

# A nation-wide screening survey of refugee children from Kosovo

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## Abstract

Within one week of arrival in Denmark, all Kosovo refugee children were screened for emotional problems with a Danish Red Cross Trauma and Symptom Form (TSF). Out of 1,371 children, the TSF was completed for 1,224 children (89%). The prevalence of separations, losses, exposure to violence, torture, extreme poverty, and hunger were described. Twenty percent of the children suffered from emotional symptoms and 24% had psychosomatic disturbances. Variables associated with the presence of emotional distress included age, duration of the flight, number of separations and losses, and exposure to violence, torture, extreme poverty, and hunger. A regression analysis showed that extreme poverty, torture, and the duration of the flight from their homes explained 16% of the variance of all emotional symptoms. The prevalence of emotional distress supports the need to deliver mental care to the victims of ethnic cleansing. The results provide guidelines for early detection of children who are at risk of developing emotional problems.

## Introduction

When ethnic cleansing forces millions to flee their homes, the host countries are presented with a need to evaluate their physical, psychological, and social problems at an early stage, so that medical and psychological counselling and treatment can be initiated. In Denmark this screening is carried out by a health visitor who evaluates the health situation and together with a doctor recommends further examinations and treatment.

In order to ensure accurate and in-depth screening of the psychological and social impairments, Danish Red Cross has developed a special Trauma and Symptom Form (TSF) for children.

The aim of this paper is to describe the prevalence of emotional disorders among Kosovo children who have come to Denmark. It is also intended to identify special demographic relationships and traumatic events, which are connected with a heightened risk of developing emotional disorders. The long term aims are: 1) to exert an influence on the education of the professional groups, which carry out this type of screening as well as on the professional groups, which meet the children at the reception centres, 2) to make the professionals

more aware of psychological problems, and 3) to enhance both the effectiveness and responsiveness of the different institutions which are in charge of this area.

Based on the Kosovo Refugee Bill (April 1999) Denmark received around 3,000 refugees from Kosovo. Of these, 1,371 were children between 0-18 years of age. The refugees were evacuated from refugee camps in Macedonia, where they had been living between four and ten weeks before arriving in Denmark. The refugees' backgrounds were very different: some of them had been displaced within Kosovo for up to one year already, while others had only left their homes a few weeks before. Chaos, separation, and uncertainty about the day-to-day developments as well as uncertainty about the future marked the stay in the refugee camps in Macedonia.

## Procedure

Since 1984 the Danish Red Cross Asylum Department has been responsible for dealing with all asylum seekers entering Denmark. All asylum seekers including displaced persons from Kosovo were offered a medical examination. A few days after their arrival at the reception centre, a health visitor examined the children. The medical history was taken concerning earlier illnesses, the child's well-being, former traumatic incidents, and psychological symptoms. In addition to the examination by the health visitor, a doctor examined all children and vaccination cards were checked.

Experienced health visitors administered the TSF. It showed that the complaints, symptoms, and reactions of the children could often be related to the experiences they had had before and during their flight. The TSF was filled in immediately after arrival as a part of the medical history. In the case of young children the parents provided the information, while older children were asked directly. The TSF contains information about the child's flight, separation and/or loss of parents, siblings and close relatives, whether the child had witnessed violence, was a victim of violence, or had itself carried out violence. It was also noted whether the child, its parents or guardian had been a victim of torture.

The child was asked whether he/she had participated in acts of war, and whether there was physical damage as a result. Subsequently, the child was asked whether he/she had lived in extreme poverty or had suffered from hunger. A series of questions suggested by Edith Montgomery<sup>1</sup> were included. Relevant symptoms are: anxiety, depression, aggression, nervousness, psychosomatic reactions, regressive traits, and problems at school. Other symptoms to look out for are: whether behaviour is introvert or extrovert, active or passive, and whether there are symptoms of post-traumatic stress disorder (PTSD) (such as traumatic memories in play, drawing, speech, uncontrolled repetitive movements/actions, evasive behaviour, extreme watchfulness, startle response due to unexpected loud noises, sleep disorders, sudden behavioural

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changes, fear of the dark, fear of strangers, separation fear, pessimistic expectations of the future, lack of confidence, and lack of trust in others).

Based on the information about the child's experiences and symptoms, the health visitor advised the parents and the child what they themselves could do and possibly recommended a visit to the health clinic at the asylum centre, where further evaluation could be carried out in a more relaxed atmosphere.

