Psychopathology following torture experiences: a retrospective record review of victims of torture presenting to the Southern African Centre for Survivors of Torture (SACST)

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Medicine in the branch of Psychiatry

Johannesburg, October 2014

DECLARATION

I,.....**Latisha Raghubir**.....

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Hereby certify that this material which I now submit for assessment on the programme of study leading to the award of Master of Medicine in Psychiatry is entirely my own work and has not been taken from the work of others, save the extent that such work has been cited and acknowledged within the text of my work.

Signed:..... Dated: 24 October 2014

DEDICATION

For my parents, Raj and Nitha Raghubir, whose love and support is never-ending.

ABSTRACT

Introduction

In a constant quest for political power and control incredulously extending from medieval times to present day, the infliction of physical and psychological torture on each other by warring factions is sadly an ongoing reality worldwide. These gross insults on human rights may have a significant impact on the psychological wellbeing of the tortured individuals and result in clinical psychiatric illness.

Methods

A retrospective record review of all clients visiting the Southern African Centre for Survivors of Torture (SACST) in Johannesburg over a one year period was conducted. Their demographic profiles and torture experiences were analysed using the information available in the centre's record system. The prevalence of psychiatric illness within this study group was explored. Attempts were made to ascertain differences in trauma experiences endured and psychopathology sustained. The validity of the Self Reporting Questionnaire 8 (SRQ8) rating scale as a screening tool for psychiatric illness was also evaluated. Ethics approval to conduct the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (Medical).

Results

The cases studied were predominantly married, previously employed males less than 40 years old with at least a secondary level of education. All of these cases had experienced some form of torture but their SRQ 8 scores were variable and could not be linked to a specific torture experience or psychiatric diagnosis. Those cases finally assessed by a psychiatrist were all suffering from a psychiatric disorder with a significant 55% diagnosed with a comorbid Major Depressive Disorder (MDD) with Post Traumatic Stress Disorder (PTSD). Only 8% had an isolated PTSD and 24% unipolar depression alone.

Conclusion

The political conflict occurring in neighbouring Zimbabwe has resulted in large numbers of their nationals fleeing across their borders and seeking refuge in South Africa due to alleged human rights abuses including political torture. Assessment of a small percentage of these individuals in this local study has confirmed the prevalence on MDD, PTSD and combined MDD/ PTSD in this population.

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LIST OF ABBREVIATIONS

DSM 5	Diagnostic and Statistical Manual on Mental Disorders, 5th Edition
MDC	Movement for Democratic Change
MDD	Major Depressive Disorder
PTSD	Post Traumatic Stress Disorder
SACST	South African Centre for Survivors of Torture
SRQ 8	Self Reporting Questionnaire 8
SRQ 20	Self Reporting Questionnaire 20
ZTVP	Zimbabwe Torture Victims Project

CHAPTER ONE: INTRODUCTION

1.1 Background

The past decade has been witness to a myriad of extreme, life threatening, devastating, population-destroying events worldwide. These have included natural events like the tsunami of 2004 in Asia, the 9/11 bombings in the USA, the recent Westgate Mall massacre in nearby Kenya and equally importantly but often underestimated, the fluctuating and on-going military conflict in various countries including many of those in Africa. All of these events result in significant loss of life and may cause serious physical and psychological injuries both to those directly affected as well as their loved ones.

Whilst the natural disasters are unpredictable and unavoidable deliberately inflicted acts of political torture and human rights abuse has devastating consequences on the victims and their families, their home lands, and on the systems they flee to for assistance. The mass exodus of Zimbabwean nationals to neighbouring South Africa to escape political violence and deteriorating socio-economic circumstances is one such example impacting on our own doorstep.

From a mental health perspective such stress may precipitate episodes of, or exacerbate a variety of severe psychiatric disorders.

These include mood disorders like major depression and bipolar disorder, psychotic disorders, and importantly, all of the major anxiety and substance use disorders.

Early recognition and treatment of psychiatric disease that may have resulted from exposure to such traumas is imperative to decrease the burden of mental ill health. It is hoped that such interventions will have a positive impact on the associated debilitating sequelae that are posed on the individual, the immediate or nuclear system surrounding the individual, and on the population at large.

The availability and accessibility of adequate affordable inpatient and outpatient psychiatric facilities, trained mental health professionals, and appropriate effective psychopharmacological medications and psychotherapeutic supportive interventions to the majority of the people at risk is essential in minimising the potentially devastating effects of mental disability.

Predictors of psychiatric outcomes as a consequence of trauma have been established in non-tortured populations, but there is minimal evidence in the literature both regionally and internationally studying tortured populations. This research hopes to highlight the psychiatric morbidity suffered by victims of political torture by studying the profile

of such victims from Zimbabwe who presented to a Johannesburg based support organisation for assistance.

Support services for these large numbers of fleeing individuals are minimal but those available provide invaluable support as almost all of these legal or illegal refugees are destitute initially.

The Central Methodist Church is the most widely known support facility and a first port of call for these immigrants. The South African Centre for Survivors of Torture (SACST) was also one such organization. Established in February 2005 and initially called the Zimbabwe Torture Victims Programme (ZTVP), the centre was situated at the Centre for the Study of Violence and Reconciliation (CSVR), located in Braamfontein, Johannesburg, South Africa. Due to recent and ongoing socio-political unrest in Zimbabwe, large numbers of Zimbabwean nationals approached the SACST, which provided assistance with referrals for medical care, counseling, legal advice, and limited social assistance. The program subsequently expanded to include assistance to torture survivors from all African countries, not just Zimbabwe. The Tree of Life project was an arm of SACST that was set up to provide psychological assistance to Zimbabwean refugees fleeing organized violence and torture in the form of healing workshops at which participants were screened and later assessed by a mental health professional with experience in the management of torture survivors. The aim of the tree of life workshops was to both

heal and empower the participants using methodology initially developed in Zimbabwe itself for working with unemployed youth, and subsequently expanded to include aspects of debriefing and group counseling.[1] Unfortunately, due to lack of funds the centre ceased functioning in 2010.

There are minimal other similar organisations dedicated to supporting such victims. The parent body of SACST, the CSVR is still functional and is a multidisciplinary institute practicing from both Johannesburg and Cape Town and focuses on research, policy development and community interventions to promote reconciliation and prevent violence in both South Africa as well as Africa. The Trauma Centre in Cape Town provides psychosocial services to survivors of social crimes, political violence and torture.

1.2 Aims and objectives

To determine the demographic profile of clients seen at/referred to the SACTS.

To determine the forms of torture reported to have been experienced by this group.

To determine the prevalence of psychiatric disorders within this client population.

To determine whether differences existed in the psychopathology of those who have either witnessed or experienced physical compared with psychological torture.

A secondary objective was to evaluate the validity of the SRQ8 as a screening tool for identifying psychiatric illness.

1.3 Study Hypotheses

A. Victims of organized violence and torture, whether physical or psychological, presenting to the Southern African Centre for Survivors of Torture (SACST), are at high risk of psychiatric morbidity.

B. Physical torture is associated with a greater degree of psychiatric morbidity than psychological torture or witnessed torture.

CHAPTER TWO: LITERATURE REVIEW

The phenomenon of torture has been increasingly debated and researched over the past few decades, specifically with regards to its associated acute and chronic psychological, psychiatric, neurological and neuro-chemical sequelae.

The United Nations Convention against Torture (2000) defines torture as:

"An act or omission by which severe pain or suffering, whether physical or mental, is intentionally inflicted on an individual for the purposes of (1) obtaining from that person, or from another person, information or a confession, (2) punishing an individual for an act that they, or a third party have committed or are suspected to have committed, or (3) intimidating or coercing an individual or third party. In addition any reason based on any form of discrimination, which, however, does not include any act that arises solely from, or is inherent in or accidental to, lawful sanctions."

Despite the adoption of the United Nations "Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment", (General assembly resolution 39/46, December 1984), it is believed that as many as ninety countries worldwide undertake physical and/or psychological forms of torture.[2,3] Research has been

conducted to ascertain the specific psychopathological symptomatology prevalent in torture survivors, symptomatology that, in many cases, persists long after the traumatic event has occurred.

