior) – the area beneath the vaginal opening where the labia minorae meet.
- Hymen: collar of tissue around the vaginal orifice
- Urethra – the connecting tube to the bladder.
- Mons pubis: the fatty tissue lying above the pubic bone of adult women, anterior to the symphysis pubis.

Hymenal injuries
The 3 most common hymen configurations are (see Figures):

– crescentic hymen, see Figure 2
– annular hymen, see Figure 3
– redundant = fimbriated hymen, see Figure 4.

Less frequent configurations are sleeve like hymen, microperfortae hymen, imperforate hymen.

Adult sexually active women will have hymenal remnants (see Figure 1).

Again, it is very important to be very precise in the description of the hymen, this

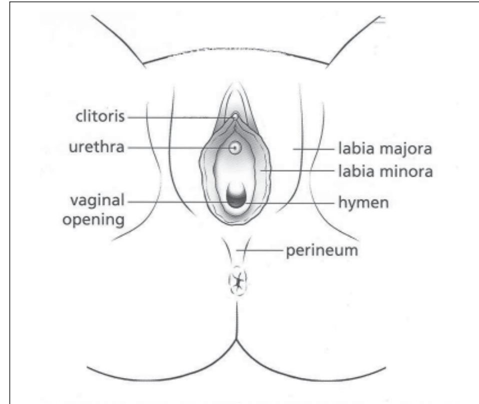

Figure 2. *Crescentic hymen.*

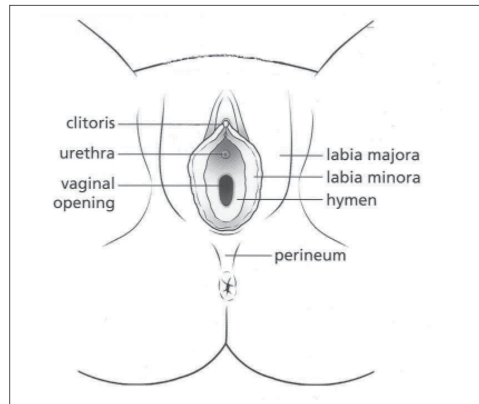

Figure 3. *Annular hymen.*

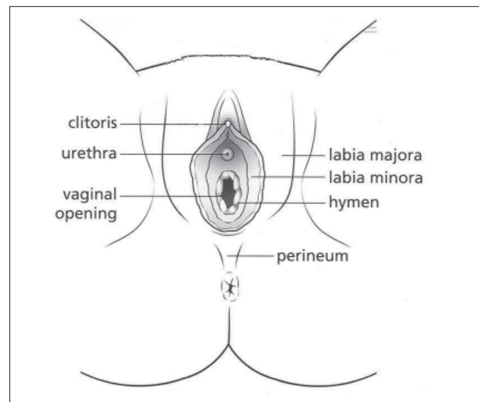

Figure 4. *Fimbriated (redundant) hymen.*

is why using clearly defined terms is very helpful. Definition of terms:

- A partial disruption of the hymen (not complete to the base of the hymen) is called a laceration if acute and a notch if non acute.
- A complete disruption of the hymen (to the base of the hymen) is called a laceration if acute and a transection if non acute.

It is usual to refer to an imaginary clock face when describing the findings on the hymen. The 12 o' clock position is always located immediately under the mons pubis and the 6 o'clock position is towards the coccyx regardless whether the child is lying on her back or on her front.[16]

- *Hymenal transection* are seen in a small proportion of prepubertal and pubertal girls with alleged vaginal penetration.
  To be noted: the absence of hymenal transection, even soon after the event, is not a proof that that penetrative abuse (including penile penetration) did not happen.
- *Notches on the hymen.* Where deep notches can be clearly visualized, penetrative injuries should be considered. Bumps, superficial notches are seen in newborns and non abused girls, suggesting that they are normal variants.
- *Posterior hymenal rim:* an absent or "narrow" posterior hymenal rim should be confirmed in the knee chest position in the prepubertal girl. Penetrative abuse must be considered in a prepubertal girl if there is complete absence or almost complete abscence of posterior hymenal tissue.
- *Size of the hymenal orifice.* Measurement of the hymenal orifice is not recommended. The diameter of the hymenal orifice is not a reliable marker of sexual abuse in prepubertal and pubertal girls.