## Results

The study included 1,224 of the 1,371 children who were received in Denmark. The response rate was 89.2%.

### Age distribution

A quarter of the children were from zero to four years of age, one quarter were from five to eight years of age, one quarter from nine to twelve years of age, and the last quarter were from thirteen to eighteen years of age. The average age was 8.2 years. Data about age were missing for 8% of the children.

### Gender

Data about gender were missing for 8% of the children. Of the stated gender, 52% were boys and 48% girls.

### Duration of flight

Twenty-five percent had been on the run for up to one month, 25% from one to two months, 25% from two to three months, and the last 25% for more than three months. The average flight time was 3.2 months.

Table 1 shows the number of children with separation and loss of relatives and others. The numbers in this and the following three tables vary depending on which column the health visitor filled in. More than half the children had been separated from their grandparents, and one third had been separated from their father for a period of time. The time of separation from their father was 6.3 months on average; the median time was two months, which implies that half of the children were separated from their father for up to two months. The time of separation from other family members was shorter, but the median time was the same. The number of separations was distributed as follows: 36% had not been separated from anybody; 42% had only been separated from one of the mentioned persons; 17% had experienced two separations, and 4.5% three or more separations.

Thirty percent had lost close relatives, 13% had lost friends, acquaintances or neighbours ("other"), and 10% had lost their father. Very few had filled in the number of months since the loss of family members; consequently it would not make any sense to use this information.

	Separation from		Loss	
	% who have been separated	number of children asked	% who have lost someone	number of children asked
Father	34	1085	10	968
Mother	7	1026	2	967
Siblings	15	1013	4	949
Guardian	10	550	3	812
Grandparents	54	896		
Close relatives			30	929
Other			13	621

The number of losses was distributed as follows: 68% had not lost anybody; 24% had lost one; 6% had lost someone from two of the mentioned groups (the number of people lost within each group was not registered), and 2.5% had lost people from three to six of the groups.

Table 2 shows that about 40% had witnessed violence, while 9% had been victims themselves. One percent had committed violence to others. Those who had committed violence and been victims themselves had all witnessed violence.

Table 3 shows that torture of the father and other people had been experienced by one child in seven. Eighty-two percent had not had any contact with torture, and 15.6% had experienced torture once. Three percent had experienced two or more of the mentioned groups being tortured.

Table 4 shows that only a few had taken part in acts of war and/or been injured as a result of acts of war. But a third of the children had at times suffered from hunger, and a quarter had lived in extreme poverty.

Table 2. Children exposed to violence.

	% exposed to violence	number of children asked
Witness to violence	41	1034
Victim of violence	9	994
Used violence	1	964

Table 3. Children exposed to torture.

	% exposed to torture	number of children asked
The child itself	1	900
Father	14	913
Mother	2	896
Guardian	3	840
Other	13	782

Table 4. Children exposed to different stressful life events.

	% exposed to stressful events	number of children asked
Taken part in act of war	1	944
Physical damage	1	939
Extreme poverty	24	923
Suffered from hunger	32	950

Table 1. Prevalence of separation from and loss of relatives and others.

Table 5 shows the occurrence of psychological symptoms of PTSD. Anxiety and nervousness were found in 10% of the children, while depression, aggression, and psychosomatic reactions were present in 4% of the children. PTSD was found in 3% of the children.

Table 6 shows a number of psychosomatic symptoms. Ten percent of the children had problems with their eating and with headaches (or toothaches). Five percent had sleeping problems and involuntary discharge of urine.

Table 7 shows the correlations between the demographic factors and the stressors.

Table 5. Children with psychological symptoms.

	%
Anxiety . . . . .	10.2
Depression . . . . .	4.1
Aggression . . . . .	4.2
Nervousness . . . . .	10.0
Psychosomatic symptoms . . . . .	3.9
Regressive traits . . . . .	2.0
Problems at school . . . . .	0.7
Behavioural problems . . . . .	2.2
PTSD . . . . .	2.9
One symptom . . . . .	11.0
Two or more symptoms . . . . .	2.2

Table 6. Children with psychosomatic symptoms.