The study of psychological disorders in refugees and displaced people has a respectable history, with formal documentation beginning during the Second World War but with renewed focus in recent years spurred by the rise in number of refugees worldwide.[4] Studies of refugee populations have revealed torture rates ranging from 8-30%.[5] Psychiatric symptomatology has been found to have a significantly higher prevalence in tortured vs. non-tortured refugees.[6] Initial data identified educated males as having higher rates of exposure to torture.[7] This has been in contrast to new evidence that finds no disparity in torture rates across gender and educational groups.[6]

Psychopathology is a broad term used to indicate psychiatric symptoms, symptom clusters or psychiatric disorders. The psychiatric illnesses most commonly plaguing victims of organized torture and violence include major depression, post-traumatic stress disorder, somatoform, substance use and dissociative disorders. Research conducted to date have revealed a 30-54% lifetime prevalence of Post- Traumatic Stress Disorder (PTSD) and 27% for Major Depressive Disorder (MDD).[8,9] There were also high rates of

Somatization Disorder (48%), Substance Abuse Disorders (37%) and Dissociative Disorders (34%) in torture survivors.[8,9]

In contrast to Mollica and De Jong,[8,9] local work by Subramaney, whilst studying a similar population in South Africa, described a higher incidence of MDD compared to PTSD.[10]

A 2004 study of Bosnian refugees in Australia found that 39 subjects suffered no subsequent psychological sequelae, 29 subjects had pure PTSD and 58 more suffered from PTSD comorbid with MDD. They stated that the comorbid group manifested more severe PTSD and higher levels of disability.[11] Van Ommeron and his team are of the opinion that anxiety and depression are both associated with the reporting of mainly physical symptoms. This shared comorbidity, according to them, may explain the somatic distress amongst those with PSTD.[12]

Despite these international multi-centre findings, it has been reported that less than one percent of highly traumatized refugees living in Western society (USA, Western Europe) request, or are referred to mental health services.[5]

A major depressive disorder has as its primary features a subjective sense of sadness coupled with impairment in neurovegetative features (sleep, appetite, energy, libido), cognitive functioning (memory, concentration, judgement and reasoning), feelings of guilt, worthlessness and anhedonia (defined as the inability to experience pleasure), as well as possible somatic complaints. Symptoms must be present for at least two weeks and cause significant impairment in functioning.[13,14]

PTSD is categorized as a trauma and stressor related disorder. In the most recently released DSM 5 in May 2013, PTSD has been changed in classification from being a pure anxiety disorder to an illness that impacts significantly both on anxiety and mood.[14] The symptoms are triggered by the experiencing through direct or indirect exposure or association a terrifying threat to physical, sexual or psychological wellbeing. The event is then relived in waking thoughts (memories), dreams (nightmares) and/or dissociative reactions (flashbacks).This is usually co-morbid with physiologic hyper-arousal. The symptoms of repeated experience, avoidance, hyper-arousal and negative alterations in cognitions and mood last more than 1 month and cause functional impairment. The disorder is also commonly co-morbid with depression and substance abuse.

Substance use disorders refer to a maladaptive pattern of substance use and substance induced syndromes can mimic the full range of

psychiatric illnesses, including mood, psychotic, and anxiety disorders. Somatoform disorders are characterized by physical signs and symptoms that suggest a medical cause but on examination no medical cause for the presentation can be ascertained. Dissociative disorders are thought to occur because of a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. Dissociation is a defense against trauma that involves the segregation of mental or behavioral processes from the rest of the person's psyche.[13,14]

PTSD is the fifth most common of the major psychiatric disorders.[15] Chronic PTSD is associated with significant comorbidity (e.g., major depression, substance and alcohol abuse, panic disorder), reduced life expectancy and mortality (suicide, medical comorbidity), as well as disability, loss of productivity, and increased health care utilization.[16] It is, therefore, crucial to identify individuals at high risk to develop PTSD in the immediate aftermath of trauma, in order to design interventions that are effective in preventing the development of PTSD and its associated disease burden.

In addition, there is increasing evidence that torture may promote long term neurological and neuro-chemical changes such as reduced regional cerebral blood flow.[17] Mollica et al described a link between traumatic brain injury, neurological deficit and psychiatric symptoms.[20]

Research into torture sequelae is increasingly emphasizing the fact that survivors may experience long term, debilitating effects. Moreover, survivors that had suffered even a momentary loss of consciousness during the torture experience may be at significantly greater risk of developing sequelae such as PTSD and post-traumatic seizure disorders, and may present with debilitating Temporal Lobe Epilepsy symptomatology. Torture survivors that experienced loss of consciousness have up to a fifty percent increased chance of developing post-traumatic seizure disorders.[18]

Reports by torture victims vary extensively. Victims may be exposed to a multitude of physical and psychological torture techniques. Debate exists as to whether the torture experience, also referred to as the stressor characteristics influences the prevalence and presentation of subsequent psychiatric presentations. Some research has indicated that refugees who have different stressor characteristics within the same torture environment may present with different psychiatric presentations. A study of 136 patients diagnosed with PTSD in Bosnia (79 veteran soldiers, 18 tortured prisoners, 15 rape victims and 24 refugees) showed that rape victims present with a greater incidence of PTSD avoidance symptomatology as compared to the tortured soldiers who presented with greater levels of hyper-arousal symptoms.[19] The presence of psychiatric symptoms is not limited exclusively to survivors of torture. Witnesses to such traumatic events may themselves present with significant levels of PTSD and

depression. Research has also indicated that politically active people may be immunized to the process and may subsequently present with less post-torture symptomatology than tortured or traumatized non-immunized civilians.[20]

Resilient coping to extreme stress and trauma is described as being a multifaceted phenomenon characterized as a complex interaction of behavioral tendencies or variables such as personality, affect regulation, coping, ego defenses and the mobilization and utilization of protective factors and resources to aid coping.[21]

Epidemiological studies indicate that about 70% of people will experience a traumatic event in their lifetime, but not all of these individuals will develop PTSD. In fact, as shown in this report, the presence of isolated PTSD is surprisingly low. PTSD is a complex disease in which gene-environment interactions determine vulnerability. Nemeroff et al describe several risk factors identified for developing PTSD following trauma exposure. These include (a) female gender; (b) pre-trauma personal and familial psychopathology; (c) prior trauma including child abuse and neglect; (d) trauma severity; (e) perceived life threat and peri-traumatic emotional response; (f) lack of social support; (g) reduced hippocampal size; (h) a variety of previously identified risk alleles including *FKBP5*, *DAT*, *COMT*, *BDNF*, *5-HTTLPR*, *RGS2*, *GABRA2*, *CRFR1*; (i) markers of inflammation including IL-6, C-reactive peptide, and tumor necrosis

factor (TNF) implicated in the pathophysiology of PTSD and mood disorders.[22]

There has been a lot of interest and research recently in the field of epigenetics with regards to trauma experiences and the development of psychiatric pathology. Simply put epigenetics means above or on top off genetics. It refers to external modifications to DNA that turn genes “on” or “off”. Nemeroff and his team have also researched this phenomenon in the areas of PTSD as referenced above as well as MDD .[23] According to Nemeroff stress, including early life stress, is an important risk factor for depression. Additionally, genes account for a substantial variation in risk.

On a biological level corticotrophin-releasing factor (CRF) has been reported to be elevated in the cerebrospinal fluid of depressed patients and CRF has been repeatedly documented to be elevated in patients with PTSD.[23,24] Raised CRF levels result in activation of the hypothalamic-pituitary-adrenal axis with the autonomic nervous system stimulation resulting in feelings of severe fear and anxiety short term and the long term biologic effects of depression and anxiety. Both these acute and chronic effects can be equally crippling and early intervention and treatment is vital.[23, 25]

Victims of torture and trauma within the context of socio-political disruption may seek refuge in the relative stability of neighboring states. Southern Africa also has a history of refugees being associated with organized violence and torture related to anti-colonial wars, insurgencies and related state repression. Angola, Mozambique, Namibia, Zimbabwe, and South Africa have all had periods where many individuals of political opposition were forced into exile.[4]

The Republic of South Africa provides refuge for approximately 30000 official refugees and approximately 140000 asylum seekers according to recent figures published by the United Nations High Commission for Refugees. [26] Rates of torture within this refugee population have been estimated at between 20 and 50 percent. Southern African literature in this field is limited but a recent study conducted by Higson-Smith et al (2007) found that although 65 percent of their study population of interviewed refugees reported a need for health care, specifically mental health care, only 46 percent had actually received health care.[27] Refugees, whether tortured or not, present to the host country a series of unique biological, sociological and psychological needs. Unfortunately as large numbers of these individuals do not hold full legal status within the Republic, both support and treatment options are limited. Moreover, tortured individuals, their spouses and children may present with an array of complex legal, socio-cultural, financial and physical problems in addition to the urgent need to secure some sort of socio-economic stability. All of these factors combine to contribute to the total

morbidity of the general population. In a study conducted by the centre in 2004 only one in five of those interviewed had found some form of steady employment. The majority of refugees who were notably largely employed in Zimbabwe remained dependant on casual work, relatives, assistance from charities, churches and political parties.[1]

It is also important to consider the concept of acculturation (adoption of the prevailing culture of an adoptive country) with its associated stress inducing components like xenophobia. Prior to commencement of this study South Africa was recovering from the extensive xenophobic violence that began in the weeks of May 2008. These incidents, despite being more sporadic, still occur currently.