To be noted: hymenal injuries heal rapidly and except for extensive injuries can leave no trace.

Lacerations to the posterior fourchette/ fossa navicularis

- Laceration to the posterior fourchette or fossa navicularis (see Figure 1 for anatomy).
- Posterior fourchette/fossa navicularis lacerations have been reported in prepubertal girls with a history of vaginal penetration, they have not been reported in girls selected for non-abuse.
- In pubertal girls, posterior fourchette/ fossa navicularis lacerations are seen in a large proportion of girls alleging penile penetration if examined within 72 hours after the abuse. Laceration of the posterior fourchette have been reported more frequently than laceration to the hymen.

To be noted: the absence of laceration to the posterior fourchette/fossa navicularis is not a proof that the alleged abuse did not take place.

Scars

Scars from hymenal transection, lacerations and tears to the posterior fourchette can persist but may be difficult to detect. Be careful not to mistake linea vestibularis for scar tissue (linea vestibularis is a white *linear* structure in the mid-posterior vestibule and is a normal anatomic variant).[17]

Genital abrasions and bruising

Genital abrasions and bruising have been reported in sexually abused girls soon after the event but can have many other causes or be absent even soon after the event.

Genital injuries tend to heal very quickly and often without leaving any trace or scarring.

The absence of genital abrasions and bruising doesn't disprove the allegation of sexual abuse in pre pubertal or pubertal girls.

Medical conditions

Lichen sclerosus, vulvitis and the use of steroid creams can be the cause of slight bleeding or superficial breakdown of the skin. Behcet disease could be responsible for genital ulcerations. Genital discoloration can be due to vitiligo. Cyst, tumors can also be present in the genital area.

Clinicians should note any predisposing conditions of the skin.

2. Anal injuries

The anus is examined with the child in lateral recumbent position/left lateral position (child lying on the left side with the right thigh and knee drawn up) or supine (holding knees to the abdomen/chest).[18] The imaginary clock face (see above) will be used to record the position of the injuries.

Anal fissures

Anal fissure can be the seen in anal assault, but it is important to exclude other causes of anal fissures such as passage of a large hard stool or constipation.

Anal lacerations

Definition of anal laceration: fissure more than 1cm in length migrating further from the anal margin.

Anal lacerations are associated with acute anal assault.

Anal skin tags

Anal skin tags have been seen in non abused children, but only in the midline.

Anal skin tags both in the midline and outside the midline have been reported in cases of anal abuse.

Anal scars

Good evidence suggest that anal scars are associated with anal abuse.[19]

Reflex Anal Dilation (RAD)

The examiner gently separate the buttocks and determine the degree of anal dilation. RAD refers to the dynamic action of the opening of the anus due to the relaxation of the external and internal sphincter muscles with the application of minimal buttock traction.[20] The anus is usually closed initially then opens, then closes again over a period of several seconds. Observation of the anus should be maintained for 30 seconds.

The examiner approximates the maximum diameter in the transverse plan, records if the rectum is visible, is there presence of stool or not, and records also the examination position and the duration of the examination.[18]

The presence or absence of stool in the rectum is not known to affect the significance of the finding of RAD.

If RAD is seen, sexual abuse should always be considered.

Anal laxity or reduced anal tone

Anal laxity is different from RAD. The anus dilates with the application of minimal buttock traction and stays dilated.

The diameter of the opening doesn't change during inspection. Possible causes include neuropathic bowel problems and myotonic dystrophy.

Anal laxity has been described in anally abused children but has also been reported in other circumstances.

Anal gaping

Anal gaping is different from RAD. The anus

is open on separation of the buttocks such that a view into the anal canal or rectum is possible and remains so for the duration of the examination in a fixed or constant way. Anal gaping may be seen in general anesthesia, with the use of relaxant drugs and is a post mortem finding.

The anus can be open to a variable degree due to severe or chronic constipation.

Anal/perianal bruising

Anal/perianal bruising has been reported following anal abuse. There are many other causes of bruising which should also be considered.[19]

The absence of anal injuries is no proof that anal assault (even penile penetrative assault) did not take place.