	%
Sleeping . . . . .	5.4
Eating . . . . .	10.5
Sight . . . . .	2.5
Hearing . . . . .	1.4
Enuresis . . . . .	5.2
Encopresis . . . . .	1.0
Urine infection . . . . .	0.6
Headaches/toothaches . . . . .	10.5
Motor function . . . . .	1.5
One area . . . . .	14.7
Two or more areas . . . . .	9.3

*Gender* has only one correlation with one stressor, as boys more often than girls have experienced either no or a lot of violence.

*Age*: The older the children were, the more they had experienced separation, loss of close relatives, and violence.

*Flight*: The longer the duration of the flight, the more separations and losses the children had experienced. Most cases of violence and poverty occurred under a short or a very long flight. The stressors connect in a vicious circle: the more separation, the more losses, violence, torture, poverty, and hunger.

In two separate correlation-analyses (not shown here) the mutual relation between symptoms and areas of problems were studied. All the symptoms were positively and significantly correlated ( $p < .0005$ ), so if there was one symptom, the probability of having other symptoms will increase. It was the same with the areas of problems with the exception that two correlations were not significant (sleeping/motor function and eating/hearing).

Table 8 shows a variable analysis of the correlation between independent and dependent factors. *Gender* has no bearing on either symptoms or problems and is therefore not included in the table. Increasing age means fewer problems relating to eating and enuresis together with increasing occurrence of PTSD and headache problems. Fear and nervousness were highest in the group of the five to eight-year-olds, but were also high in the group of nine to twelve-year-olds.

The longer the displacement time, the more depression, aggression, and nervousness, and the more psychosomatic problems. Those with a short or long time of fleeing had more eating problems. The more people the child has been separated from, the higher the prevalence of PTSD, depression, regressive traits, and behavioural problems. There was also an increasing proportion of fear, nervousness, and aggression, but with the exception that the curve "breaks", i.e. falls, for those who have experienced the most separations.

The same phenomenon can be seen with *loss*: when the frequency of symptoms increases, more losses are experienced, but in the group with the most losses the curve "breaks", and symptom levels fall. The only exception is behavioural problems, which continue to rise.

Table 7. Correlations between demographic factors and stressors.\*)

	Gender	Age	Duration of flight	Separation	Loss	Violence	Torture	Poverty
1) Gender								
2) Age	2.1 (3)							
3) Duration of flight	1.8 (2)	4.1 (6)						
4) Separation	3.2 (3)	58.2 (9) <sup>5)</sup>	54.6 (6) <sup>5)</sup>					
5) Loss	0.0 (3)	15.2 (9)	42.8 (6) <sup>5)</sup>	218.9 (9) <sup>5)</sup>				
6) Violence	7.5 (2) <sup>1)</sup>	43.5 (6) <sup>5)</sup>	15.6 (4) <sup>3)</sup>	26.4 (6) <sup>5)</sup>	47.3 (6) <sup>5)</sup>			
7) Torture	0.5 (2)	0.8 (6)	32.8 (4) <sup>5)</sup>	51.8 (6) <sup>5)</sup>	278.1 (6) <sup>5)</sup>	75.2 (4) <sup>5)</sup>		
8) Poverty	1.6 (1)	5.8 (3)	10.8 (2) <sup>3)</sup>	32.9 (3) <sup>5)</sup>	42.5 (3) <sup>5)</sup>	38.0 (2) <sup>5)</sup>	46.6 (2) <sup>5)</sup>	
9) Hunger	2.0 (1)	5.0 (3)	32.6 (2) <sup>5)</sup>	48.9 (3) <sup>5)</sup>	50.0 (3) <sup>5)</sup>	89.1 (2) <sup>5)</sup>	37.7 (2) <sup>5)</sup>	405.2 (1) <sup>5)</sup>

\*) c2 is first mentioned. Degree of freedom in brackets.  
 $p < 1) .05, 2) .01, 3) .005, 4) .001, 5) .0005$ .

Table 8. Correlations between demographic factors, stressors, symptoms, and areas of problems. One-way ANOVA. F-ratio values.