A comprehensive policy for the integration and rehabilitation of tortured refugees has yet to be determined. As such, extensive evaluation of the prevalence of psychological and psychiatric sequelae within these populations will allow further conceptualization of the manner in which the host community may aid in the aforementioned rehabilitation and reintegration process. Research into correlations between type of torture endured and the psychopathological presentation may assist in providing a further comprehensive insight into the short and long term needs of survivors of torture.

CHAPTER 3: METHODOLOGY

3.1 Site of the Study

The research study was conducted at SACST in Johannesburg, South Africa.

3.2 Study design

Individuals engaging the services of the SACST completed several documents designed to aid in formulating a comprehensive assessment. These included the completion of the Self Reporting Questionnaire 8 (SRQ 8), a widely used psychiatric screening instrument. The SRQ 8 tool (appendix 3) was originally developed in Zimbabwe in Shona and is used to identify 8 symptoms that are common and should be easily identifiable to all population groups within a preceding week. This assessment tool was derived from the Self Reporting Questionnaire 20 (SRQ 20) which was developed by the World Health Organization in 1980 to detect non-psychotic mental disorders, and is extensively utilized in the developing world.[15] The main symptoms identified in the SRQ 8 include impaired sleep, feelings of sadness, uselessness and fatigue, loss of interest in daily activities with a resultant impairment in daily functioning as well as impaired decision making abilities, and finally, suicidal ideation. All of these symptoms correlate

closely with the symptoms needed to make a diagnosis of a major depressive episode according to DSM 5 as well as standard South African psychiatric training, thus theoretically enhancing the suitability of the SRQ 8 as a psychiatric screening tool in developing populations of sub-Saharan Africa. A score of 4 and above indicates significant psychological impairment and warrants immediate assistance.[28]

Individuals approaching the SACST were also asked to complete an intake form that detailed demographic data such as age, gender, home area, legal status in South Africa, a description of events leading to referral, and details regarding witnessed and/or experienced traumatic events (appendix 2). This included physical and psychological torture scores calculated by the original trauma practitioner based on the initial interview.

Each client of the centre had an individual file which contained the forms specified above as well as clinical notes by the attending psychiatrist should the client have been referred for psychiatric intervention.

These records were utilized to undertake a retrospective review of the SACTS data base in furtherance of the stated objectives of this study.

The forms were closely analyzed to determine the proportion of the sample obtaining SRQ 8 scores of 4 or higher, thereby suggesting significant psychological impairment.

3.3 Study population

Two hundred files of cases referred to the SACTS starting from 1 February 2007 were reviewed. Non-random, convenience sampling was conducted due to practicality and time constraints.

Inclusion criteria included all files of cases referred to the centre from 1 February 2007 for review until 200 files were reached. The sample size of 200 was chosen for expedience. The resultant period assessed was 1 February 2007- 31 January 2008.

The absence of self-reported accounts of significant torture experiences on the SACTS intake form was regarded as an exclusion criterion.

3.4 Data analysis

The statistical software program STATA 10.1 was used for the analysis of the data.

A descriptive analysis of the demographic profile of the participants and their torture experience was performed.

Quantitative analyses were done based on the categories of demographic data, torture experiences, psycho-pathology and SRQ8 scores.

SRQ8 scores were compared with subsequent psychiatric diagnoses using the Fischer's exact test.

P-values </= 0.05 were considered significant.

Detailed analysis of the forms of torture experienced, subsequent psychiatric illness and possible correlations was also explored.

3.5 Funding

The costs of the research were mainly related to administrative costs like travel, stationary and photocopying, and these costs were born by the researcher.

3.6 Ethical considerations

The study was granted ethical approval by the Human Research Ethics Committee of the University of the Witwatersrand. The protocol number is M071108 (appendix 4).

The original title of the report was expanded on recommendation of the Postgraduate committee on presentation of the protocol. Notification of the change in title from the original application for ethics approval was submitted to the above Ethics Committee.

All data was personally collected by the researcher on site from the records at SACST.

Anonymity was observed at all times and no information identifying specific study individuals was recorded.

Permission to conduct the study was also obtained from the project coordinator of SACST.

CHAPTER FOUR: RESULTS

As stated in the literature review, despite the fact that SACST had opened itself to provide assistance for torture survivors from all of Africa, of the 200 files assessed all the cases were from Zimbabwe. Of these, 197 cases were found to have experienced some form of torture. Three cases reported no significant torture experiences and were excluded from the study and further analysis. The final sample size was thus 197 cases/ victims.

4.1 Demographic profile

Of the 197 cases assessed, 144 (73.1%) were male and 53 (26.9%) were female. Ninety two cases (46.7%) were younger than 30 years old. Seventy eight (39.6%) of the cases studied were between the ages of 31 and 40. A smaller proportion, 27 cases (13.7%) were greater than 40 years of age.

With regards to marital status, no information was recorded for 1 case. Of the remaining 196 cases, 115 (58.7%) were married, 77 (39.3%) single with the remaining 4 (2%) being either divorced or widowed.

The following tables summarize the demographic profiles of marital status and occupation respectively.

Table 4.1 Summary of Demographic Profile: Marital Status

			Marital Status			
Variable	**Total**	**Mean Age**	**Married**	**Single**	**Divorce/ Widow**	**Unknown**
Participants	197	32.55	115	77	4	1
Male	144	31.30	92	52	0	0
Female	53	31.76	23	25	4	1

Table 4.2 Summary of Demographic Profile: Occupation

		Level of Education			
Variable	**Total**	**Primary**	**Secondary**	**Tertiary**	**Unknown**
Participants	197	11	121	63	2
Male	144	5	83	55	1
Female	53	6	38	8	1

The cases displayed a wide variety of occupations. Examples of the vast range of jobs included artisans, salespeople, clerks, teachers and principals, nurses, students, packers, labourers, and managers. Of the total only 30 (15.4%) were unemployed. The highest numbers of individuals, 34 (17.4%) were educators and of note is that 21 cases (10.8%) were involved in a politically related job. These politically related jobs included working as politicians, bodyguards of the opposition Movement for Democratic Change (MDC) political party and soldiers.

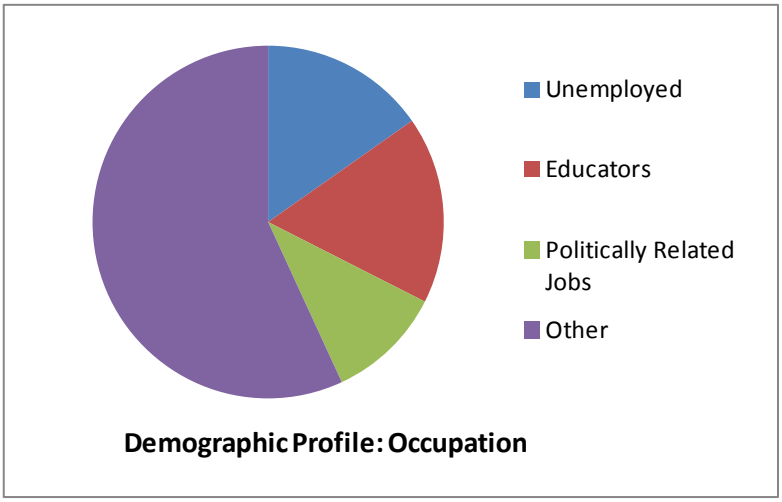

Figure 4.1 Demographic Profile: Occupation

4.2 Torture Experiences

With regards to the torture experiences, 179 (90.9%) had witnessed physical torture and 176 people (89.3%) had witnessed psychological torture. 171 people (86.8%) had experienced physical torture and 194 people (98.5%) -almost all of the cases- had experienced some form of psychological torture. 189 (96%) cases had experienced or witnessed both physical and psychological torture.