3. Testing

Forensic samples

The collection of forensic samples to search for cellular material or semen from which the DNA of the perpetrator(s) can be extracted should be considered if such facilities exist.

The persistence of semen or other cellular material is:

- Up to 48 hours on the skin or hair.
- Up to 48 hours in the mouth.
- Up to 72 hours in the vagina of a prepubertal girl.
- Up to 7 days in a pubertal girl.
- Up to 72 hours in the anal canal.

Sexually Transmitted Infections (STI) testing

Always consider testing for sexually transmitted diseases, no matter how long after the alleged assault. Depending on the cases:

- Culture for *Neissera gonorrhoeae* (vulval, vaginal, meatal, urethral, rectal, pharyngeal swabs depending on case).
- Nucleid acid amplification tests (NAATs) for *Chlamydia trachomatis* (vulval, vaginal, rectal, pharyngeal swabs or urine sample depending on case).
- In case of genital ulcer or blister:
  – swab for herpes simplex virus culture or PCR
  – dark ground microscopy for *Treponema pallidum*
  – swab for bacterial culture.
- If vaginal discharge: microscopy/culture for *Trichomonas vaginalis,* Candida, bacterial vaginosis
- Blood testing for HIV, hepatitis B and C, syphilis.

If the STI testing is done as a part of medico-legal proceedings, there should be a chain of evidence for the samples taken.

Conclusion

Thorough, patient and considerate examination is a requirement for proper forensic documentation of sexual torture in children. Acute signs of trauma may disappear quickly.

The absence of genital or anal signs does not exclude the possibility that penile, digital or object penetration did occur.

The drawings are published with courtesy of the Haven Paddington in London, UK

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Weeping in silence: the secret sham of torture among Palestinian children

Abdel Hamid Afana, PhD*

"I saw the Israeli soldier standing next to the shop. I looked for my mum and then he shot me. One bullet on my hand and another one went through my back and out through my stomach" S. a young girl was recovered from her wounds at a Gaza hospital.[1]

The torture of children is one of the world's secrete and embarrassing scandals pleading for actions to be enforced at the national and international levels. Most of tortured children suffer in silence, scared to tell their stories and their perpetrators the same institutions that are expected to protect them and promote their safety and wellbeing. Despite the absolute prohibition of torture under any circumstances, torture among children has become visible in almost every continent.[2] This is a horrific and gloomy future for many children in different parts of the world.

From the nasty detention places in India, to street children in Brazil, Chile and Argentina;[3] from Guatemala,[4] the Philippines, Nepal, Congo, and Iraq to Palestine, children are deliberately targeted, interrogated, and detained by military services.[5, 6] It is really unfortunate that most countries where children are tortured have signed the international conventions of children's rights. Different international and national organizations across the globe have drawn attention of policy makers, mental health professionals and government officials to torture practices committed against children world wide, including Palestinian children.

As indicated in Amnesty International report 2000,[2] children are tortured for various reasons. Some are deliberately tortured in police stations, detention camps and the armed forces. They are targeted for various reasons such as political activism or alleged participation in political struggle, social marginalization, identity and belief and other unjustified reasons.

The main objective of this paper is not to analyze torture and its individual, family and community consequences, nor to emphasize the devastating political and inhuman situations surrounding the Palestinians in general and Palestinian children in particular. The aim of this paper is to highlight the tip of the iceberg around torture and its negative consequences encountered by Palestinian children born and living in protracted political violence, witnessing indiscriminate killings, torture, house demolition, and atrocities committed against themselves, their own family and peers. The impact of these events has affected every aspect of Palestinian life and leaves traces and deep scars

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in the social and economic fabric, in the political and family structures, and also at the individual level. Torture practiced against Palestinian children has raised questions about the injustice and unfair application of International Conventions of Child's rights and UN Conventions Against Torture in the Palestinian context.

The course of developing human rights is established through the presence of social justice, equity, community development and social change, the right to live in peace, dignity and integrity, and not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment (CIDT). These are not only non-degradable in time of wars and emergency; they are also ensured without any restrictions whatsoever.[7] Torture is prohibited and is illegal under any circumstances.

Torture represents an extreme kind of trauma and human rights violation in which the perpetrator actively seeks not only to threaten the victim and extract a confession but also to dehumanize, control, humiliate, and oppress individuals. Despite international efforts to prevent torture, however, such extreme forms of abuse have been practiced by many countries. The 11 September 2001 was a turning point in indirectly increasing torture practices when many countries adopted the so called "war on terror" using the slogan of "protecting public security" providing pseudo justifications to use torture. But, in reality torture is used as a tool for repressing political oppositions and it is used as a means of instilling fear in the community and society at large, which is indeed a great obstacle to community and democratic development.[8]

In 1992, Amnesty International indicated that systematic torture took place in around 90 nations or countries. It is striking to look at Amnesty report a few years later to find the number of known countries practicing torture is steadily increasing to reach more than 160 countries practicing torture as a tool of political repression and extraction of confession and information.[9] It is even worse with the secret detention and prisons. It is really unfortunate that torture has been practiced by countries that guard, protect and promote human rights. This has created a bad model of culture followed by countries that secretly practice torture.

Torture as described in Article 1 of UNCAT, is defined as "any act which consists of the intentional infliction of severe pain or suffering [both physical and/or psychological] involving a public official [directly or indirectly at the instigation or consent or with the acquiescence of public official or another person acting in an official capacity], and for a specific purpose [extracting a confession or information, punishment, intimidation discrimination]". It is a very serious and evil violation of human rights, personal integrity and dignity, where perpetrators assume a situation of powerlessness of the victim, which usually means deprivation of personal liberty or a similar situation of direct factual power and control by one person over another.

Palestinians, particularly children, are people who have never felt safe and secure even before the 1967 Israeli occupation of the West Bank and Gaza Strip. Since 1948 Palestinians have experienced oppression, multiple, repetitive and continuous exposure to traumatic experiences, social exclusion, repression and related socioeconomic and political problems. Palestinians describe the 1948 as "Al Nakbah" (catastrophe). It is imprinted in the collective consciousness of Palestinian children across generations. It represents the loss of the homeland, the livelihood, and political power. It also represents the disintegration of society, the frustration

of national aspiration and the beginning of a rapid process of destruction of Palestinian culture. Al Nakbah is the moment when the majority of Palestinians became homeless, a state that is associated with a deep sense of insecurity and memories of loss, where the house key of the symbol of the former home. The return to their homeland has become the dream that transmits from one generation to another and souls are connected to land.[10]

Palestinians' quality of life, children in particular, is poor, and their daily lives are constantly threatened by daily traumatic events. Moving between Palestinian towns means crossing checkpoints, which requires permits that are often rejected. Treatment by the Israeli solders at the checkpoints is often "cruel and degrading". Further, the closing of borders between the Occupied Palestinian Territories and Israel, sometimes for many months, has caused serious consequences for Palestinians, who cannot enter or exit at all during these periods, with devastating results: denial of livelihood for the majority of the population and resulting skyrocketing unemployment. Absence of freedom of movement makes it a prison-like atmosphere.

Since Hamas took over the Gaza Strip in 2006, Israel has maintained a strict siege, with people and goods allowed in or out only for essential humanitarian purposes. The effects of the siege on economic and social conditions in Gaza have been devastating. There is a great shortage of fuel and cooking gas, and power cuts are frequent, putting the health of the entire population in danger.

According to the UN, studies done in the Gaza Strip in 2008 showed that children have high levels of distress and fears. Children were highly exposed to traumatic events, such as witnessing a relative being killed, seeing mutilated bodies, and having homes demolished or damaged. These studies also reported several psychosocial problems, including behavioural problems, fears, speech difficulties, anxiety, anger, sleeping difficulties, lack of concentration at school, and difficulties in completing homework.[110]

The Israeli military invasions in December 2008 to January 2009 of the Gaza Strip severely intensified this pre-existing humanitarian crisis. In less than three weeks, around 1,414 Palestinians were killed in the Gaza Strip, of whom 313 were children under the age of 18 years. Many others were left physically disabled by the unbalanced Israeli war against Palestinians in the Gaza Strip.[1, 12] As indicated by Jesoor organization, which is one of the local organizations in the Gaza Strip that deal with trauma and torture victims in the Gaza Strip, masses of children are suffering from trauma reaction symptoms, which requires a holistic mental health intervention in order to help Palestinian children and their families to recover and cope with their traumatic events and dramatic stories.[13]

One of the tragic stories reported by Al-Hag,[14] a Palestinian human rights organization, during the Israeli incursion to the Gaza Strip in January 2009, is Samouni's family in the Al Zaytoun neighborhood of Gaza City. Sixty family members, including the grandfather, grandmother and their children, in addition to other family members were trapped in a house belonging to one of the Samouni family members. The house was bombarded by the Israeli Defense Forces leaving dead bodies and wounded persons, including children, without medical help. Some risked their lives carrying a dozen of dead bodies outside the house. Thirteen family members who were alive, eight of them children, were forced to live

with dead bodies for three days without access to medical care, food, water and electricity. The Red Cross and other humanitarian agencies were denied access to help the wounded and evacuate children and others who were alive. The tragic story ended with 26 family members killed, among them 10 children, while those who survived still carry the anguish of being with dead bodies of their beloved ones.

Since the Israeli occupation of Palestinian territories in 1967, the torture and cruel, inhuman and degrading treatment of Palestinian prisoners has been widespread and part of the official policy of the Israeli army and security apparatuses. It was reported by the Palestinian Center for Human Rights11 from the year 1967 up to 1988; more than 600,000 Palestinians were held in Israeli jail for various periods of time ranging from one week to a life sentence in jail. During the first Intifada, from 1987 to 1994, around 175,000 Palestinians, including children under the age of 18 years, were arrested by Israel Forces.

The degree and forms of torture practiced against Palestinians in Israeli detention and jails have varied throughout the years, but the policy of torture has been systematic and legitimized by Israel's judicial system and government. The Landau Commission claimed to restrict the use of torture, but approved the use of "moderate" physical pressure and "non-violent psychological pressure" during the interrogation of Palestinian detainees.[15]

It is worth pointing out that violations regarding the detention and torture of Palestinians do not distinguish between males or females, nor do they distinguish between adults and children. These methods, including the means and forms of torture, detention and interrogation conditions, court procedures and applicable laws, and the way in which prisoners are treated, apply to all Palestinians. As reported by the Defense of Children International/Palestine Section,[16] at the end of October 2007, there were approximately 319 Palestinian children from the Occupied Palestinian Territories in Israeli custody. These children were either under arrest and being held for interrogation purposes, had been charged with offences under Israeli military law and were awaiting trial or sentence, or were serving terms of imprisonment inside Israeli prisons. Palestinian child prisoners are detained in cells with adult criminal prisoners, often in situations where there are real threats to their lives, causing the children to live with an increased level of anxiety and psychological stress due to the physical and verbal threats that they are subject to by these criminal prisoners.

B'Tselem,[17] which is an Israeli Information Centre for Human Rights in the Occupied Territories, published a report containing testimonies, some of these are video taped, of children less than 18 years old who were arrested between October 2000 and January 2001 on suspicion of them throwing stones. In most cases, they were arrested in their homes in the middle of the night, taken to a police station and tortured by police interrogators until the following morning. The objective of the police was to obtain information about the activities of other children and other activists in their neighborhood. The methods of torture used, as described in the report, includes forcing the minors to stand in painful positions for prolonged periods, beating the minors severely for many hours, at times with the use of various objects, splashing cold water on the detainees in the facility's courtyard in wintry conditions, pushing the minor's head into the toilet bowl and flushing the toilet, making death threats, cursing and degrading the minors.

B'Tselem, reported that 1,588 Palestinian children under the age of 16 to 18 years were in custody of the Israeli Security Forces in 2009 compared to 3,806 children in 2008. The children were detained or sentenced and/or administratively detained. Table 1 gives some statistics on Palestinian minors detained by the Israeli Defense Forces (IDF). Table 2 highlights the number of Palestinian minors who were detained by the Israeli Prison Facilities (IPF) and IDF in 2009. The table also describes the age, day of detention and type of detention used against the Palestinian minors.

Administrative detention is a detention of persons by a state without trial or charge, usually the claimed reasons for the arrest is security reasons. This practice has been criticized by human rights organizations as a breach of civil and political rights of people. As indicated by the DCI/PS[16] and B'Tselem,[18] Israeli Military Order 1229 of 1988 empowers military commanders to detain Palestinians, including chil-

Table 1. *Palestinian minors detained by IDF in 2007.*

Month	Date of statistics	Under age 16	Age 16-18	Total
December	31.12.07	0	4	4
November	26.11.07	0	18	18
October	28.10.07	0	20	20
September	24.9.07	0	11	11
August	12.8.07	0	5	5
July	18.7.07	0	2	2
June	18.6.07	0	4	4
May	13.5.07	0	5	5
April	10.4.07	0	9	9
March	4.3.07	0	12	12
January	3.1.07	0	8	8
Grand Total				98

Source: www.btselem.org/english/Statistics/Minors_in_IDF_Detention.asp

Table 2. *Palestinian children detained by Israeli Forces*

Month	Detained by	Date of detention	Age of the child	Detainees	Detained until end of legal process	Sentence	Administrative detention	Total
April	IPS	30 April	Under 16	7	21	19	0	47
			16-18	20	152	159	2	333
March	IPS	31 March	Under 16	5	27	21	0	53
			16-18	28	161	164	2	355
Feb.	IPS	28 Feb.	Under 16	10	31	13	0	54
			16-18	29	175	136	6	346
	IDF	26 Feb.	Under 16	0	0	0	0	0
			16-18	–	–	–	0	12
Jan.	IPS	3 Feb.	Under 16	5	36	9	0	50
			16-18	28	180	111	5	324
	IDF	28 Jan.	Under 16	0	0	0	0	0
			16-18	–	–	–	0	14
Grand Total								1.588

Source: www.btselem.org/english/Statistics/Minors_in_Custody.asp

dren as young as 12, for up to six months if they have "reasonable grounds to presume that the security of the area or public security require the detention." The initial six month period can be extended by additional six-month periods indefinitely. The terms "security of the area" and "public security" are not defined, their interpretation being left to the military commanders. The Order gives flexibility to the Military to repeat the detention as they like because it does not identify a maximum cumulative period of the detention. This procedure denies the detainee the right to a fair trial and the ability to adequately challenge the basis of his or her detention. The number of Administrative detentions among Palestinian children is increasing; 125 Palestinian children were administratively detained in 2008.[6]

Torture and ill-treatment are frequently used in military and political conflicts in order to warn, punish, and get information about the opponents.[19, 20] Traumatic events tend to accumulate. People seldom face only political violence, they also carry with them their private history and childhood unhappiness.

In the Palestinian setting, exposure to systematic oppression, trauma, torture, violence and long-term social suffering, including collective punishment, is chronic and ongoing. Usually young people, children and women pay the highest price. They have been subjected to a range of violent and traumatic experiences over time, not the least of which is 'witnessing the destruction of a social world embodying their history, identity, and living values'. In recent times, other than ongoing Israeli military re-occupation of the West Bank and Gaza Strip, there has been death, injury, shelling, bombing, sonic bombs, house demolition, the destruction of a vast amount of agricultural land, closures, siege, spiraling poverty and other visible effects of war.[21, 22]

In her informative study about collective exposure to political violence[23] Giacaman showed that Palestinian children have reported being exposed to tear gas and sound bombs, having seen shooting and explosions, and having seen strangers being arrested, injured and humiliated. Having one's home sealed or demolished, having been beaten by Israeli settlers and having been stripped in public were reported least often. Table 3 highlights the percentage of traumatic exposure among Palestinian children.

Mental health problems caused by constant traumatic events, torture and threat of violence intrusion into Palestinian children's

Table 3. *Percentage of exposure to traumatic events once or more during the preceding year.*

Type of traumatic event	Total (n=3415) (%)
House searched	35
House occupied and you in it	14
House occupied and you thrown out	9
House shot at	22
House bombed or shelled	8
Shelling in the neighborhood	31
Beaten by the Israeli army	15
Used as a human shield	6
Exposed to tear gas	60
Exposed to sound bombs	63
Body searched	30
Shot at or hit	25
Detained or arrested	17
Interrogated	13
Saw stranger being arrested	62
Saw stranger being injured	49
Saw stranger being killed	28
Saw family member arrested	31
Saw family member injured	17
Saw family member being killed	7
Saw friend/neighbour arrested	37
Saw friend/neighbour injured	22
Saw friend/neighbour killed	11
Humiliated	23
Saw stranger being humiliated	67
Saw family member humiliated	29
Saw friend/neighbour humiliated	35

Source: reference no. 23.

lives, whether at home or at school, was high. Such a protracted conflict situation promotes a general state of fear, apprehension and insecurity throughout the population, particularly among children,[22, 24-26] El-Helou et al[22] showed that 88% of children in the Gaza Strip had a close family member beaten by the Israeli soldiers, while 56% of the sample witnessed, or knew of the arrest of their close family members and 31% reported that they have close relatives in prison. The majority of children (95%) reported that the Israeli soldiers broke into their homes on at least one occasion.

The adverse psychological impacts of these traumatic events have been highlighted in various studies among Palestinian children. Baker[27] showed that Palestinian children living in the West Bank suffer from psychosomatic and pathological symptoms. The psychosomatic symptoms include headaches, stomachaches, difficulty in awakening, difficulty in sleeping, nightmares and loss of appetite. Haj-Yahia[28] reported high levels of adjustment and developmental problems among Palestinian adolescents who witnessed interparental violence which is often associated with child abuse.[29] Thabet & Vostanis[30] reported the frequent abnormal behaviors among children that have been noted by teachers include lying (10.5%), disobedience (10.5%), and bullying (11%). Frequent emotional disturbances noted included worries (17.3%), fears (11.8%), and feeling miserable (5.9%).

In their study about the prevalence of Posttraumatic Stress Disorder (PTSD) among Palestinian children living in the area of bombardment where children themselves reported their exposure to military violence, whether being targeted or witnessing it towards others, Qouta[31] showed that 54% of the children suffered from severe PTSD, while 33% from moderate and 11% from mild and doubtful levels of PTSD. Those children most vulnerable to avoidance symptoms were those who had personally been targets of military violence and whose mothers were better educated.

Political violence has negative impact not only on the Palestinian children also on their perception of the parenting styles they experience. Punamaki[32] has indicated that the more that children are exposed to traumatic experiences, the more they suffer from adjustment problems related to parenting, meaning the more they perceive their parents negatively, as punishing, rejecting, strict, controlling, and lacking intimacy and love, all of which increases children's psychological adjustment problems. Moreover, the poorer parenting the children experience, the more they suffer from high neuroticism and low self-esteem.

Conclusion

In her statement to the Security Council Open debate on Children and Armed Conflict in April, 2009, Coomaraswamy Radhika said "In February I visited Gaza and Southern Israel after weeks of war. As it was just days after the fighting had ended, the children, their teachers and parents in Gaza were in a state of shock and they still had horror in their eyes ... Everyone hopes for peace and in Southern Israel, where children also live in fear, girls and boys spoke freely of reaching out to their Palestinian brothers and sisters".[33] Palestinian children are the most vulnerable victims of Israeli occupation, political violence, poverty, war and torture.

The impact of torture on Palestinian children is generally much greater than on adults, as children have a lower threshold for pain and less understanding of why others use torture. The international com-

munity has officially condemned torture, especially child torture, as the most dreadful violation of human rights and has listed torture as a war crime. But despite the pledge of numerous countries to eradicate torture, this barbaric practice continues urging the international community, humanitarian organizations, human rights activists, health professionals, law institutions and others to urgently break their silence and save the lost generation of Palestinian children.

Article 24 of the United Convention on the Rights of the Child 1989 (ratified by all UN member States including Israel, except for two) provides that State Parties are to ensure that all children have the right to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, without discrimination.

"Israel argues that international human rights law such as the 1948 Universal Declaration of Human Rights; the 1984 Convention Against Torture and the 1989 Convention on the Rights of the Child do not apply to its occupation of the Palestinian territories". Furthermore, guidelines, standards and rules set by various United Nations bodies are not legally binding on States.[16] Constantly Palestinian children ask "why cannot we live as other children in the world do".

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