	Age	Duration of flight	Separation	Loss	Violence	Torture	Poverty	Hunger
<b>Symptoms</b>								
Anxiety	3.45 <sup>1)</sup>	0.69	11.89 <sup>5)</sup>	3.89 <sup>2)</sup>	3.72 <sup>1)</sup>	24.77 <sup>5)</sup>	152.09 <sup>5)</sup>	59.03 <sup>5)</sup>
Depression	2.56	17.34 <sup>5)</sup>	10.94 <sup>5)</sup>	19.64 <sup>5)</sup>	7.36 <sup>4)</sup>	18.21 <sup>5)</sup>	47.20 <sup>5)</sup>	40.58 <sup>5)</sup>
Aggression	2.07	6.49 <sup>3)</sup>	5.73 <sup>4)</sup>	4.42 3)	1.64	33.45 <sup>5)</sup>	40.21 <sup>5)</sup>	17.34 <sup>5)</sup>
Nervousness	5.75 <sup>4)</sup>	10.89 <sup>5)</sup>	7.03 <sup>5)</sup>	4.34 3)	12.52 <sup>5)</sup>	25.86 <sup>5)</sup>	53.84 <sup>5)</sup>	52.34 <sup>5)</sup>
Psychoso-matic	2.34	3.63 <sup>1)</sup>	0.58	6.34 <sup>5)</sup>	4.79 <sup>2)</sup>	4.94 2)	22.67 <sup>5)</sup>	3.16
Regressive	2.50	1.24	3.32 <sup>1)</sup>	8.87 <sup>5)</sup>	7.33 <sup>4)</sup>	27.15 <sup>5)</sup>	15.64 <sup>5)</sup>	3.27
Problems at school	0.14	0.99	0.49	1.95	0.81	13.01 <sup>5)</sup>	1.43	0.37
Behavioural problems	1.30	1.48	6.07 <sup>5)</sup>	15.90 <sup>5)</sup>	13.08 <sup>5)</sup>	17.43 <sup>5)</sup>	13.11 <sup>5)</sup>	8.30 <sup>3)</sup>
PTSD	8.65 <sup>5)</sup>	1.46	3.86 <sup>2)</sup>	12.10 <sup>5)</sup>	9.05 <sup>5)</sup>	9.60 <sup>5)</sup>	54.94 <sup>5)</sup>	41.54 <sup>5)</sup>
<b>Problems</b>								
Sleeping	0.97	2.33	2.34	1.68	1.50	0.46	1.81	2.88
Eating	7.99 <sup>5)</sup>	4.36 <sup>1)</sup>	0.90	0.68	2.96 <sup>1)</sup>	0.60	0.01	0.94
Sight	2.52	0.11	1.33	0.61	0.34	1.06	0.04	0.35
Hearing	0.39	1.41	0.96	0.68	0.01	3.00 <sup>1)</sup>	1.50	0.01
Enuresis	3.86 <sup>2)</sup>	0.92	0.32	1.31	0.22	1.84	10.01 3)	2.46
Encopre-sis	0.89	0.08	0.69	1.72	0.06	0.54	1.91	0.50
Urine infection	1.10	0.22	0.74	0.95	0.34	2.03	2.93	1.27
Head-/toothache	2.95 <sup>1)</sup>	0.78	1.74	1.12	6.76 <sup>4)</sup>	0.53	12.78 <sup>5)</sup>	3.20
Motor function	0.65	2.16	3.61 <sup>1)</sup>	0.86	0.42	1.03	0.21	9.50 <sup>3)</sup>

p< 1) .05, 2) .01, 3) .005, 4) .001, 5) .0005.

With regard to *violence* we see a general increase in the frequency of symptoms, but school and eating problems along with headache tendencies fall at the highest level of violence experienced. Looking at *torture* we see an increasing tendency to depression, psychosomatic traits, regressive traits, school and behavioural problems, and PTSD. For aggression, fear, and nervousness together with hearing problems, the curve rises, but falls a little for those who have experienced most torture. Extreme *poverty* and *hunger* are clearly associated with an increasing frequency of all symptoms and problem areas.

The final regression analysis based on the total number of symptoms as dependent variable can explain 16% of the variation by three factors: Extreme poverty, torture experiences, and displacement time. A parallel analysis based on the problem areas could only explain 1% of the combined variation and was therefore discontinued.

## Discussion

In the summer of 1999, a psychological evaluation was carried out by the Asylum Department at the Danish Red Cross in order to identify possible needs of treatment in connection with the health evaluation of the war-refugees from Kosovo. The study covered 90% of all refugee children from Kosovo. Separation, loss of close family, witnessing violence and torture, together with extreme hunger affected 25% of all the children according to the children and their parents.