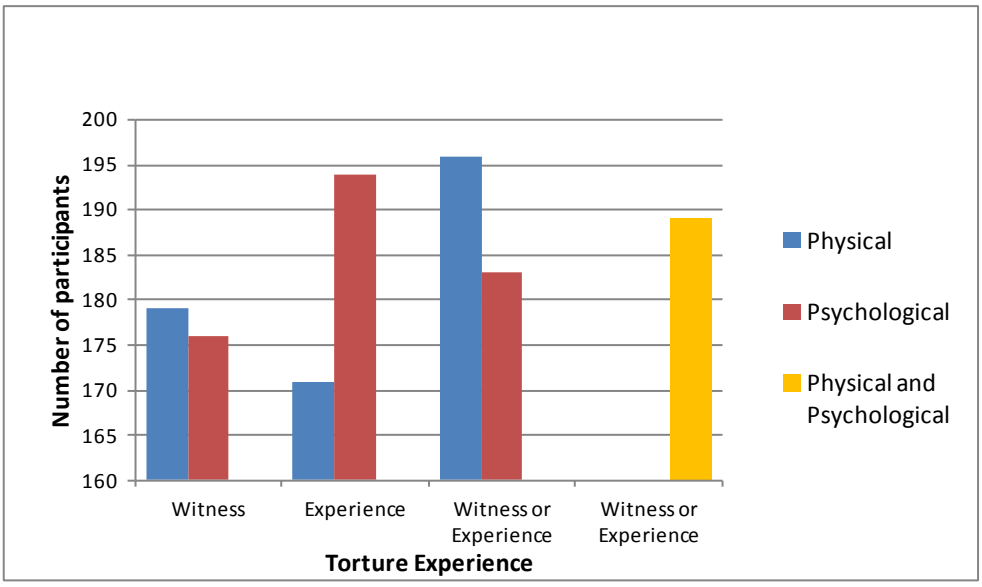

Figure 4.2 Torture Experience

183 victims (92.9%) from the entire study population of 197 either witnessed or experienced some form of psychological torture. Almost the entire study population, 196 victims (99.5%) had either witnessed or experienced some form of physical torture.

Of all the victims studied 67 (34.0%) had experienced loss of consciousness as a result of the torture experience.

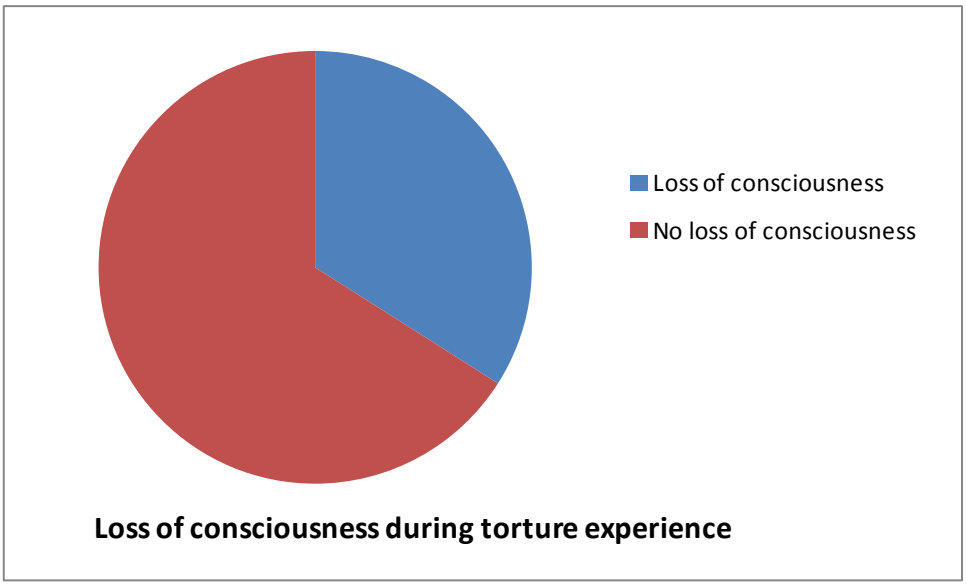

Figure 4.3 Loss of consciousness during torture experience

4.3 SRQ 8 scores and torture experiences

SRQ8 scores were recorded as an indicator of the need for psychiatric intervention following the torture experience. In this study population, 41 participants (20.8%) had an SRQ8 score of 3 or less, 94 (47.7%) scored between 4-6, and 62 (31.5%) scored greater than 6.

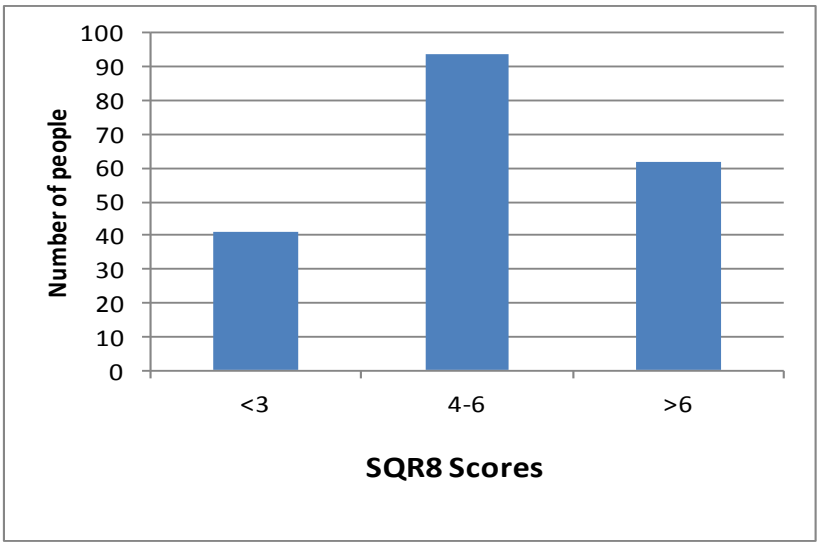

Figure 4.4 SQR8 Scores

This indicates that 156 of the victims (79.2%) warranted further psychiatric intervention. Of this group only 105 victims were actually referred for further treatment. The reasons for the lack of referral of 51 victims (25.9%) with SRQ8 scores >=4 were unfortunately not evident from the information collected.

Of the 105 people who were referred for further intervention, only 62 patients (31.5%) were subsequently assessed by psychiatrist, diagnosed and treated. This means that 43 participants (21.8%) were referred for treatment but never entered the second stage of the assessment process and psychiatric consultation. There was therefore a loss of 94 study individuals (47.7%) to psychiatric follow-up with SRQ8 scores of 4 or greater. The majority of the patients not attended

to was due to a lack of follow-up on behalf of the patients/participants themselves.

In addition, the 41 participants who received an SRQ8 score of 3 or less on the initial screening were automatically excluded from any further psychiatric intervention.

4.4 Psychiatric disorders

Of these 62 subjects that subsequently received further formalized psychiatric intervention, almost all were diagnosed with psychiatric impairments. Fifteen of the victims (24.2%) were diagnosed as suffering from and treated for a major depressive disorder alone and 5 victims (8.1%) were treated for a post-traumatic stress disorder alone. Thirty four victims (54.8%) received intervention for a combination of a major depressive disorder together with a post-traumatic stress disorder. Eight victims (12.9%) who received further psychiatric intervention were treated for various other disorders.

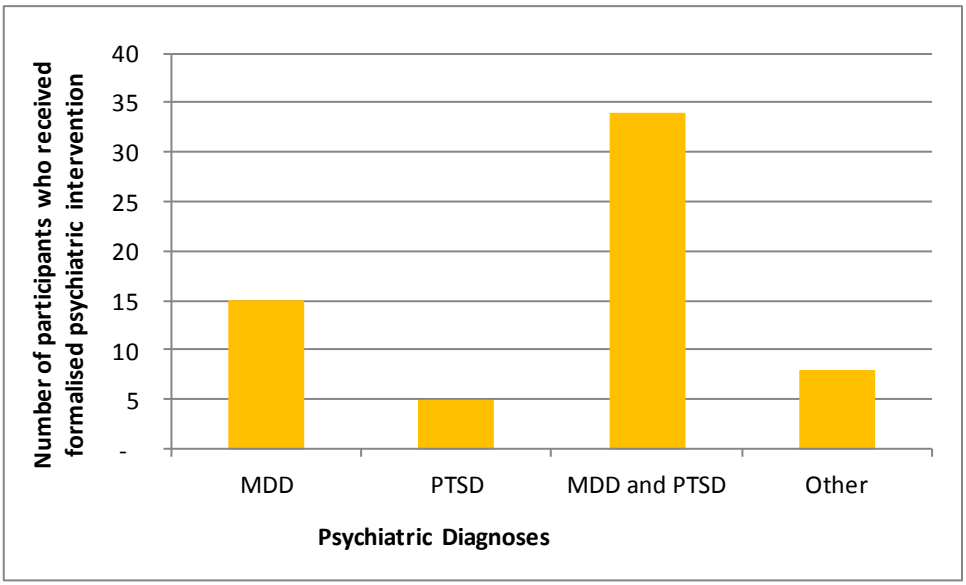

Figure 4.5 Psychiatric Diagnoses

In aid of further analysis, the SRQ8 scores were subdivided into 2 groups of those scoring 4-6 and those scoring 7-8. The results are detailed in Table 4.2