The completed analysis showed that *gender* is not a significant factor. At first, this may be surprising. The explanation may be that when the number of violent episodes exceeds a certain level and there is a corresponding breakdown in the existing social and cultural life, there is a reduction in the significance of gender differences. After a long adjustment period, one could imagine that gender difference would reappear with regard to symptom development.

Older children experienced more violent events than younger ones, who probably withhold more, and whose cognitive abilities are not always capable of understanding the extent of all

the atrocities. Increasing age is connected with increasing frequency of PTSD; however, the middle age group of children is characterized by high anxiety levels. There are at the same time relatively few associations connected to age. Montgomery<sup>1</sup> reached a similar conclusion with regard to gender and age in her study of refugee children from the Middle East, who had also just arrived in Denmark.

The study also showed that the length of flight in itself is a traumatizing factor which is connected with a greater number of separations and losses. 1) A long time of flight is associated with many violent experiences and extreme poverty. 2) The same conclusion is valid for long periods in flight where waves of ethnic cleansing have involved immediate departure for many. The long duration of the flight has left its mark in the form of heightened depression, nervousness, and aggression.

Both violent assaults and symptom development become a vicious circle, as the occurrence of any symptom or any assault increases the risk of even more incidents and symptoms. Long separation time, loss, violence, torture, and extreme poverty are all particularly associated with increased occurrences of depression, aggression, nervousness, behavioural problems, and PTSD.

Psychosomatic symptoms are associated with long flight, loss, violence, and extreme poverty. Regressive symptoms are related to direct assault and extreme poverty.

Problems at school are an indication of only one type of assault, e.g. torture. Loss of hearing is the only psychosomatic problem that is related to torture. Whereas relatively few of the children have been subjected to torture, hearing loss in some cases might be a psychological defence against the assailants' shouting and the victims' screams.

In earlier studies of refugee children<sup>1</sup> the meaning of separation, loss, violence, and torture was analysed to show the association with specific symptoms. New in this particular study is that hunger and extreme poverty can also have very negative consequences. When basic survival is strongly threatened, this apparently influences the severity of the

psychological problems the children have to the same extent as direct assaults.

Many of the described symptoms are known from asylum centres and the administration in the local municipalities, who meet the refugees at a later stage. For this reason it would be obvious, in a future study, to follow a group of refugees for some years after arrival, to observe what changes appear in their symptomatology in relation to their physical problems and the social integration process. To what extent do the problems disappear, to what extent do they stabilize, and to what extent do they change over time?

It is also worth mentioning that we have seen that the amount of symptoms does not continue to rise for the children who have experienced most stressors. It may imply that there are threshold values to the amount of strain or that resilience occurs in some children.

Three stressors: torture, duration of the flight, and extreme poverty could explain 16% of all symptoms. Future studies, which include more factors, will probably be able to explain an even greater part of the variance.

Comparisons with other published studies are difficult because of differing aims and methods. This study is unique because it deals with a total population of refugees from a limited area, because a large part of the population escaped during a short time, because the time spent in the refugee camp was short, and because a large group came to Denmark together and were treated equally.

The primary limitation of the study is that the health visitor in a relatively short time has to judge the children via an interpreter, based on the information from their parents or from the children themselves, if they are old enough. The children's disinclination to talk to complete strangers about the horrors they have experienced may limit the value of the results. There is also a risk of problems of understanding because of the large cultural differences. Another Danish study of the same group of Kosovo children<sup>2</sup> shows a higher

amount of traumatization (PTSD). The cause of this difference could be that Stæhr uses a self-rating questionnaire, which the children fill in themselves (Impact of Events Scale).

This particular study is primarily based on the observations of the health visitor and the information from the parents. Therefore the parents may not know how affected their children are. More information about the emotional signs could be obtained by interviewing the children themselves. In any case, it would be worth continuing to study exposed populations with different methods to find out how effective these methods are.

The advantage of using a standardized form is that it improves the reliability of the data. If properly conducted it is an effective method and can give more valid information about atrocities and their effects than the unstructured interview<sup>3</sup>. Interviews may also be difficult to carry out because of the time involved. The results of the present analysis will be included in the making of a new version of the Trauma and Symptom Form.

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# TORTURE



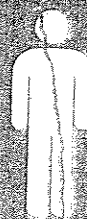
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