Table 4.3: Psychiatric Diagnosis and SRQ8

Diagnosis	SRQ8-4-6(n)	SRQ8- 7-8(n)	Total(n)
MDD	5	10	15
PTSD	3	2	5
MDD & PSTD	20	14	34
Other	4	4	8
Total	32	30	62

As can be seen from this table more than fifty percent of participants (n-34) that were diagnosed as suffering from a psychiatric disorder were in fact diagnosed as suffering from a major depressive disorder co-morbid with a post-traumatic stress disorder. Only 5 individuals (8.1%) had a post-traumatic stress disorder alone and 8 individuals (12.9%) were diagnosed with other disorders. These were mainly also mood disorders and were possibly also in direct relation to the reported trauma experiences. They included 4 individuals who were diagnosed with a mood disorder secondary to head injury, 2 individuals with an adjustment disorder with depressed mood and 1 young individual (age 31-40) with a possible frontal lobe dementia with associated mood dis-inhibition. The 8th and last of the individuals with "other" diagnoses interestingly had an SRQ 8 score of 6 and was found on assessment to have no psychiatric impairment.

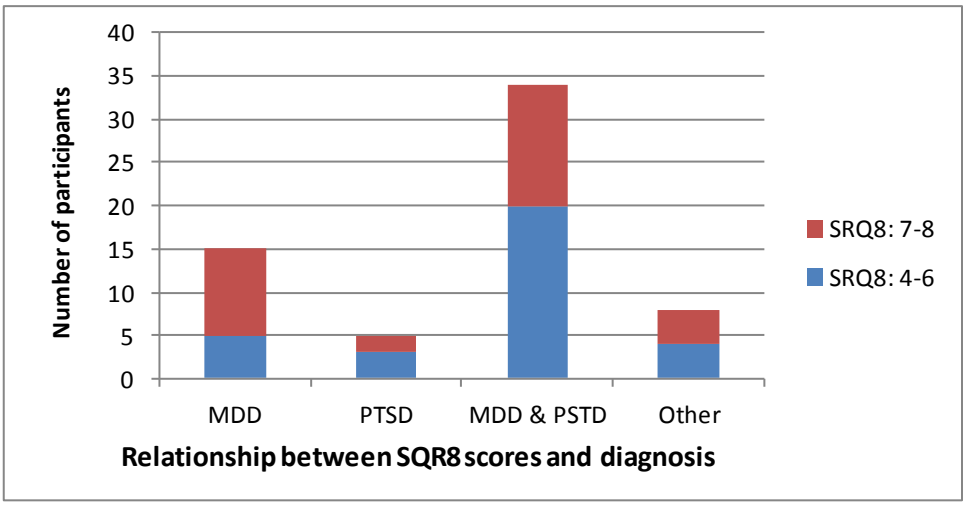

Figure 4.6 Relationship between SQR8 scores and Diagnosis

Further comparison of the scores obtained on the SRQ8 scale by the above participants in an attempt to examine the significance of association between the SRQ8 score obtained and subsequent psychopathology was done by performing Fisher's exact test. This test yielded a result of 0.388 and was not statistically significant.

As stated previously, 21 victims were working in politically related jobs. Two of these 21 victims obtained SRQ 8 scores <- 3 and were excluded from further follow-up. Analyses of the torture experiences of these 19 cases revealed that only 11 of them (57.9%) were assigned a psychiatric diagnosis. Three cases (15.8%) were diagnosed as suffering from PTSD alone, 6 (31.6%) from a combination of PTSD and MDD, and 2 cases (10.5%) from other diagnoses. This means that of this subgroup of 21 individuals who were potentially exposed via politically related careers, only 9 (47.4%) were diagnosed with a related psychiatric disorder. In addition, there were no cases of MDD alone in this subgroup.

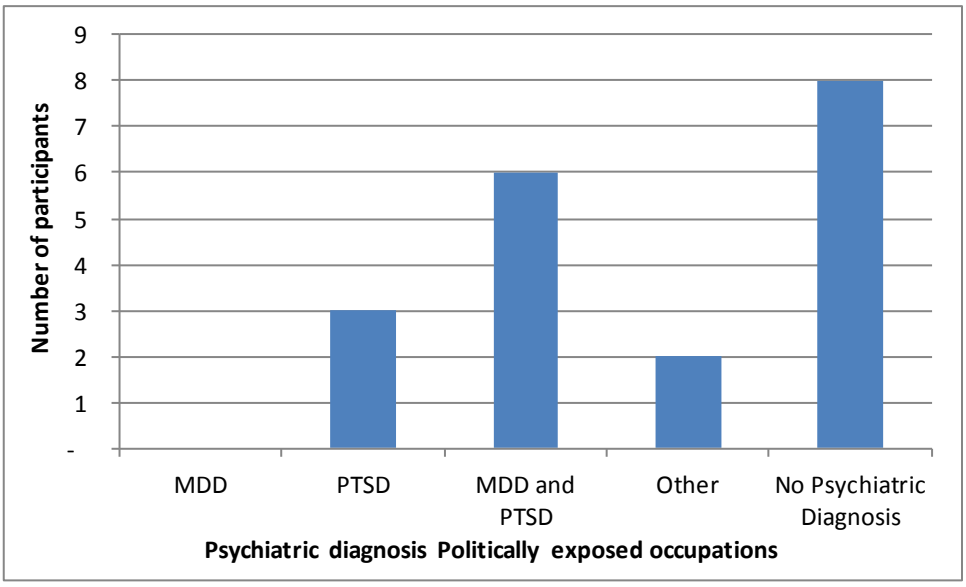

Figure 4.7 Psychiatric Diagnosis: Politically exposed occupations

The portion of the population who were not exposed to politically related occupations and who scored >-4 on the SRQ 8 scale and hence would have been deemed high risk for mental illness totaled 137 individuals. Within this subgroup only 45 persons (32.8%) were finally diagnosed with a trauma-related psychiatric illness.

Table 4.4: Occupation and Psychiatric Illness

Occupation	Psychiatric Diagnosis(n)	No Psychiatric Diagnosis(n)	Total(n)
Political job	11	8	19
Non-political job	45	92	137
Total	56	100	156

These 2 groups were then compared in order to ascertain if being exposed occupationally to the country's politics increased risk of subsequent psychiatric illness. This comparison yielded an odds ratio of 1.84 (95%CI 0.61;5.42) and a p-value of 0.2124.

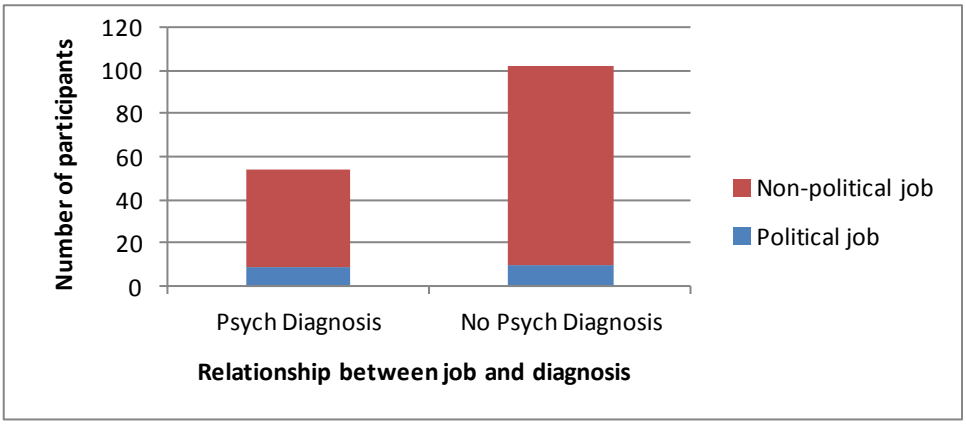

Figure 4.8 Relationship between Job and Diagnosis

Correlations between level of education and subsequent psychiatric illness were also investigated. The 2 individuals where no information regarding educational status was recorded were omitted.

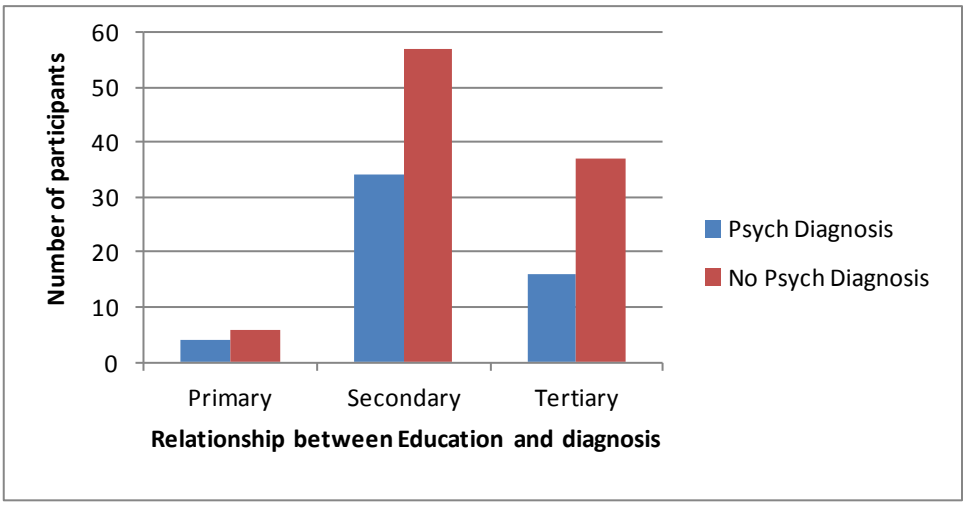

Figure 4.9 Relationship between Education and Diagnosis

There was no statistically significant relationship between the above variables and the p-value was 0.681.

A total of 54 victims (27.4%) from the entire population group of 197 survivors of torture were documented to have been commenced on psychotropic medications for mental ill-health triggered by the alleged torture experiences.

CHAPTER FIVE: DISCUSSION

This section looks at closer interpretations of results obtained with regards to the primary study integers of demographics, torture experiences, rating scale scores and psychopathologies.

5.1. Demographic profile

Analyses of the demographic characteristics revealed that greater than two thirds of the study population were male. In addition, the majority (86%) were less than 40 years of age and more than half of the population were married. These results are in keeping with the available literature as well as with the general concept that the portion of the population that is active politically is the young, working, economically productive male .[29,30]

The ZTVP (now SACTS) has conducted a number of epidemiological studies on Zimbabwean refugees in South Africa since its inception in 2004. The demographic profile of the first report released in May 2004 described a predominantly younger male population with a mean age of 28years.[1] Education and employment levels were high with greater than half of interviewees having had a matric level of education and more than two thirds having actively worked in Zimbabwe prior to seeking refuge in South Africa.[1] A further report

of female victims of torture released by the organisation in November 2006 was consistent with findings in the above report as well as with the results revealed in my review. It consisted of a generally young population with an average age of 29 years, approximately two thirds of whom had been employed in Zimbabwe.[1] The most recent report released by the organisation in March 2008 once again yielded similar findings with the participants being mostly male with an average age of 28 years.[4]

The study population can also be considered to be generally relatively well educated with 93.5% having either a secondary or tertiary level of education. This again is in keeping with the concept that highly educated individuals are more socially aware and politically active. In this review just under 1/3 of the population (28%) were a combination of teachers and participants in specific politically related jobs, and possibly greater targets of torture attacks.

In addition, it is noteworthy that a very small proportion of the population was unemployed prior to fleeing their country. The resultant effect is that, in general, of a young, educated and actively working population from Zimbabwe persistently and seeking refuge in the Republic of South Africa. The recipient country has lower levels of education and higher unemployment rates. In addition, those officially registered as asylum seekers in South Africa are prohibited from working for six months and hence reliant on external sources of

support for survival. As such, many of these refugees who are highly skilled individuals are forced to illegally take on unskilled work.[24] This leaves open the question of whether these people are constantly migrating across our borders because they are unable to continue being victims of torture despite being faced with the possibly harsher living conditions compared to that of their homeland.

5.2 Torture Experiences

In this study there were minimal differences in the numbers of people who had witnessed or experienced either physical or psychological torture as the vast majority of them had either witnessed and/or experienced physical and/or psychological torture of some sort.

There was a high yet similar rate (both approximately 90%) of subjects who had reported to have witnessed either physical or psychological torture.

Looking at experiences of torture, the number of people experiencing psychological torture was notably greater than the number of people experiencing physical torture. This is in keeping with a recent series of unpublished reports by the Amani Trust which describes psychological torture as being the most common form of torture.[32]

This record review revealed that 92.9% had witnessed or experienced some form of psychological torture compared with 99.5% witnessing or experiencing various forms of physical tortures.

From the statistical analysis of the data collected it was not possible to determine whether differences existed in the psychopathology of those who had been physically tortured versus those who had witnessed torture or who had experienced psychological forms of torture. This is in part because in the SACTS initial screening assessments of these survivors of torture that were utilized to collect the data the differentiation was not highlighted. However it is also in part as a result of the four groups witnessed / experienced / physical / psychological) being so closely linked with so much overlap that it was not possible to statistically isolate specific differences in psychopathology amongst them.

Within this group, approximately 1/3 of those physically tortured experienced a loss of consciousness during the torture process. This is presumed to be as a result of head injuries but this has not been confirmed. Although the aims of the review did not include an analysis of the impact of head injury on psychopathology in the study population, this is of concern as a contributing or compounding factor to the development of subsequent psychiatric illness. Mollica et al commented on traumatic head injury and structural pre-fronto-temporal brain deficits showing an association with the symptom

severity of depression in Vietnamese ex-political detainees.[33] The information collected by SACST also did not look further into the possibility of these victims suffering from a post-traumatic seizure disorder. This would have been an important illness to investigate because as mentioned previously torture survivors that experienced loss of consciousness have up to a fifty percent increased chance of developing post-traumatic seizure disorders.[18]

5.3 SRQ 8 scores and torture experiences

A secondary objective of the study was to evaluate the validity of the SRQ 8 rating scale as a screening tool for identifying psychiatric illness. Establishing the validity of a tool requires establishing both reliability and accuracy. This review was limited by the design of the initial screenings and referrals of refugees seeking assistance from SACST and hence flow of patients into the psychiatric system.

Firstly all those individuals who scored 3 or less on the initial SRQ 8 scale were automatically excluded from further psychiatric evaluation. However based on the results annotated in section 4.2 all 197 study participants were victims of some form of torture and an extremely concerning 96% had witnessed or experienced **both** psychological and physical forms of torture. There is, therefore, amongst these 41 individuals (21.8%) with lower SRQ 8 scores, a strong possibility that some of them may also be suffering from a psychiatric illness

triggered by their torture experience that has never had the opportunity to be assessed and treated.

There could be varying reasons why these individuals obtained low scores. Firstly there could be genuine resilience as described by Agaibi and Wilson.[21] In this context, these individuals may have indeed some features of resilience e.g. sufficient coping skills and intact personalities that protected them against severe psychopathology in the face of their torture experiences.

There could also be under-reporting of symptoms as a result of fear of unknown systems and protocols in an alien host country. The questions asked on the SRQ 8 scale are also of a relatively personal nature and participants may possibly have been embarrassed to fully disclose their difficulties, especially keeping in mind that 73% of the entire study population was male. Also to be noted is that this is a population that has actively migrated to seek refuge in neighboring South Africa. They may therefore either view themselves as genuinely strong and survivors or alternatively withhold disclosure of their true symptoms for fear of being considered weak.

Conversely, however, it must also be noted that in the group with higher SRQ 8 scores there is also always the possibility of over-

reporting of symptoms in the hope of enhancing or maximizing the aid received by SACST.

Secondly, based on SRQ 8 scores alone 156 victims (79.2%) were high risk and needed further psychiatric assessment. One quarter of the group (25.9%) were lost to further referral and assessment for no apparent reason. It is possible that a proportion of these individuals were referred to the Tree of Life instead of formalized psychiatric assessment by a doctor. The type or level of mental health professional involved at the Tree of Life was not specified.

In addition, one fifth failed to arrive for their scheduled psychiatric assessments. The possible reasons for the poor follow-up rate are numerous. Importantly, this is an indigent population experiencing socio-economic and psycho-social strain with no fixed abodes, poor support structures, low levels of post-migration employment and an often harsh and non-accepting host culture. It is probable that returning for a repeat scheduled appointment was at times a physical and financial impossibility.

The ability to attend required follow-ups was also possibly affected by the very difficult and lengthy process it is to attain refugee status and hence legal permission to stay in South Africa. According to South African law, people can qualify for refugee status if they can present

evidence that their lives have been in danger due to being persecuted in their own countries because of their race, tribe, religion nationality, political opinion or membership of a particular social group. A person can also be granted refugee status if there is war in their country.[33]

It is difficult to provide specific proof of having been subject to any extreme form of human rights violations and the definition of war is broad-based and subject to interpretation.

Taking the above factors into account it was not possible, in this review, to assess the validity of the SRQ 8 scale as a screening tool for psychiatric illness.

5.4 Psychiatric Disorders

The first important observation in this study was that almost every single subject that was referred for and received formal psychiatric assessment by a psychiatrist was diagnosed with a psychiatric illness and commenced on medication. This leaves open a number of concerns regarding this study population. The first concern is that were more individuals who were referred for assessment but failed to follow up for various practical and logistic reasons actually assessed would they too also all be diagnosed with mood or anxiety disorders and hence be in need of treatment? Alternatively, it is also possible that the population that ultimately accessed specialist psychiatric

health services were genuinely referred appropriately. It is also important to note that the person screening for psychopathology and referring to the psychiatrist may not have been highly skilled and hence not all subjects with SRQ8 scores >4 were referred.

In addition, one is left to question the emotional state of the entire study population despite referral protocols, SRQ8 scores and the expertise of the various screeners and consulting psychiatrist considering that the entire group was exposed to some form of torture in their home country. These highly emotionally crippling experiences coupled together with the equally traumatic process of fleeing from home, loved ones and relative security to rebuild a life without structure and support in an alien country and culture leaves all of these individuals at high risk of struggling to cope and developing a depressive illness.

All of the 8 possible positive responses on the SRQ8 questionnaire are in keeping with the symptoms that correlate closely with those required to diagnose a major depressive episode. Based on this one could make an assumption that individuals with higher SRQ8 scores were more likely than the rest of the population to be suffering from a major depressive disorder.

Approximately 75% of the entire population that was psychiatrically assessed was found to suffer from depression. This was either a unipolar depressive disorder or in combination with PTSD. Sixty three percent suffered from PTSD (alone or in combination with MDD) and only 8% suffered from PTSD alone. These results are in keeping with the concept that the experience of severe trauma rarely causes a clinical anxiety disorder in isolation. The resultant psychological and emotional turmoil that such experiences inevitably evoke are likely to leave most individuals, irrespective of their degrees of individual resilience susceptible to mood impairments and depression.

This is in keeping with both Subramaney's South African study and international literature by Momartin and van Ommeron.[10,11,12] Subramaney postulated that the higher incidence of MDD compared to PTSD may be due to a number of variables such as the nature of the trauma experienced, the nature of the diagnostic criteria used and the under reporting of symptoms.[10]

It would be ideal to explore within this research population the possible contributory risk factors described by Nemeroff.[22,23] There appears to exist a developmental trajectory between genes and the environment where genetic vulnerability is combined with the presence or absence of social support mechanisms in the face of traumatic life experiences. This influences phenotypic plasticity such

that the resultant outcome can vary between resilience and vulnerability.

5.5 Limitations

The main limitation of the study was that being a retrospective record review all the information gathered and analyzed was obtained previously by non-medical third parties. The interviewer training and level of expertise was unknown. There were multiple people tasked with obtaining the initial information and hence inter-observer bias also factors.

Selection of participants reviewed in the study was done based on a specified number in a calendar time period and not random.

The referral of participants for further psychiatric intervention was based on the very basic and nonspecific SRQ 8 questionnaire. The use of more formal and internationally recognized rating scales may possibly have yielded more reliable results. Suggestion of tools that could have been used to screen for depression include the Hamilton Rating Scale for Depression (HAM-D) and the Montgomery-Asberg Depression Rating Scale (MADRS). For assessment of PTSD the Impact of Event Scale-revised (IES-R) or the PTSD checklist may have been more appropriate. However it must also be noted that

these rating scales are more detailed and would require the interviewer to be trained to administer them.

A further centre-based limitation was the lack of referral of one quarter of attendees who scored 4/more on the SRQ 8 for further psychiatric assessment. It was not apparent the reasons for the lack of referral. An additive patient-based limitation is that a further 22% of attendees with SRQ 8 scores of 4 and above were appropriately referred but failed to follow-up for unknown reasons of their own. This represents nearly half of the entire study population and is possibly a significant factor impairing the ability of the current data to assess the validity of the SRQ 8 as a screening tool.

The literature persistently comments on the high numbers of female victims of torture. The initial data recorded by SACST did not make any reference to tortures specific to women e.g. sexual torture. Women's mental health is a personal interest. Being both more physically and emotionally vulnerable than their male counterparts, it is my opinion that this is a traumatic gender vulnerability that warrants exploration and possible therapeutic intervention in support organisations like SACST.

The lack of detailed specification between the main study variables of the four groups of torture (witnessed/ experienced/ physical/

psychological) is a short-coming of the study and should further similar studies be conducted at similar organisations the above factors need to be taken into consideration and addressed where possible. As the current SACTS recorded data recorded does not enable clear distinction between the variables, individual interviews with the attendees at the centre would possibly be a solution to gaining detailed information specific to the torture experiences endured and subsequent psychiatric sequelae.

Despite these limiting factors the findings of this study highlight the humanitarian crises faced by survivors of political violence and torture, the need for awareness and acknowledgement of the above, the need for establishment and funding of essential support structures and also the potential economic contribution this young educated immigrant population offers.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

The currently available literature, both international and localised to Africa, detailing trauma experiences and subsequent related psychiatric illness is very limited. The message that they all convey is essentially the same- survivors of torture do suffer from significant psychopathology, especially MDD and PTSD. The findings in this local record review of survivors of political turmoil and torture experiences from neighbouring Zimbabwe are in concurrence with the above.

Irrespective of the form of torture experienced, this review highlighted the high prevalence of subsequent psychiatric illness in those victims that were able to receive formalised psychiatric assessment. In keeping with the available literature reviewed it echoes the need for early and professional psychiatric interventions to decrease morbidity and also to optimise not only survival but also growth and development of this educated and skilled migrant population into the host nation. Effective appropriate interventions can be postulated to benefit the Republic of South Africa. This assistance if considered from a humanitarian perspective will enable, even if of varying degrees individually, the psychological healing of the torture victims. This has the ability to significantly decrease the long-term consequences of chronic ill health, both physical and mental, and hence minimise the strain on an already heavily burdened South African public health care system. The desired resultant effect is that

of a mentally healthy, well-educated, working refugee population integrating into society and contributing to growing the economy.

Currently, acknowledgement of the mental health sequelae of politically related traumas/ tortures is low. The financial resources necessary to sustain vital support organisations like SACST is minimal. It is hoped that further research in this field to highlight the plight suffered by these survivors of political turmoil aids public awareness of this genuine humanitarian crisis and improves tolerance, empathy, respect and basic life support of these torture seeking safety, shelter and acceptance worldwide.

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APPENDIX 1 DATA COLLECTION SHEET

Title: Examining Psychopathology in Victims of Torture

No: ☐

SACTS reference no: ☐

DATA COLLECTION SHEET

1. Demographics

1a. Sex: Male ☐ Female ☐

1b. Age:

<20	21-30	31-40	41-50	51-60	>60

1c. Marital Status:

Single	Married	Divorced	Widowed

1d. Occupation: _____

1e. Level of education:

Primary	Secondary	Tertiary	Nil

2. Experience of torture

	Witnessed	Experienced
Physical torture		
Psychological torture		
Physical and psychological torture		

3. Loss of consciousness during torture experience

Yes	No

4. SRQ 8 total score

0-3	
4-6	
7-8	

5. Present state of health

Physical score	
Psychological score	
Sleep score	
Total score	

6. Referral to psychiatric services

Yes	No

7. If Yes , outcome

Diagnosis:		
Medication commenced:	Yes	No

APPENDIX 2 ZTVP INTAKE FORM

SECTION ONE:

Demographic Information:

Name: **.....**Sex: .....Date of birth: ..…….. Age: .....…..

Address…….

I.D. Number:……

Marital Status:

Married: YES / NO Length of marriage:……..

Type of marriage:
Civil marriage: YES / NO
Traditional marriage: YES / NO
Polygamous marriage: YES / NO
Living with partner: YES / NO

If not married:
Single: YES / NO
Divorced: YES / NO
Widowed: YES / NO

Children / Dependents:
Number of own children:..... Number of dead children:.....

Number of dependents (*how many people are you currently supporting?*) ……

Education:
Nil education:.....

Primary /Secondary /Tertiary
(*last level of education*) …….
(*What year was this?)*....

Employment:
Employed (*last employed as*?)...
……..

Unemployed (*since when?*) …….

Reason for unemployment ……..
……..

Client Declaration:

I…… am willing / not willing to have the circumstances of my experience to be sent to the relevant Commissions and agencies for action to be taken against the perpetrators and grant the **Zimbabwe Torture Victims Project** the powers to do whatever is necessary to achieve this goal.

Client Signature…….. Witness……

SECTION TWO

Self Reporting Questionnaire (SRQ-20)

Read each statement aloud to the patient. Patients should be asked to respond YES or NO to each question. Try to restrict discussion about each question during testing: you may wish to discuss the answers after the test as whole has been given. Tick the box below - YES or NO - as required by the patient's answer.

		YES	NO
i.	Do you often have headaches?		
ii.	Is your appetite poor?		
iii.	Do you sleep badly?		
iv.	Are you easily frightened?		
v.	Do your hands shake?		
vi.	Do you feel tense, nervous or worried?		
vii.	Is your digestion poor?		
viii.	Do you have trouble thinking clearly?		
ix.	Do you cry more than usual?		
x.	Do you feel more unhappy than usual?		
xi.	Do you find it difficult to enjoy your daily activity?		
xii.	Do you find it difficult to make decisions?		
xiii.	Is your daily work suffering?		
xiv.	Are you unable to play a useful part in life?		
xv.	Have you lost interest in things?		
xvi.	Do you feel that you are a worthless person?		
xvii.	Has the thought of ending your life been in your mind?		
xviii.	Do you feel tired all the time?		
xix.	Do you have uncomfortable feelings in your stomach?		
xx.	Are you easily tired?		

TOTAL SRQ-20 SCORE: .....

SRQ-20 ANXIETY SCORE: .....

SRQ-20 DEPRESSION SCORE: .....

SECTION THREE:

Part one: Personal description (Narrative)

Please indicate the events that you have experienced recently. (Please specify where and when these events occurred) ***Use extra paper if necessary***

Part Two: Head injury

1. Did you experience any of the following?	**YES**	**NO**	**DATE**
Drowning	……	…...	
…….....			
Suffocation	……	……	
…….			
Blow to the head	……	…...	
…….			

2. Did you lose consciousness? If yes, for how long were you unconscious? (tick as applicable)……..
Less than 30 mins……30-60 mins……60-120 mins……more than 120 mins…….

Part three: Present State of Health

The following questions describe the client's possible present state of health. Read each one carefully and ask the client to describe how much the symptoms have bothered him or her in the past week.

0 – **none 1 - a little 2 - a lot 3 – extremely**

1	Headache	0	1	2	3
2	Dizziness	0	1	2	3
3	Impaired concentration	0	1	2	3
4	Impairment of memory	0	1	2	3
5	Impairment of hearing	0	1	2	3
6	Numbness or pins and needles in arms/legs	0	1	2	3
7	Pains in shoulders or arms	0	1	2	3
8	Pains in legs, including feet	0	1	2	3
9	Backache	0	1	2	3
10	Chest pain	0	1	2	3
11	Palpitations	0	1	2	3
12	Abdominal pains	0	1	2	3
13	Nausea	0	1	2	3
14	Vomiting	0	1	2	3
15	Diarrhoea	0	1	2	3
16	Constipation	0	1	2	3
17	Pain on urination	0	1	2	3
18	Male pain in the genitals, female pelvic pain	0	1	2	3
19	Lacking control on urination or defaecation	0	1	2	3
20	Convulsions or loss of consciousness in the last month	0	1	2	3
21.	Sleep disturbances	0	1	2	3
	Difficulty in falling asleep	0	1	2	3
	Early wakening	0	1	2	3
	Disturbed sleep	0	1	2	3
	Nightmares	0	1	2	3
22	**Menstrual disturbances** If "yes", circle by number: Absence of menstrual periods Too frequent periods Bleeding between periods Very heavy bleeding during periods State Duration of disturbances in months.....	0	1	2	3

PHYSICAL SCORE	
SLEEP SCORE	
PSYCHOLOGICAL SCORE	
TOTAL SCORE	

SECTION FOUR

EXPERIENCE OF VIOLENCE

Description of incidents:

Did adults in the family witness the violence?	YES / NO
Did children in the family witness the violence?	YES / NO
Did other family members experience any violence?	YES / NO

PHYSICAL ASSAULTS	**Yes**	**No**
Slapping or kicking or punching		
Blows with rifle buns, sticks, whips, irons		
Exposure to extreme cold or heat		
Hanging or suspension		
Prolonged standing or crouching		
Submarine, immersion, asphyxiation, strangling		
Burnings		
Electrical shocks		
Rape		
Other forms. Specify		
Total number of Physical Assaults		
DEPRIVATION		
Deprived of food, comfort or communication		
In communication, minimal food and comfort, overcrowding for more than 2.3 days		
Lack of water (more than 48 hours)		
Immobilization, restraint, total darkness (more than 48 hours)		
Lack of sleep (less than 4 hours per night) for 5 days or longer		
Lack of needed medication or medical care for more than 48 hours		
Total number of Deprivation		
SENSORY OVERSTIMULATION		
Constant noises		
Screams and voices		
Powerful lights		
Constant lighting		
Special devices		
Drugs		
Total number of Sensory Over stimulation		

Psychological Torture And Ill-Treatment	**Yes**	**No**
Verbal abuse		
Threats against person		
False accusations		
Abuse with excrement		
Sexual abuse (without violence)		
Menaces against own life		
Menaces against family		
Simulate execution		
Total number of Psychological torture		

WITNESSING VIOLENCE, ILL TREATMENT OR TORTURE:

Assaults		
Slapping, kicking or punching		
Blows with rifle butts sticks whips or irons		
Hanging or suspension		
Prolonged standing or crouching		
Submarine, immersion. Asphyxiation or strangling		
Burnings		
Electrical shocks		
Rape		
Other forms. Specify		
Executions		
Beating		
Shooting		
Stabbing, cutting		
Hanging, strangling		
Burning		
Other forms. Specify		

Total number of Witnessing: .....

Summary of Scores from Assessment:

Section Two

TOTAL SRQ-20 SCORE: .....

SRQ-20 ANXIETY SCORE: .....

SRQ-20 DEPRESSION SCORE: .....

Section Three

Part Two Head Injury

Length of unconsciousness:.....

Part Three (Present State of Health)

Physical Score	
Psychological Score	
Sleep Score	
Total Score	

Section Four (History of Violence)

Physical Torture	
Deprivation	
Impact score	
Sensory over stimulation	
Psychological torture & ill treatment	
Psychological score	
Witnessing assaults	
Witnessing executions	
Witnessing score	

Comments:_____

_____

_____

_____

____

Name of examiner:.....

Date of examination:……

APPENDIX 3 : SELF REPORTING QUESTIONNAIRE (SQR8)

Self Reporting Questionnaire (SQR8)

Read each statement aloud to the patient. Patients should be asked to respond YES or NO to each question. Try to restrict discussion about each question during testing : you may wish to discuss the answers after the test as a whole has been given.

[NB- these questions relate to the last 7 days]

	YES	NO
1. Do you sleep badly?	.....	.....
2. Do you cry more than usual?	.....	.....
3. Do you find it difficult to enjoy your daily activity?	.....	.....
4. Do you find it difficult to make decisions?	.....	.....
5. Is your daily work suffering?	.....	.....
6. Are you unable to play a useful part in life?	.....	.....
7.Has the thought of ending your life been in your mind?	.....	.....
8.Do you feel tired all the time?	.....	.....

TOTAL SRQ-8 SCORE :……

APPENDIX 4 ETHICAL CLEARANCE CERTIFICATE

R14/49 Dr Latisha Raghubir

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M071108

NAME: (Principal Investigator)	Dr Latisha Raghubir
DEPARTMENT:	Psychiatry Centre for the Study of Violence and Reconciliation Braamfontein Centre, Johannesburg, South Africa
PROJECT TITLE:	Examining Psychopathology in Victims of Torture
DATE CONSIDERED:	30/11/2007 (Initial Approval) 14/01/2008 (Certified)
DECISION:	Approved unconditionally
CONDITIONS:	Transfer of Principal Investigator (Dr Kevin Martin to Dr Latisha Raghubir)
SUPERVISOR:	Dr U Subramaney
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	25/10/2013 (Recertified)

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES