

**A STUDY OF TORTURE VICTIMS AT THE CENTRE FOR THE
STUDY OF VIOLENCE AND RECONCILIATION (CSV), USING THE
HARVARD TRAUMA QUESTIONNAIRE (HTQ) AS AN
ASSESSMENT TOOL**

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Declaration

I, Preethi Jayrajh declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Medicine in the branch of Psychiatry at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

(Signature of candidate)

Date: October 2019

Dedication

For my husband Tashlyn Dowra

Acknowledgements

My family for their unwavering support: to my parents Anand & Sharitha Jayrajh and my brothers Avishkar & Shakthi Jayrajh

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Abstract

Refugees and Asylum Seekers often flee their countries of origin fearing persecution. Many of these people have faced trauma including torture. Torture is associated with psychiatric sequelae, commonly Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD). This study looks at the psychiatric outcomes of torture and/or trauma victims, their demographic profile and whether differences in outcomes exist between exposure to physical trauma and other forms of trauma.

Objectives

To assess the psychiatric outcomes of attendees at the Centre for the Study of Violence and Reconciliation (CSV), the majority of whom are refugees and asylum seekers. To specifically assess for symptoms of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD). To assess the demographic profiles of the patients who presented at this clinic and their associations with PTSD and MDD symptoms. To determine if specific types of torture determine different outcomes.

Methods

A retrospective record review was conducted at the CSV of patients who presented from the 01 January 2014 to 03 July 2017. A total of 227 patients were included in the study. The CSV assessment tool was used. This includes section IV of the Harvard Trauma Questionnaire and the Hospital Anxiety and Depression Scale.

Results

This study found that being widowed, unemployed or originating from Ethiopia, Somalia or The Democratic Republic of Congo (DRC) significantly predicted Major Depressive Disorder. No significant association was made with PTSD. Of the sample, 164 (72, 2%) screened positive for PTSD and 142 (62.5%) screened positive for Depression. Despite the majority screening positive for psychopathology, only 21.2% of the patients were referred to a psychiatrist for further intervention.

Only 16.7% of the sample were placed on pharmacotherapy. Sexual Abuse/Rape significantly predicted MDD. There was a trend towards developing MDD after witnessing torture.

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List of Abbreviations

CBT	Cognitive Behaviour Therapy
CIDT	Cruel Inhumane and Degrading Treatments
CSVR	Centre for the Study of Violence and Reconciliation
DRC	Democratic Republic of Congo
DSM	Diagnostic and Statistical Manual of Mental Disorders
GAD	Generalized Anxiety Disorder
HADS	Hospital Anxiety and Depression Scale
HTQ	Harvard Trauma Questionnaire
LHR	Lawyers for Human Rights
JRS	Jesuit Refugee Services
MDD	Major Depressive Disorder
M&E	Monitoring & Evaluation
NET	Narrative Exposure Therapy
PTSD	Post Traumatic Stress Disorder
SSRI	Selective Serotonin Reuptake Inhibitor
TTP	Trauma and Transition Program
UNCAT	United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment

UNHCR United Nations High Commissioner for Refugees

WHO World Health Organisation

WHO-AIMS World Health Organisation Assessment Instrument for Mental Health Systems

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CHAPTER 1 – LITERATURE REVIEW

1.1. Introduction

Torture is a vicious act, whereby the perpetrator uses their position of power to commit deliberate physical, emotional and/or mental suffering upon the victim.

Victims of torture often experience higher rates of psychiatric comorbidity. These individuals often present with Post Traumatic Stress Disorder and higher levels of anxiety and depression (Williams & van der Merwe, 2013). As a result of torture and other circumstances, these people often have to abandon their country of origin and seek refuge in another country. However, the effects of torture often persist for years after the traumatic events.

1.2 Background on Refugees

A refugee is a person who “owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself to the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” (UN General Assembly, 1951). Whereas, an asylum seeker is a person who seeks refugee status but whose status is still pending (United Nations, n.d.).

According to the United Nations High Commissioner for refugees, as of 2015 there were 67.75 million displaced people globally. In South Africa alone, it is estimated that there were 1,096,063 asylum-seekers and 121,645 refugees. Ongoing conflict in Somalia, Eastern Democratic Republic of Congo, Burundi and Mozambique has driven the recent surge of displaced persons in South Africa. Furthermore to this, ongoing economic and political instability in neighbouring Zimbabwe has affected this number (UNHCR, 2016). This may be due to Zimbabwe’s close geographical proximity to South Africa, that makes South Africa a country of refuge.

Refugees flee their countries of origin for many different reasons, including war, persecution and human rights violations (Tribe, 2002). In particular, extensive human rights abuses in Zimbabwe in the early twenty-first century saw a surge of refugees into South Africa along with the emergence of xenophobic violence the following decade (The Centre for the Study of Violence and Reconciliation, 2015).

A study on Zimbabwean refugees, conducted in Polokwane, Limpopo, looked at factors prior to, during and after migration to South Africa. Reasons for fleeing Zimbabwe included lack of basic needs and health care, economic instability and political violence. Trauma experienced during the migration process included physical violence, witnessing violence and female refugees being forced into “survival sex” (Idemudia, et al., 2013).

Experiences after the migration process, such as separation from family, a hostile environment, loss of socio-economic status and an unfamiliar language, also contribute to the refugees’ mental health (Tribe, 2002).

Prevalence rates for psychiatric conditions in refugee populations have varied. A 2006 study of Cambodian refugees found 86 % of the sample suffered from Post-Traumatic Stress Disorder (PTSD) while 80% suffered from Depression (Carlson & Rosser-Hogan, 1991). Refugees in Western countries are ten times more likely than the general host population to have PTSD (Fazel, et al., 2005). A meta-analysis on tortured populations and mental health effects found vastly varying degrees of prevalence of mental illness from 0% to 99% for PTSD and ranges of 3% to 85.5% for depression (Steel, et al., 2009). The differences in rates can be attributed to multiple factors: differences in political and environmental circumstances, as well as differences in study parameters.

1.3 Torture

Definitions of torture have differed. Torture was defined by the United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (UNCAT) as any “act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for

an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions” (United Nations General Assembly, 1984). Whereas trauma is defined by the American Psychological Association as “an emotional response to a terrible event like an accident, rape or natural disaster” (American Psychological Association, 2016).

In essence, torture is a form of trauma. Torture involves at least two people, a victim and the perpetrator. It's a means in which the perpetrator destroys the victims' sense of identity but subjecting them to extreme physical and/or psychological pain as a means to coerce information from them or as a form of punishment. Thus the victim is made to reveal information that may perceive them to be traitors to their communities or beliefs (The Association for the Prevention of Torture, 2001).

Torture is often divided into physical and psychological torture. Psychological torture includes extreme exhaustion, sensory deprivation, water and sleep deprivation, solitary confinement, threats, witnessing trauma or torture of another victim (Berliner, et al., 2004).

Psychological torture is generally speaking more difficult to define and can encompass anything that causes significant mental pain and suffering without touching the body (Reyes, 2007).

1.4 Post Traumatic Stress Disorder

The DSM 5 describes Post Traumatic Disorder as a condition that may develop following exposure to “death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to a trauma, indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics).” The patient would also have re-experience symptoms, avoidance symptoms, negative cognitions and hyperarousal.

These symptoms would have to persist for more than a month and cause functional impairment. PTSD is highly prevalent in certain populations, namely those that have experienced combat, incarceration or rape (American Psychiatric Association, 2013).

1.5 Major Depressive Disorder

Major Depressive Disorder (MDD) is characterised by low mood, anhedonia, changes in neurovegetative functions such as sleep, energy, appetite and libido, and changes in cognition (American Psychiatric Association, 2013). In its severest forms it is a debilitating illness with lifetime incidence as high as 20%. The aetiology of depression is multifaceted, with genetics, neurochemical and endocrine mechanisms all playing a role. Stress is a major determinant in alterations of these systems (Belmaker, R & Agam, G, 2008).

1.6 Psychiatric Sequelae of Torture Victims

Both MDD and PTSD are psychiatric pathologies that are known to follow exposure to torture (Kinzie, et al., 2012). Risk factors that have been identified for the development of PTSD following major trauma include female gender, co-morbid physical illness, and trauma that involved a head injury (Haagsma, et al., 2012). The National Centre for Post Traumatic Stress Disorder published similar findings for PTSD: females, those with lower levels of education and income and being widowed or divorced were more likely to develop PTSD (Halligan & Yehuda, 2000).

An unpublished retrospective record review done at the Southern African Centre for Survivors of Torture by Raghubir found that the majority of torture victims required psychiatric follow up, however approximately only one third were referred to a psychiatrist. Most of these patients were found to have MDD (24%) and PTSD (8%) (Raghubir, 2014)

Another study done at a South African Trauma Clinic (the Victim Empowerment Program at the CSV) found that in the given time frame, only 3.5% of the patients at the clinic were referred for psychiatric assessment. Of these, the rate of PTSD (5.9%) was found to be less than half than that of MDD (17.6%). Thirty-one percent

(31%) of these patients fulfilled criteria for more than one psychiatric diagnosis (Subramaney, 2006).

Syrian Refugees have been studied in recent years. Physically injured Syrian Refugees in Turkey were found to have high rates of Major Depressive Disorder (22.5%). Fifteen percent of the sample in this study had Post Traumatic Stress Disorder (Al-Nuaimi, et al., 2018). Another study on Syrian refugees in Lebanon found a lifetime prevalence of PTSD to be 35.4% while point prevalence was 27.2%. The only demographic factor to influence lifetime prevalence of PTSD was originating from the Syrian city of Origin, Aleppo (Kazour, et al., 2017)

A large study of Syrian refugees residing in Sweden and Turkey was conducted using the Havard Trauma Questionnaire as a screening tool for PTSD. This study found that witnessing trauma, threats to life and assault were high predictors of developing PTSD. Country of resettlement was found to also influence PTSD, where refugees residing in Sweden had lower levels of PTSD compared to refugees residing in Turkey (Chung, et al., 2018)

The type of torture experienced often determines the development and extent of PTSD. Kira *et al* found that psychological torture and rape led to worse outcomes in terms of PTSD, as opposed to physical torture (Kira, et al., 2013). Basoglu found that “Cruel Inhumane and Degrading Treatments” (CIDT) led to higher rates of PTSD than physical torture (Basoglu, 2009).

Refugees were identified as a vulnerable group with regards to the development of PTSD. One prospective study done in the Netherlands examined refugees at presentation and followed them up seven years later, using the Harvard Trauma Questionnaire as a screening tool for PTSD. High rates of PTSD were found both at presentation and follow up. Reasons for persistent high rates have been attributed to poor utilization of the health care systems due to various factors, which included language and cultural differences and poor understanding of illness. However, this same study found that those refugees who utilised health care services, saw an improvement in PTSD symptoms (Lamkaddem, et al., 2014).

Lack of refugee status, as per required documentation, and multiple traumatic episodes have also been identified to contribute to developing PTSD and MDD (Knipscheer, et al., 2014)

A cross sectional, multistage survey done on Somali refugees in Ethiopia found a 38.3% prevalence of MDD. Several factors were associated with a higher rate of MDD. These included multiple traumatic exposures, witnessing a murder, female gender and being denied amenities or health care (Feyera, et al., 2015)

A retrospective record review of refugees living in the United States of America found that sexual assault led to a higher psychological suffering (Hooberman, et al., 2007)

Research in treatment of tortured refugees is limited. Various factors contribute to this including language barriers and cultural factors. However, a combination of pharmacotherapy, psychotherapy and psycho-education (a multidisciplinary team approach) of torture victims has been shown to improve outcomes (Kinzie, et al., 2012).

1.7 Treatment

The treatment of PTSD and MDD often overlaps. Pharmacologically, antidepressants are generally the first line treatment in torture victims, but individual drugs' side effect profile should be considered and treatment individualized. Often a combination of pharmacological treatment is prescribed (Kinzie, 2011).

Psychological treatments for PTSD include trauma focused Cognitive Behaviour Therapy (CBT) and Narrative Exposure Therapy (NET) (Williams, 2013). CBT strategies include helping the patient to normalize their behaviour and reactions subsequent to torture, as well as allowing patients to find a new sense of self and identity. NET involves allowing the patient to narrate their experiences, which is recorded. This can be used by the patient as a record of their experiences or for legal purposes. The therapist is the facilitator in this process (Randers, 2008). Other psychological treatments include insight therapy, psychodynamic therapy and relaxation therapy. Relaxation therapy in particular assists with the physical and pain symptoms that are often long lasting. However, there is no one modality of

psychological therapy that is shown to be superior to another when treating tortured individuals. Rather, a patient centred, individualised approach is recommended (Berliner, et al., 2004)

1.8 Assessing Trauma

The Harvard Trauma Questionnaire (HTQ) was adapted from the Hopkins Symptom checklist by the Indochinese Psychiatry Clinic. The Questionnaire comprises of five parts including questions related to post traumatic symptoms, torture experiences, questions related to head injuries and questions regarding personal experiences. The HTQ has been validated and is a quick and simple tool in assessing trauma patients (Mollica, et al., 1992)

The HTQ has been adapted across cultures. It has a wide range of use. One such use is in the clinical setting as a screening tool for vulnerable persons, to assess the need for further evaluation. It has been used in research to assess outcomes of treatments, to assess and record the symptomology of PTSD across cultures and to assess the variables that influence outcomes (Mollica, et al., 2004)

A cut off score of more than 2.5 for questions 1-16 in part IV of the HTQ is used to indicate symptoms of PTSD after exposure to trauma (Mollica, et al., 2004).

In the scope of this study, the terms “PTSD” and “PTSD symptoms” will refer to a positive HTQ screen (i.e a score of more than or equal to 2.5). The terms “diagnosed PTSD” would refer to a formal diagnosis of PTSD made by a clinician.

1.9 Assessing Depression

The Hospital Anxiety and Depression Scale (HADS) consists of question related to both anxiety and depression. A score of between 8-10 on the relevant section of the HADS indicates borderline symptoms for anxiety or depression, while scores of more than 11 indicate clinical anxiety or depression (Soares-Filho, et al., 2009) (Appendix 3). Sensitivity has been defined as the ability of a test to positively identify the presence of a disease or illness, while specificity is the tests ability to correctly identify negative results in non-diseased individuals (Parikh, et al., 2008). The HADS

has been validated as a screening tool for depression and anxiety. (Spinhoven, et al., 1997). The HADS-D was found to have a sensitivity of 0.80 and a specificity of 0.88 (Olsson, et al., 2005). In the scope of this study, the terms “depression,” “depressive symptoms” or “depressive features” will be referred to when a HADS-D screen is positive. While Major Depressive Disorder (MDD) will be a formal diagnosis given by a psychiatrist after assessment.

CHAPTER 2 – AIMS AND OBJECTIVES

2.1 Aims

To determine psychiatric outcomes in the attendees at the CSVr, the majority of whom are refugees & asylum seekers, following torture, using the CSVr assessment tool [which includes part four of the HTQ and the Hospital Anxiety and Depression Scale (HADS)] to assess for PTSD and depressive symptoms respectively.

2.2 Objectives

- 1) To ascertain if an association exists between the demographic profile of clients referred to the trauma clinic at the CSVr with PTSD symptoms and/or depressive symptoms.
- 2) To determine the presence of symptoms associated with PTSD and depression, in refugees and asylum seekers presenting to the CSVr.
- 3) To determine the various psychiatric outcomes (i.e. referral to specialist psychiatric services and commencement of intervention/s) following the determination of the presence PTSD symptoms and/or depressive symptoms.
- 4) To determine if differences in outcomes exist between exposure to physical trauma (including torture, sexual abuse/rape) and other forms of trauma (e.g. emotional, deprivation, having witnessed death etc).
- 5) To determine whether changes occurred over subsequent follow-ups, with regards to PTSD symptoms and depressive symptoms, using the HTQ and HADS scores as measures.

CHAPTER 3 - METHODS

3.1 Setting

The study was conducted at the Trauma and Transition Programme (TTP) at the Centre for the Study of Violence and Reconciliation (CSVR), Jorissen Street, Braamfontein.

The CSVR was founded in 1989, at the height of political violence in South Africa. It has since grown into a centre whose primary aim is to prevent violence and promote peace. The staff consists of a multidisciplinary team of psychologists, social workers, lawyers, a psychiatrist and criminologists. The centre is involved in research, policymaking & education. The TTP which works with individuals exposed to violence (including torture) providing psychosocial support and intervention to victims. Referrals to the CSVR arose from any organisation, clinical unit or body that encounters a person who may require assistance in this regard. Self-referrals are also seen.

The attendees that present to the TTP are seen and information obtained using the standard assessment form used at the TTP at the CSVR (Appendix 2). This standard assessment form comprises sections of questions for: demographic data, event information (torture/trauma experience), connections with others, coping, locus of control, part IV of the Harvard Trauma Questionnaire (screening for PTSD symptoms), Hospital Anxiety and Depression Scale (which screens for depressive symptoms), a clinical section for additional notes and treatment goals and recommendations. This assessment form is administered by any of the clinical staff as noted above. The clinical section of the assessment form is administered to the patients every three months, if they do present for follow-up, regardless if they were referred to a psychiatrist. Records of this data are kept electronically on a secured database. The majority of the attendees are asylum seekers and refugees, but undocumented migrants may also present to the clinic. It is important to note, that of the small number of South African Citizens seen, most may have migrated from other countries and obtained South African citizenship. For this reason, for purposes of this report, all attendees may be referred to as either “attendees” or “refugees and/or asylum seekers.”

A rehabilitation model is in place at the CSVR as illustrated in Figure 3.3.1 (Bandeira, 2013). The centre provides ongoing psychosocial counselling and therapy to all victims of torture that are able and willing to attend.

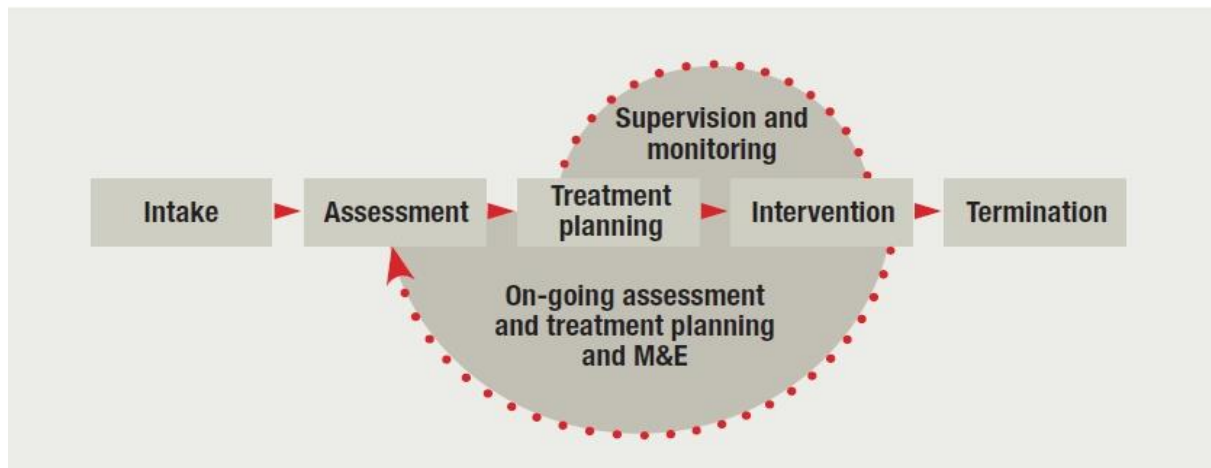


Figure 3.3.1 : The rehabilitation model in place at the CSVR

3.2 Procedures

A retrospective record review of this database of torture victims that presented to the CSVR was conducted. This database was reviewed by the researcher in June-July 2017, and all patients that presented to the clinic between 01 January 2019 and 03 July 2017 were considered for inclusion. This cut-off date was chosen as a sufficient sample size was reached at this point. All males and females, with a history of exposure to torture and/or other trauma were considered for the study. Data from the whole standard assessment form was extracted, however certain sections were pertinent to this study: demographic data, torture/trauma experience, HADS-D scores and Part IV of the HTQ. Part IV of the HTQ was selected as this section specifically references trauma symptoms. Patients who had no standard assessment form completed within the above stipulated dates were excluded.

A proportion of patients who are seen and assessed with the standard assessment form are then referred to see the psychiatrist. Over and above the electronic data base, physical files for these patients who are seen by the psychiatrist were also reviewed. All patients who are referred to the psychiatrist have a physical file

opened. In total there were 79 files. Of these 31 were excluded from the study: 3 were not concurrently found on the electronic database (thus would have important data missing), 15 were out of dates for the study, 12 had no standard assessment form completed and 1 did not arrive for the appointment with the psychiatrist. Therefore, 48 patient files were reviewed.

Data was extracted from the database and files using the attached data collection sheet (Appendix 5), bearing the allocated number

3.3 Measures

A section on traumatic events experienced is included in the CSV-R assessment tool. These trauma categories are divided into three broad categories: “Personal experience”, “Witnessed” and “Happened to someone I know.” Categories included in this study are having personally experienced torture, personally experienced rape/sexual assault, personally experienced lack of shelter, witnessed rape/sexual abuse and witnessed torture. The first two categories refer to “physical torture/trauma”. The latter three categories fall under “psychological torture.”

3.4 Data Analysis

All statistical analyses was conducted using R software (R version 3.4.4; <https://www.r-project.org>). All tests were two-tailed probability values, and statistical significance accepted when $\alpha \leq 0.05$. The data set for this study was generated mainly from assessments of categorical scores, so appropriate non-parametric analyses were used. A General Linear Model (GLM; glm2 package) was used to analyse how the demographic parameters (fixed and continuous factors) and the exposure to physical trauma and other forms of trauma influenced the relationship between PTSD and Depression scores (yes, no) on the HTQ and HADS-D respectively. All GLM analyses involved binomial models with a logit link function. χ^2 statistics were generated using the car package and z statistics, including estimate and SE values, were generated in the glm2 package for specific pairwise comparisons for fixed factors. All other statistics are χ^2 tests for proportions. The data are presented as counts or percentages, as appropriate.

3.5 Ethics

Permission to conduct this study was granted to the researcher by the CSVr (Appendix 1).

The protocol for the study was submitted to the Human Research Ethics Committee of the University of the Witwatersrand Faculty of Health Sciences and ethics clearance was obtained. (Appendix 4)

The identity of the participant was not reflected in any of the research documentation. All participants whose records have been reviewed was assigned a unique reference number to maintain anonymity.

CHAPTER 4 - RESULTS

A total of 232 refugees and asylum seekers who presented to the Centre for the Study of Violence and Reconciliation (CSVr) between 01/01/2014 and 03/07/2017 were considered in this study. Of these, data for 227 people could be used in the analyses because they had a full complement of assessments and data. In this study a HTQ score of more than or equal to 2.5 indicated a positive screening for PTSD, and a HADS score of more than or equal to 11 indicated a positive screening for depression.

4.1 The Demographic Profile of Patients

Of the 227 patients included in this study, 49.3% (n=112) were female and 50.6% (n=115) were male. The majority of the patients were married (51.7%). The majority of the patients had an education, 19.82% (n=45) completed secondary school while 22% (n=50) of the sample had completed tertiary education. However 66.51% (n=151) were unemployed at the time of assessment. Table 4.1.1 shows a summary of the demographic factors of the patients included in this study.

Table 4.1.1 A table of the demographic profiles of the patients seen at the CSVR

Category	Variable	N	Percentage
Gender	Female	112	49%
	Male	115	51%
Marital Status	Divorced	19	8%
	Married	116	51%
	Single	67	30%
	Widowed	22	10%
Highest level of education	Completed primary	15	7%
	Completed secondary	45	20%
	Missing	25	11%
	No schooling	15	7%
	Post-graduate	15	7%
	Some primary	19	8%
	Some secondary	43	19%
	Tertiary	50	22%
Employment	Highly skilled / professional	4	2%
	Minor	5	2%
	No data	7	3%
	Semi skilled labour	18	8%
	Skilled labour	8	4%
	Student	2	1%
	Unemployed	151	67%
	Unskilled labour	32	14%
Documentation & Nationality	Asylum seeker	96	42%
	Citizen	12	5%
	Refugee	92	41%
	Undocumented	12	5%
	Burundi	13	6%
	Congolese (Brazzaville)	2	1%
	Congolese (DRC)	83	37%
	Eritrean	4	2%
	Ethiopian	42	19%
	Rwandan	3	1%
	Somali	43	19%
	South African	12	5%
	Ugandan	5	2%
	Zimbabwean	14	6%

The incidence of PTSD was not influenced by any of the demographic parameters considered in this study (Table 4.1.2, Figures 4.1.1; 4.1.2. to 4.1.7). Depression was not predicted by the age (Figure 4.1.8) but was predicted by marital status, employment and country of origin (Table 4.1.2, Figure 4.1.9 to 4.1.11). Being widowed (Estimate = 2,89, SE = 1.12, $z = 2.57$, $p = 0.010$; Figure 4.1.9), unemployed (Estimate = 0.92, $z = 2.31$, $p = 0.021$; Figure 4.1.10) originating (Figure 4.1.11.) from the DRC (Estimate = 0.16, SE = 0.24, $z = 2.14$, $p = 0.032$), Ethiopia (Estimate = 0.16, SE = 0.24, $z = 1.96$, $p = 0.050$) and Somalia (Estimate = 0.17, SE = 0.24, $z = 2.00$, $p = 0.046$) significantly predicted depression.

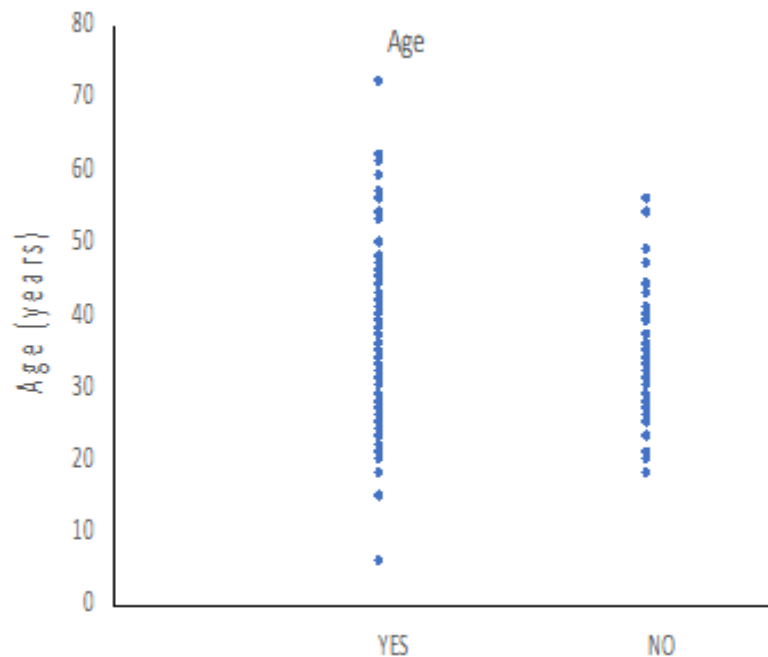


Figure 4.1.1. Distribution of age of refugees and asylum seekers at CSVr in relation to the presence (Yes) and absence (No) of PTSD symptoms.

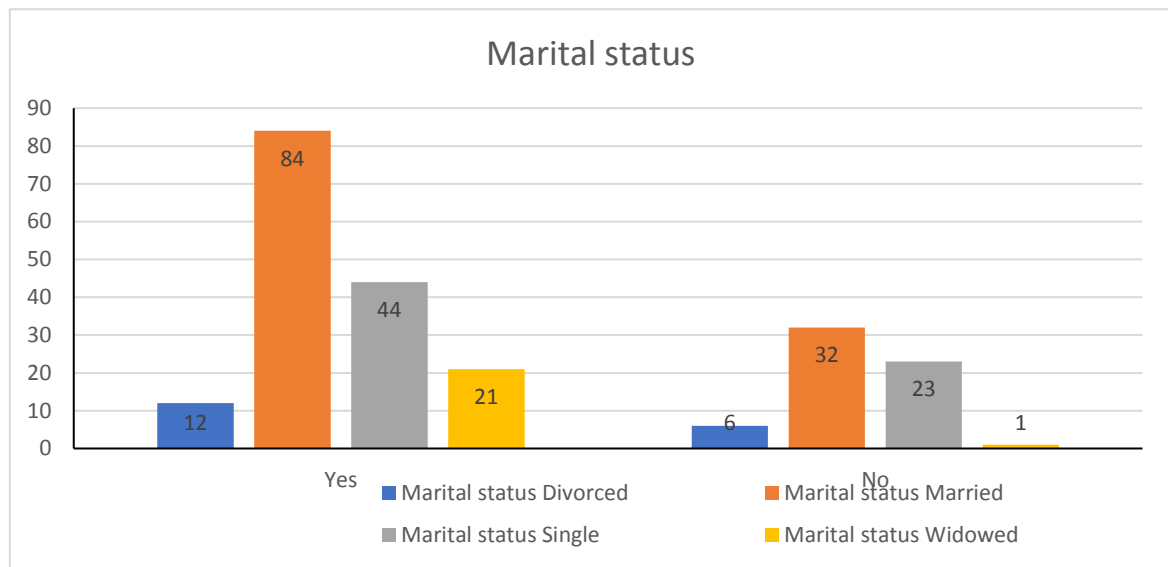


Figure 4.1.2. Marital Status of the patients at the CSVR who screened positive (Yes) or negative (No) for PTSD

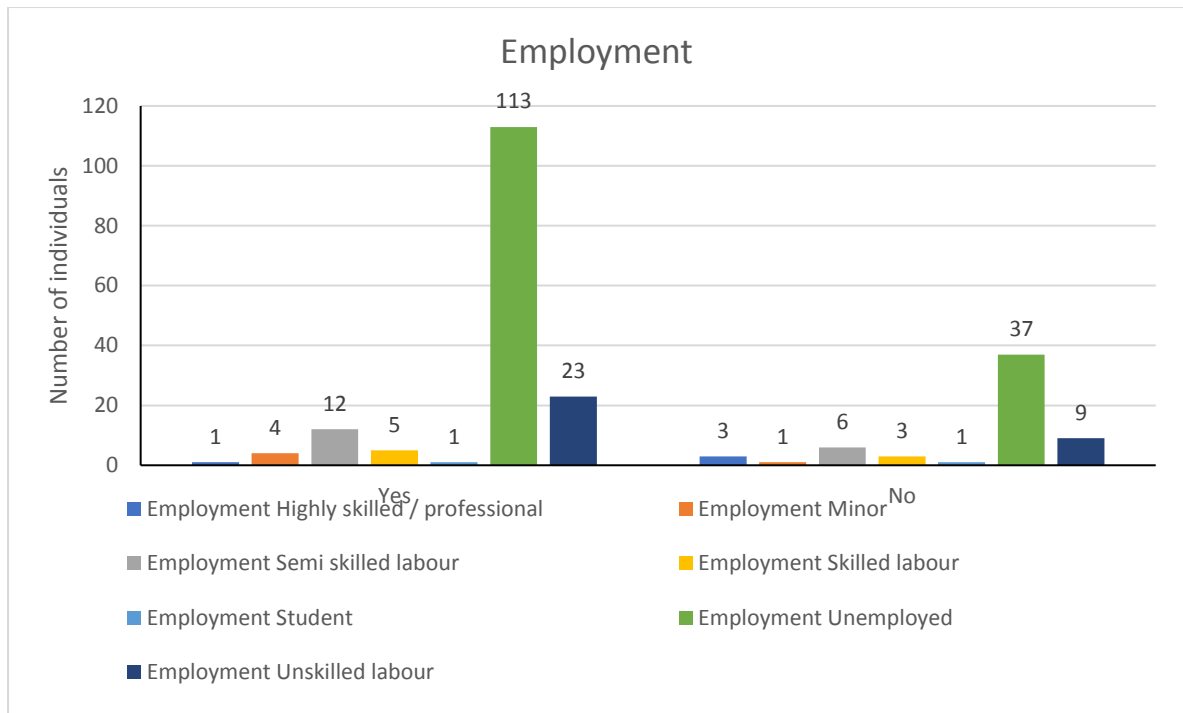


Figure 4.1.3. Employment of patients at the CSVR who screened positive (Yes) or negative (No) for PTSD

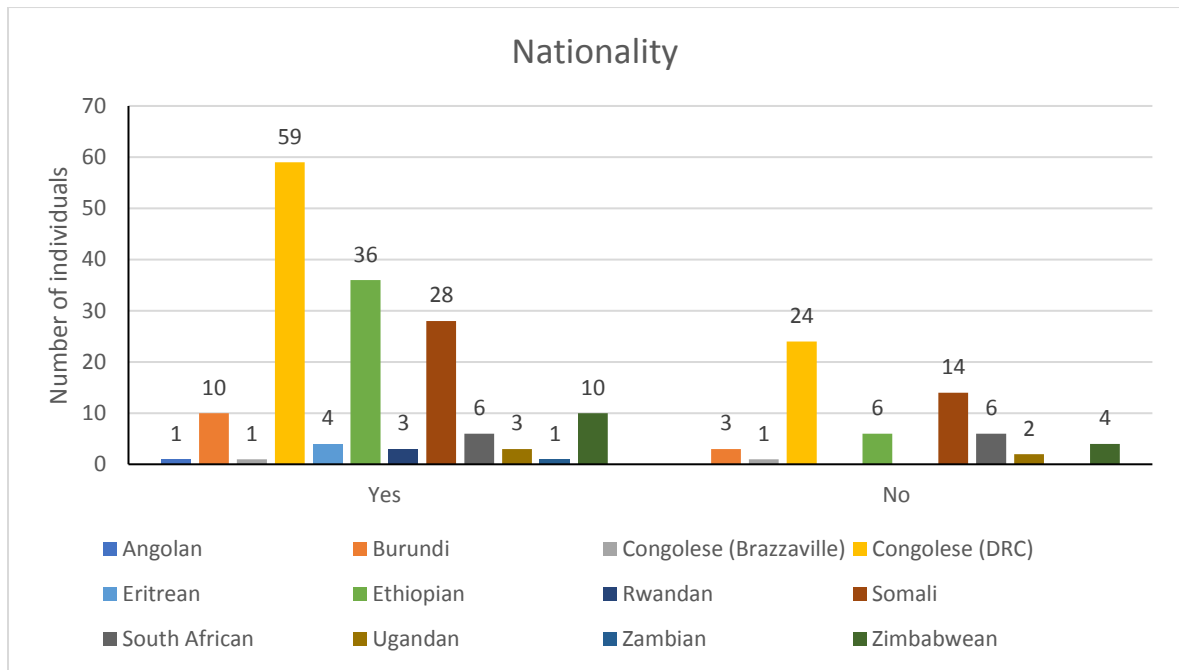


Figure 4.1.4. Nationality of patients at the CSVR who screened positive (Yes) or negative (No) for PTSD.

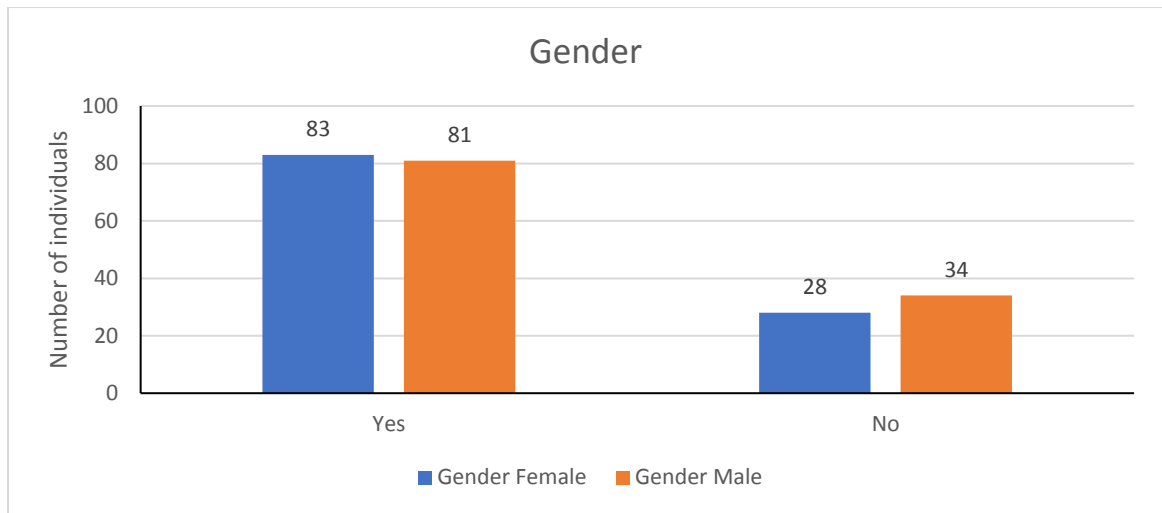


Figure 4.1.5. Gender of patients at the CSVR who screened positive (Yes) or negative (No) for PTSD.

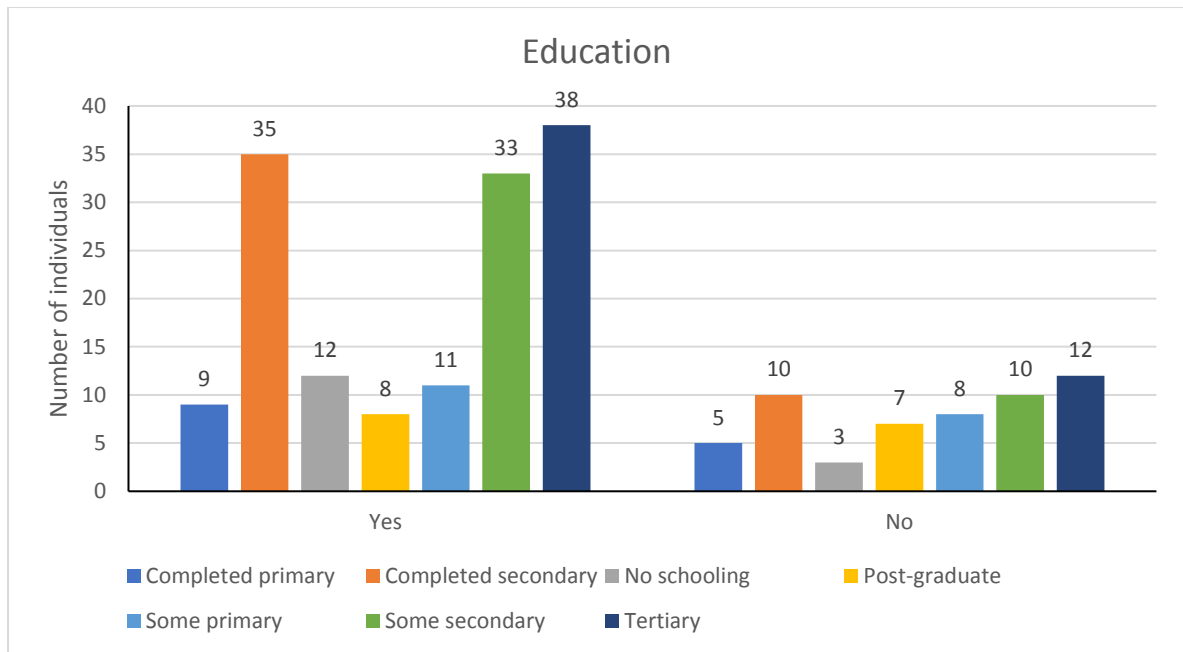


Figure 4.1.6.. Level of Education of patients at the CSVR who screened positive (Yes) or negative (No) for PTSD.

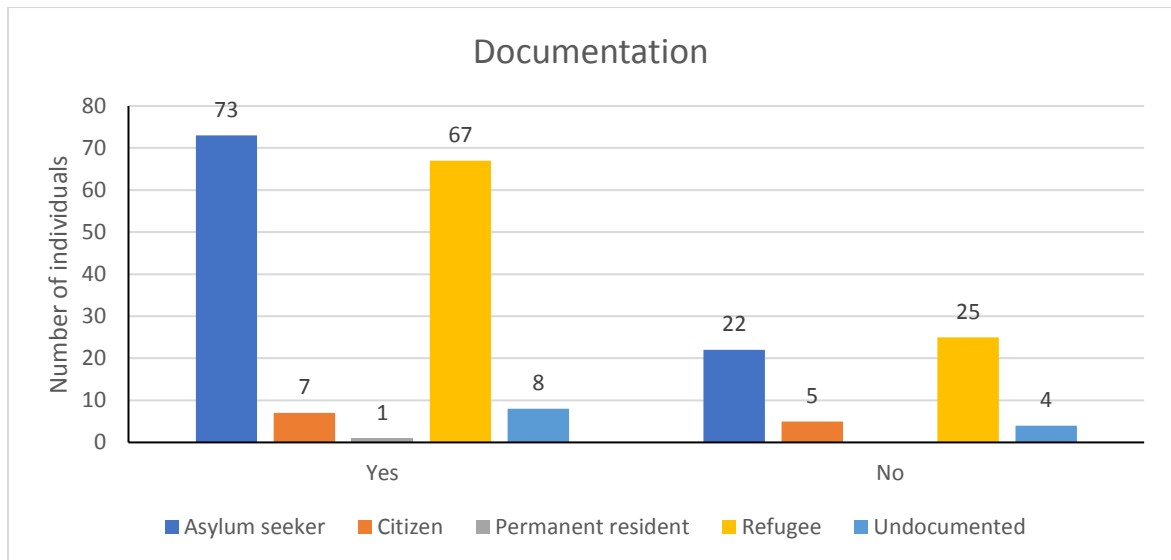


Figure 4.1.7. Documentation of patients at the CSVR who screened positive (Yes) or negative (No) for PTSD.

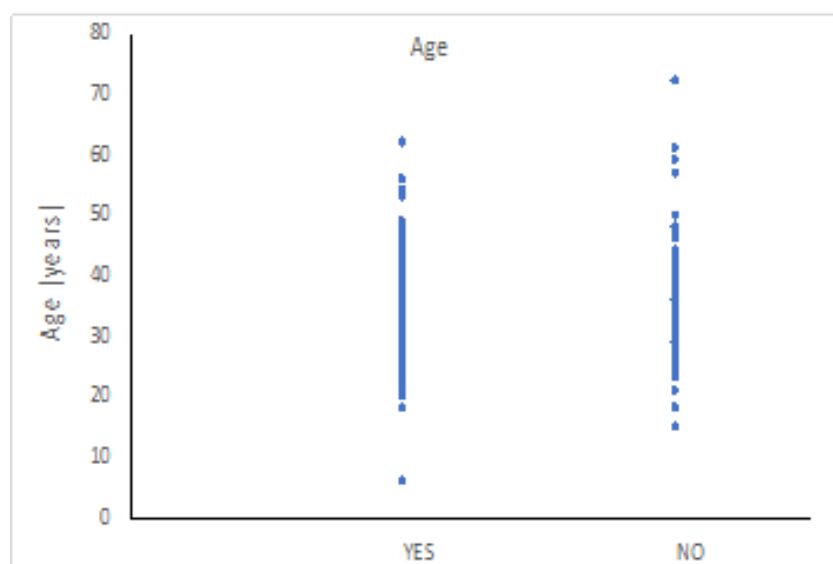


Figure 4.1.8. Distribution of age of refugees and asylum seekers at CSVR in relation to the presence (Yes) and absence (No) of depression symptoms.

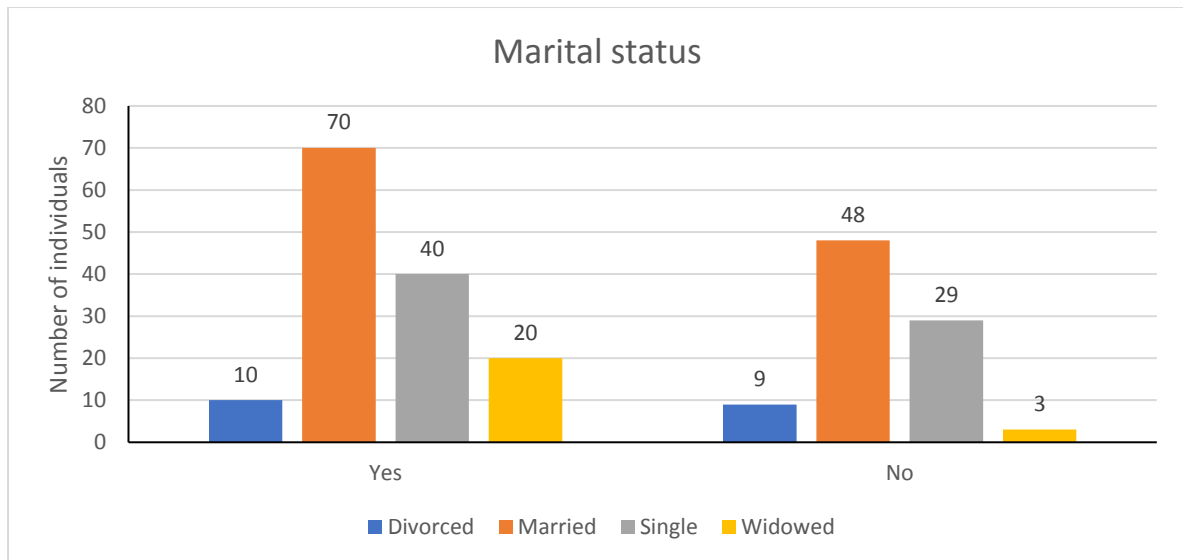


Figure 4.1.9. Marital Status of refugees and asylum seekers at the CSVR who screened positive (Yes) or negative (No) for depression.

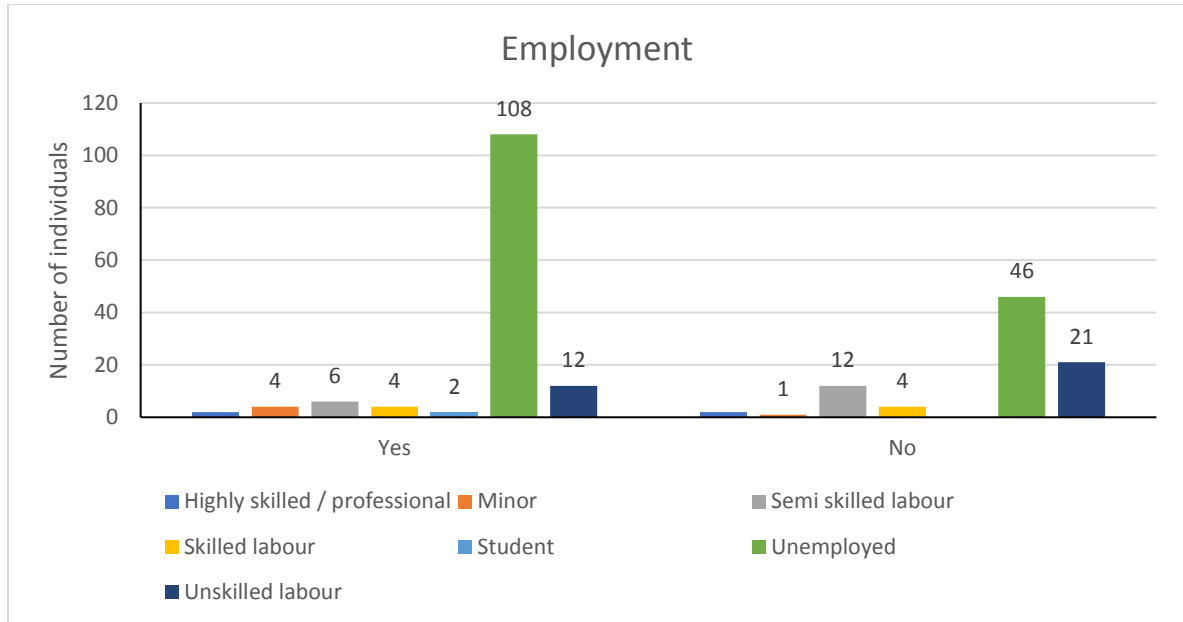


Figure 4.1.10. Employment of refugees and asylum seekers at the CSVR who screened positive (Yes) or negative (No) for depression.

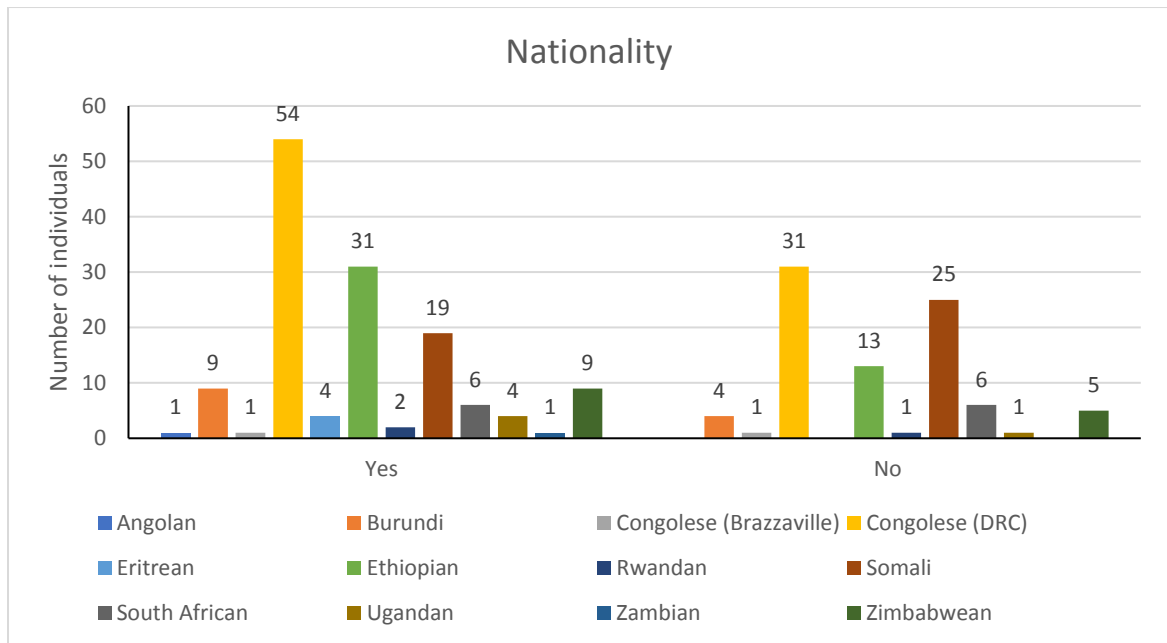


Figure 4.1.11. Nationality of refugees and asylum seekers at the CSVR who screened positive (Yes) or negative (No) for depression.

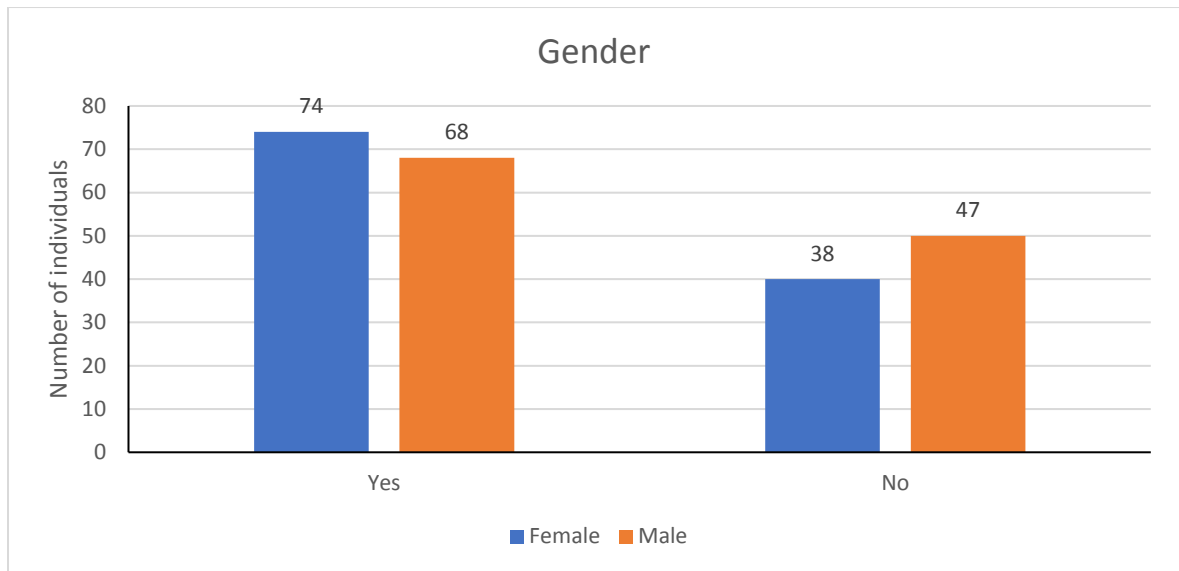


Figure 4.1.12. Gender of refugees and asylum seekers at CSVR who screened positive (Yes) or negative (No) for depression.

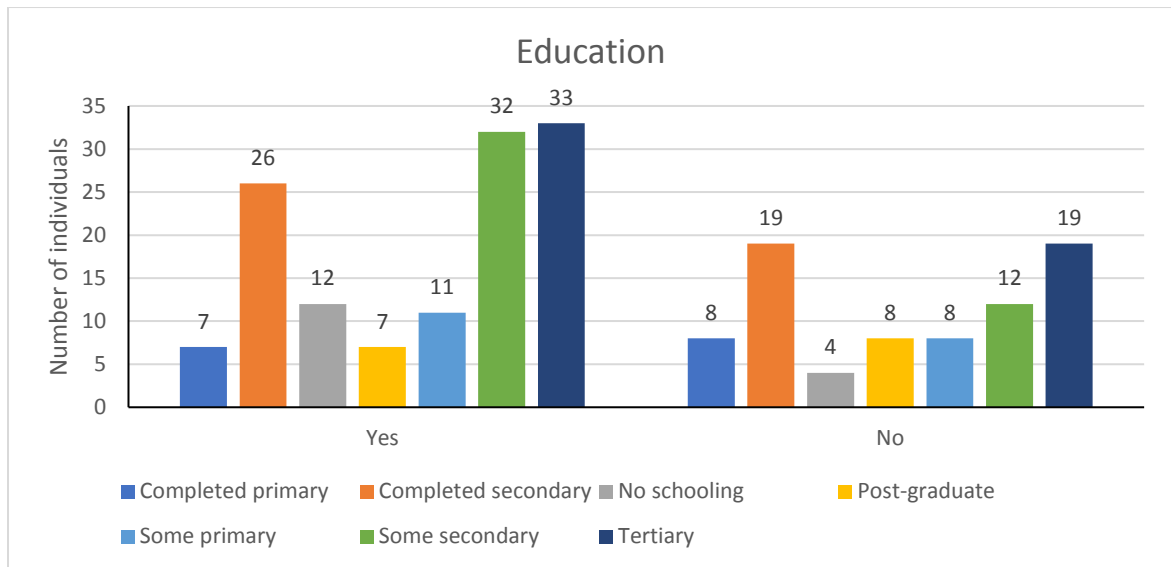


Figure 4.1.13. Level of Education of refugees and asylum seekers at CSVr who screened positive (Yes) or negative (No) for depression.

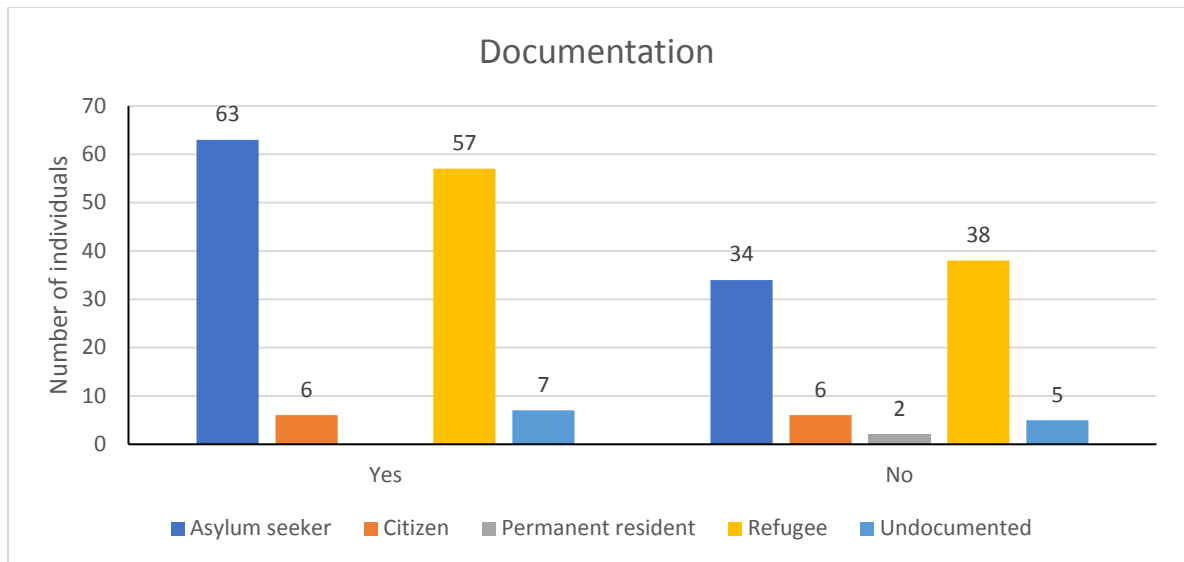


Figure 4.1.14. Documentation of refugees and asylum seekers at CSVr who screened positive (Yes) or negative (No) for depression.

Table 4.1.2. Statistical output of a General Linear Model (shown as χ^2 , df, p) analysing the relationship between demographic parameters and PTSD. Values in bold are significant.

Demographic parameters	PTSD		
	χ^2	df	P
Gender	0.39	1	0.537
Age	7.44	42	0.998
Marital status	5.01	5	0.415
Highest level of education	5.50	12	0.939
Employment	0.82	8	0.999
Documentation	1.79	6	0.938
Country of origin	3.35	14	0.998
Number of children	0.20	1	0.658

Table 4.1.3. Statistical output of a General Linear Model (shown as χ^2 , df, p) analysing the relationship between demographic parameters and Depression. Values in bold are significant.

Demographic parameters	Depression		
	χ^2	df	P
Gender	1.17	1	0.280
Age	44.47	42	0.368
Marital status	15.92	5	0.007
Highest level of education	12.40	12	0.414
Employment	24.31	8	0.002
Documentation	4.60	6	0.596
Country of origin	24.24	14	0.043
Number of children	0.94	1	0.332

4.2 Symptoms associated with PTSD and Depression:

For the PTSD scores, significantly more refugees and asylum seekers presented with symptoms (HTQ score of ≥ 2.5) than those that did not ($\chi^2 = 46.04$; $df = 1$; $p < 0.001$; Figure 4.2.1). Significantly more refugees and asylum seekers presented with depression symptoms (HADS score of ≥ 11) than those that did not ($\chi^2 = 14.31$; $df = 1$; $p < 0.001$; Figure 4.2.2.)

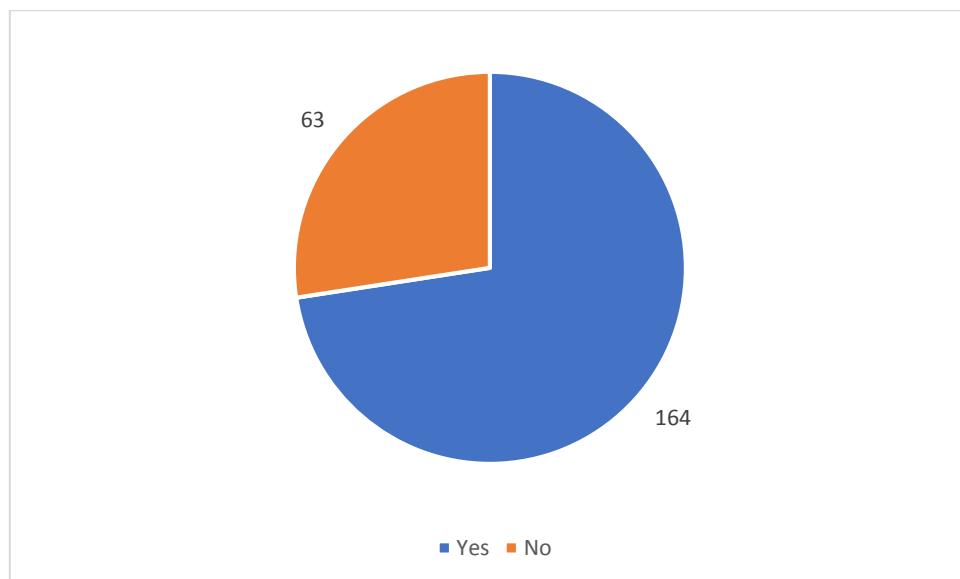


Figure 4.2.1 The number of refugees and asylum seekers at CSVr that were assessed with symptoms of PTSD

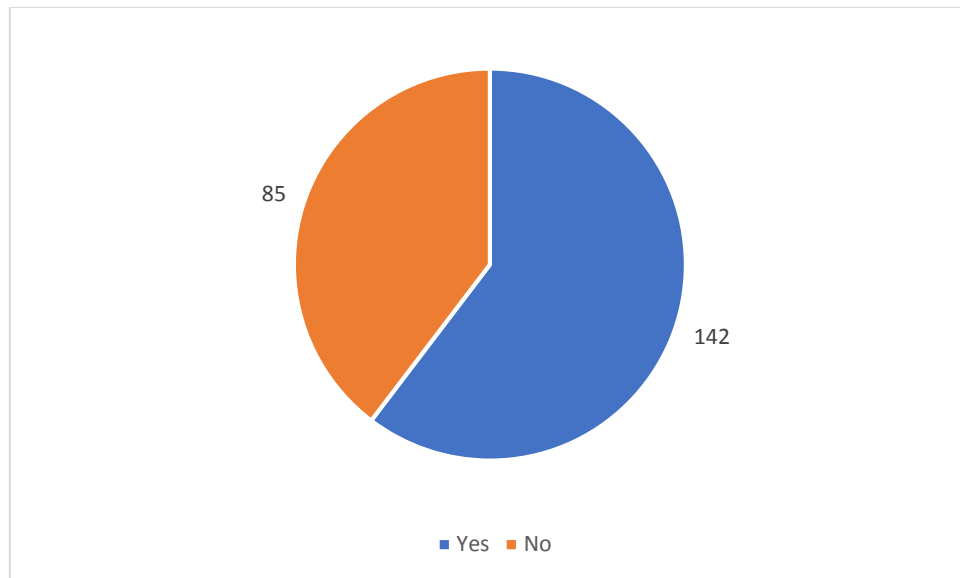


Figure 4.2.2 The number of refugees and asylum seekers at CSVR that were assessed with symptoms of depression.

4.3 Psychiatric outcomes of PTSD and Depression

Of the total 227 patients considered in the study, 164 (72.2%) screened positive for PTSD and 142 (62.55%) screened positive for Depression. However only 49 patients (21.58%) were referred to the psychiatrist. 48 (21.2%) were seen by the psychiatrist and 38 (16.7%) were placed on medication. Moreover, of the 164 patients who screened positive for PTSD (Figure 4.2.1), a significantly small number (41 patients; 25%) were referred to a psychiatrist ($\chi^2 = 41.0$; $df = 1$; $p < 0.001$; Figure 4.3.1). Similarly, only 34 of 142 (23.9%) patients that were initially screened with depression (Figure 4.2.2) were referred to a psychiatrist (Figure 4.3.2), which was significantly less than chance ($\chi^2 = 34.75$; $df = 1$; $p < 0.001$).

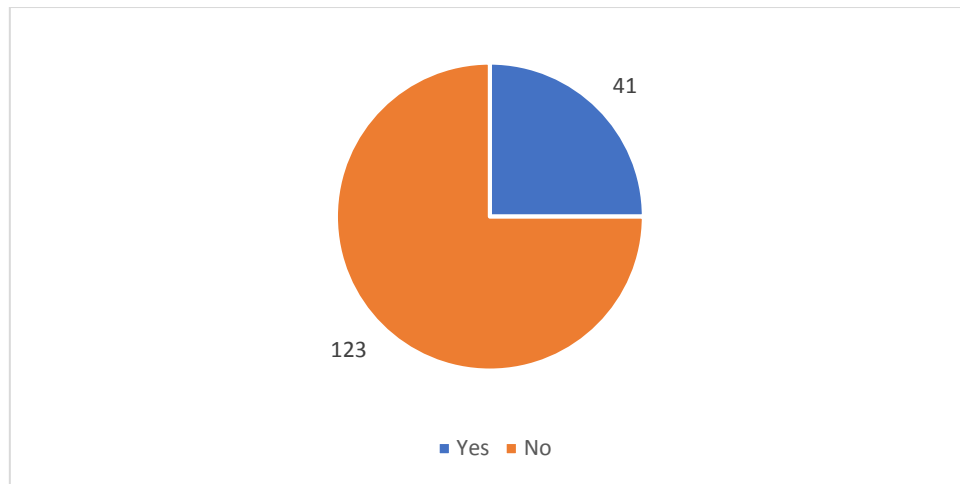


Figure 4.3.1 The total number of refugees and asylum seekers at CSV that were assessed with symptoms of PTSD, and the number (Yes) referred to a psychiatrist.

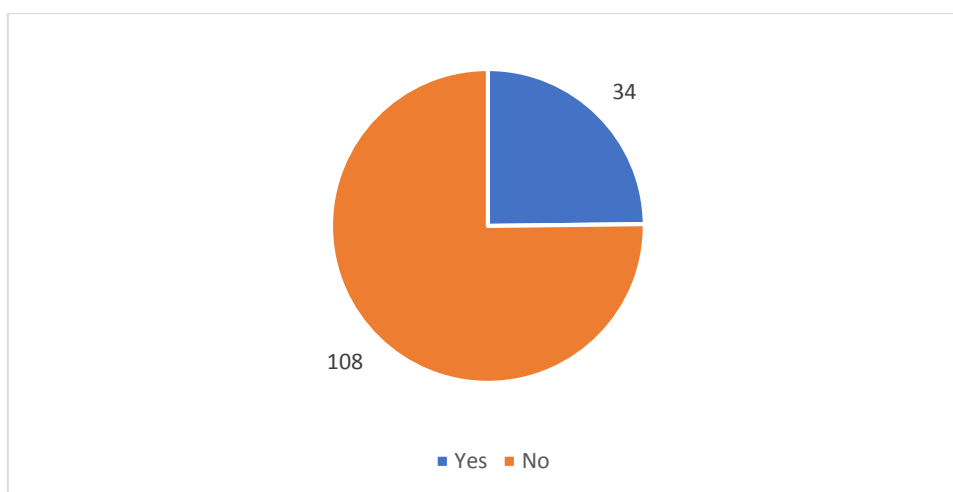


Figure 4.3.2 The total number of refugees and asylum seekers at CSVr that were assessed with symptoms of depression, and the number (Yes) referred to a psychiatrist.

Of the 48 patients seen by the psychiatrist, 38 were placed on medication, the majority of which was a Selective Serotonin Reuptake Inhibitor (SSRI). The types of medication that was prescribed was compared. Significantly more patients were prescribed Fluoxetine (n=23) compared to Citalopram (n=5), Venlafaxine (n=2) and other types (n=8), which differed significantly from chance ($\chi^2 = 33.53$; df = 3; $p < 0.001$)

Of the 10 that were not placed on medication: two patients were epileptic and four were found to be psychotic, these patients were referred for further treatment. One of the patients was found to have defective personality traits, one assessed with dysthymia, one had missing data in the file and one patient was breastfeeding therefore pharmacotherapy was omitted.

4.4 Effects of physical trauma and other forms of trauma

The following trauma experiences were recorded: A total of 182 (81.1%) patients personally experienced torture, 41 (18.1%) patients witnessed torture, 77 (33.9%) experienced rape/sexual abuse, 51 (22.5%) witnessed rape/sexual abuse and 153 (67.4%) personally experiences lack of shelter.

Table 4.4.1. Statistical output of a General Linear Model (shown as χ^2 , df, p) analysing the relationship between types of trauma and PTSD.

Type of trauma	PTSD		
	χ^2	Df	P
Personal experience of rape / sexual abuse	2.17	2	0.334
Personal experience of torture	3.25	2	0.197
Personal experience of lack of shelter	2.25	2	0.325
Witness of rape / sexual abuse	0.51	2	0.775
Witness of torture	0.40	2	0.819

Table 4.4.2. Statistical output of a General Linear Model (shown as χ^2 , df, p) analysing the relationship between types of trauma and Depression. The value in bold is significant and the asterisk indicates a tendency to significance

Type of trauma	Depression		
	χ^2	Df	P
Personal experience of rape / sexual abuse	10.29	2	0.006
Personal experience of torture	0.41	2	0.814
Personal experience of lack of shelter	0.97	2	0.616
Witness of rape / sexual abuse	2.57	2	0.277
Witness of torture	5.97	2	0.051*

The incidence of PTSD (HTQ score of more than or equal to 2.5) was not predicted by personally experiencing or witnessing trauma (Table 4.4.1, Figures 4.4.1. and 4.4.2). In contrast, depression was predicted by personal experience of rape / sexual abuse, with a significant predictability between experiencing sexual trauma and depression than not showing depression (Estimate = 0.98, SE = 0.32, z = 3.09, p =

0.002; Figure 4.4.8). There was also a trend of witnessing torture influencing depression (Table 4.4.1), and interestingly there was significantly reduced predictability of witnessing torture and showing depression (Estimate = 0.87, SE = 0.41, $z = 2.13$, $p = 0.033$; Figure 4.4.9).

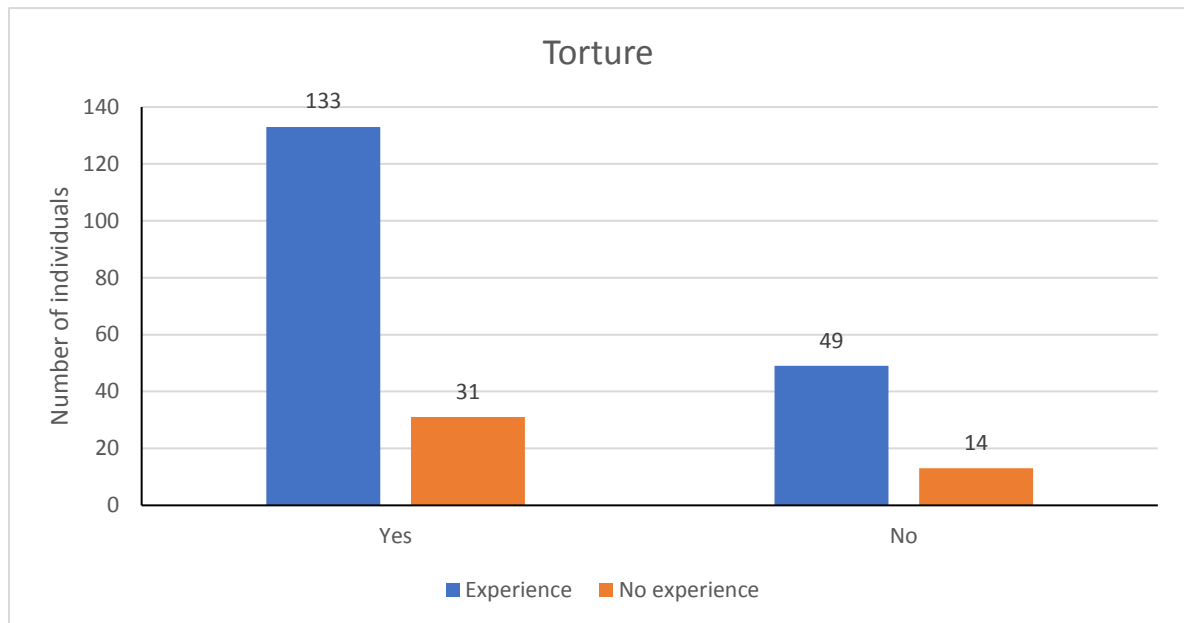


Figure 4.4.1. The number of refugees and asylum seekers at CSVr who screened positive (Yes) and negative (No) for PTSD, that did or did not experience torture

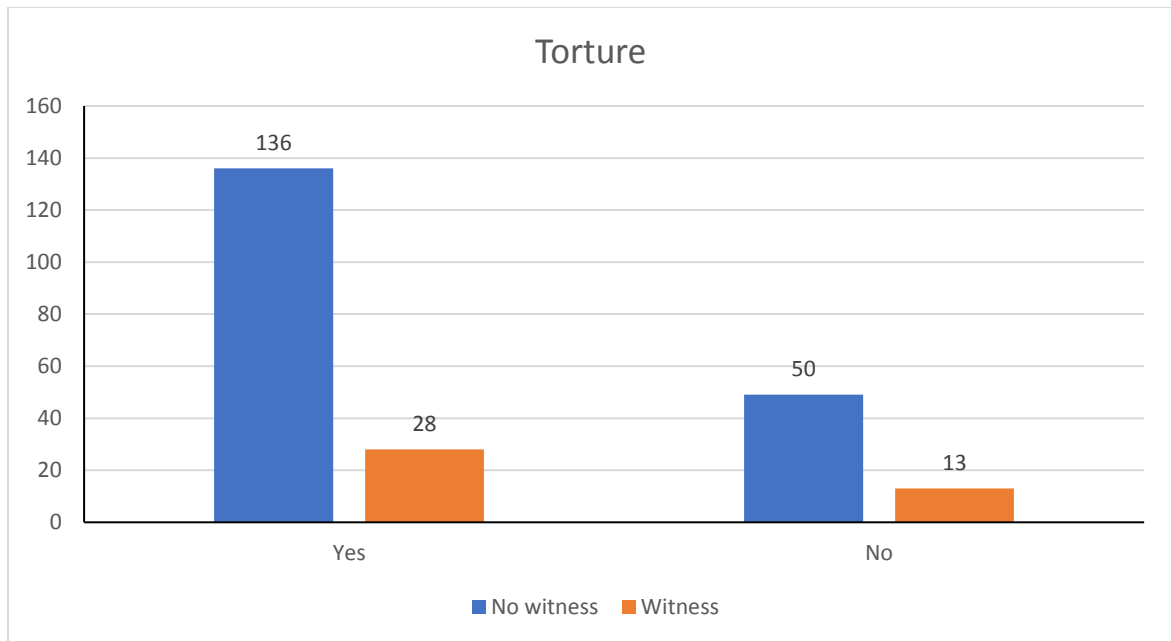


Figure 4.4.2. The number of refugees and asylum seekers at CSV who screened positive (Yes) and negative (No) for PTSD that did or did not witness torture.

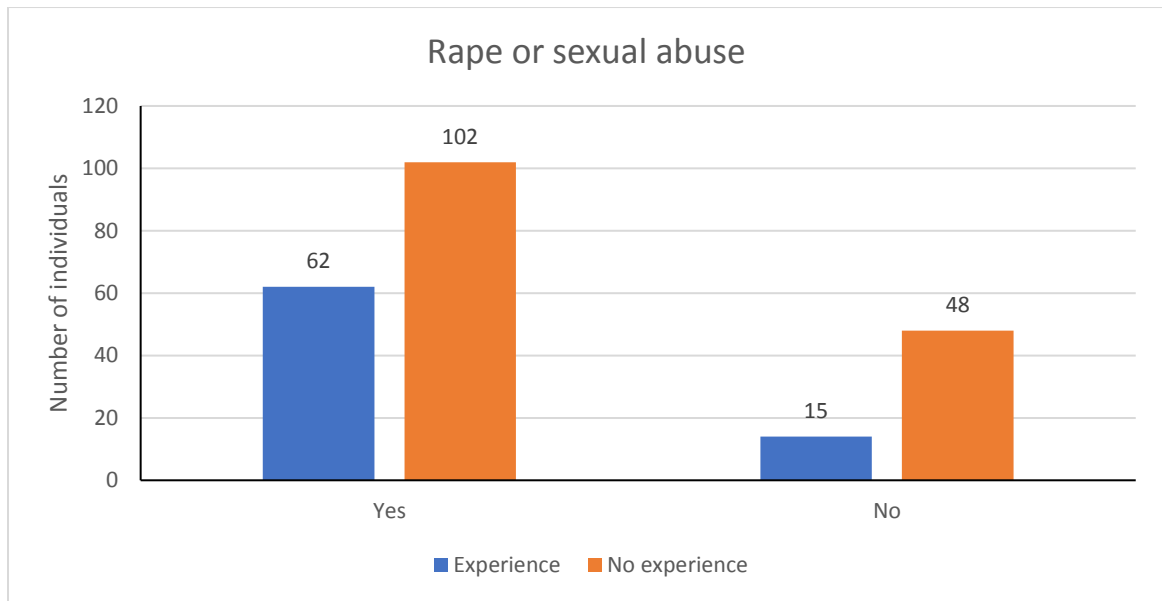


Figure 4.4.3. The number of refugees and asylum seekers at CSVR who screened positive (Yes) and negative (No) for PTSD that experienced and did not experience Rape or sexual abuse.

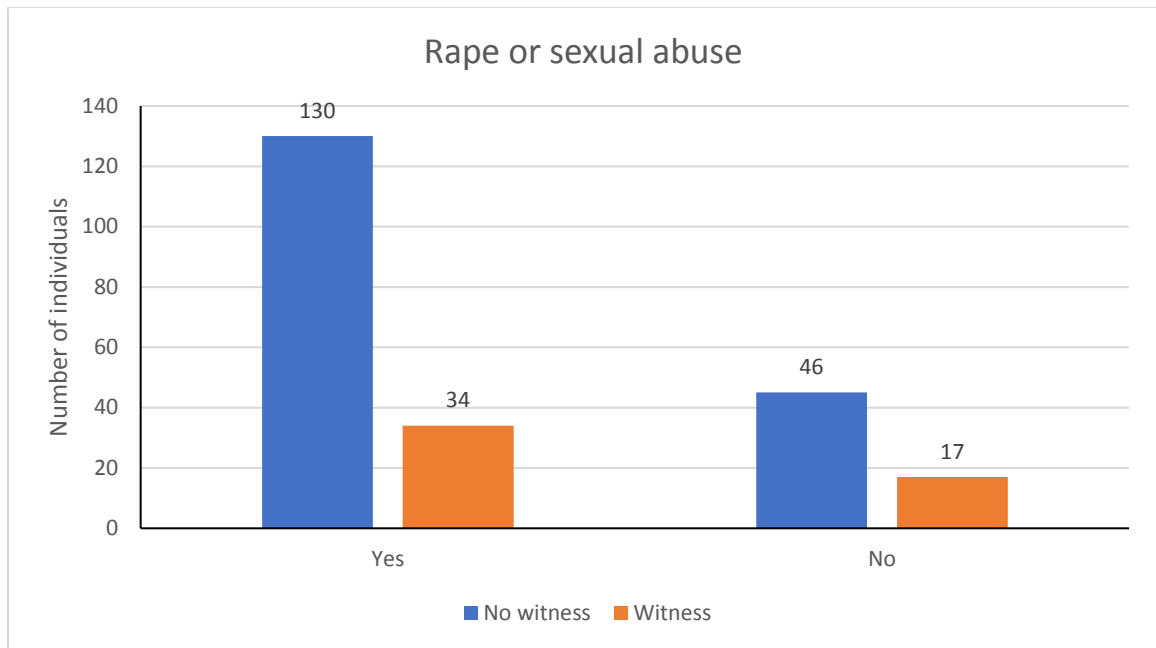


Figure 4.4.4. The number of refugees and asylum seekers at CSVR who screened positive (Yes) and negative (No) for PTSD, that did or did not witness rape/sexual abuse

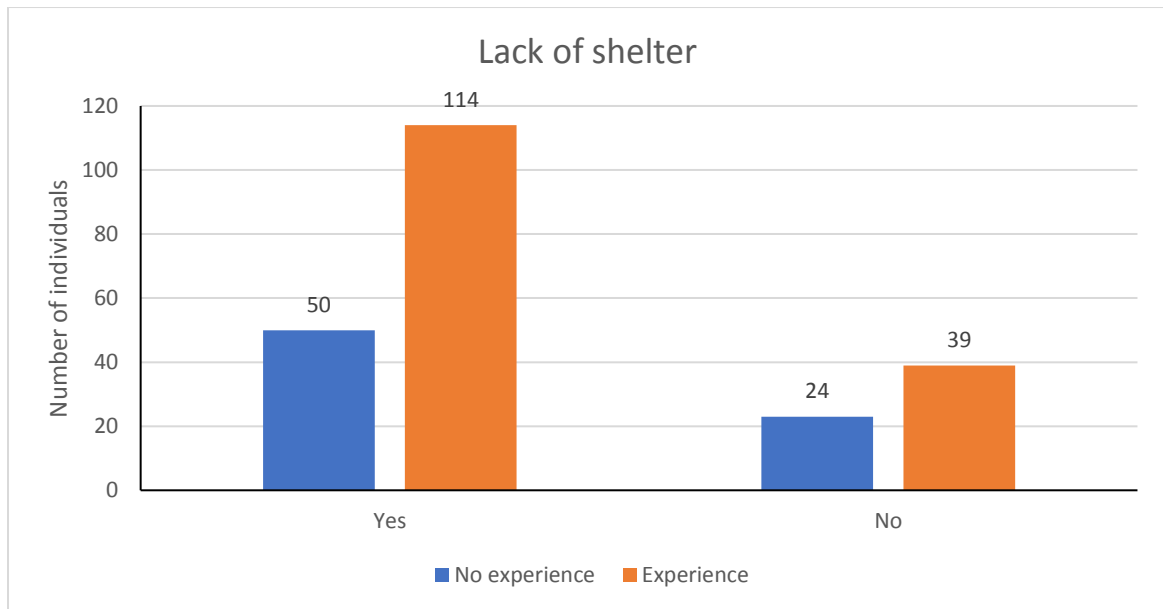


Figure 4.4.5. The number of refugees and asylum seekers at CSVR who screened positive (Yes) and negative (No) for PTSD that experienced and did not experience lack of shelter.

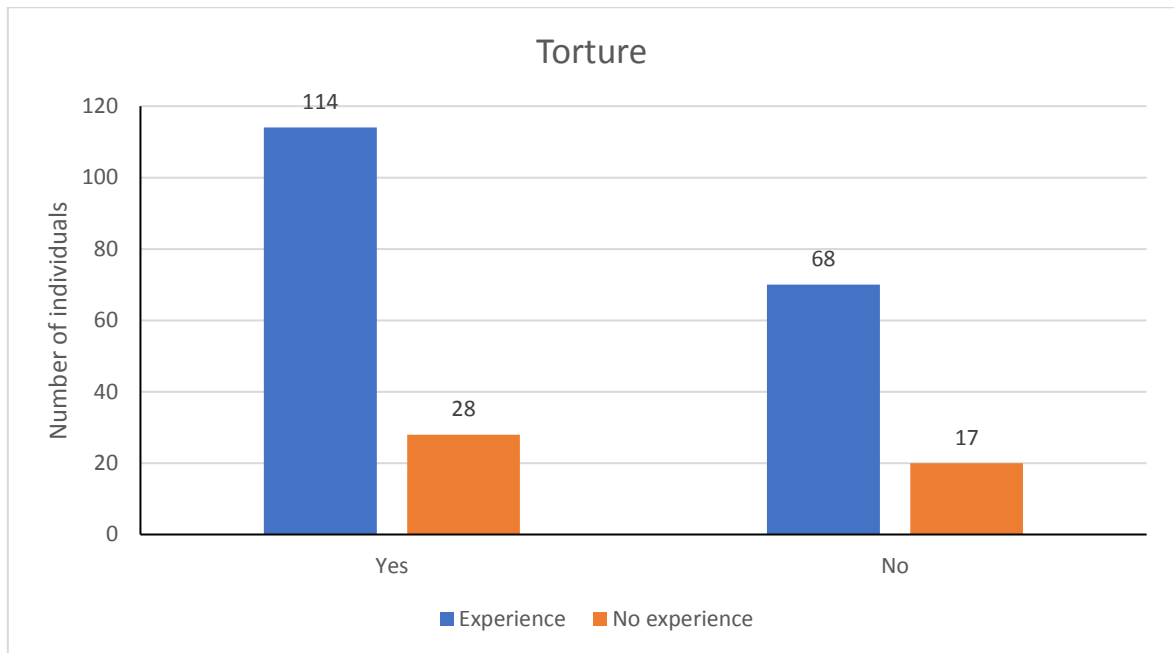


Figure 4.4.6. The number of refugees and asylum seekers at CSVR who screened positive (Yes) or negative (No) for depression that did or not experience torture

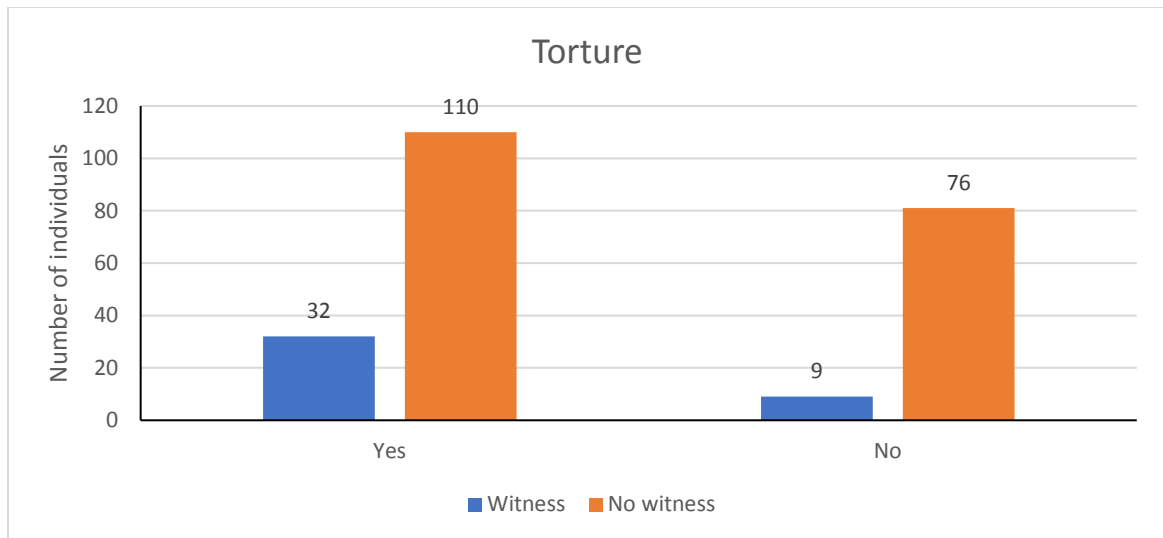


Figure 4.4.7. The number of refugees and asylum seekers at CSVR who screened positive (Yes) or negative (No) for depression that did or not witness torture.

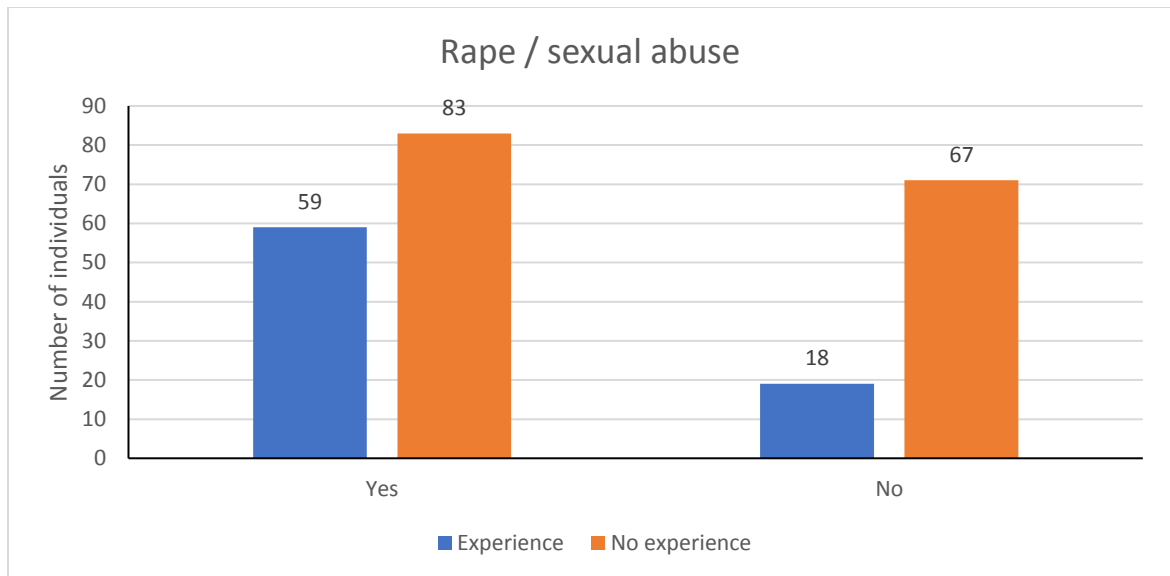


Figure 4.4.8. The number of refugees and asylum seekers at CSVr who screened positive (Yes) or negative (No) for depression that did or not experience rape or sexual abuse.

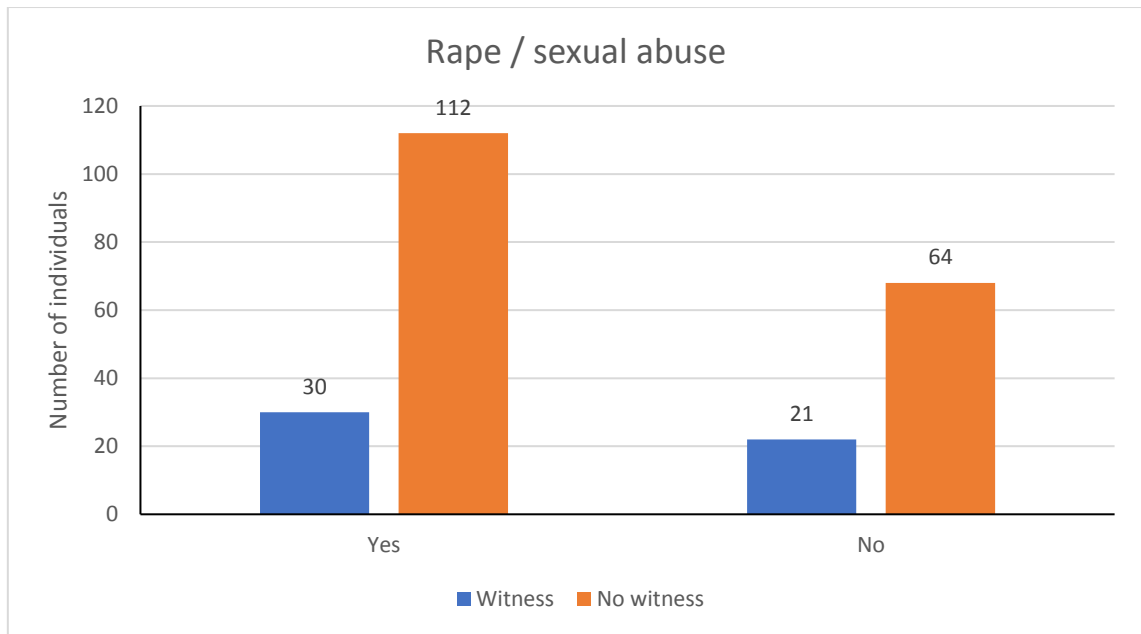


Figure 4.4.9. The number of refugees and asylum seekers at CSVR who screened positive (Yes) or negative (No) for depression that did or not witness sexual abuse or rape.

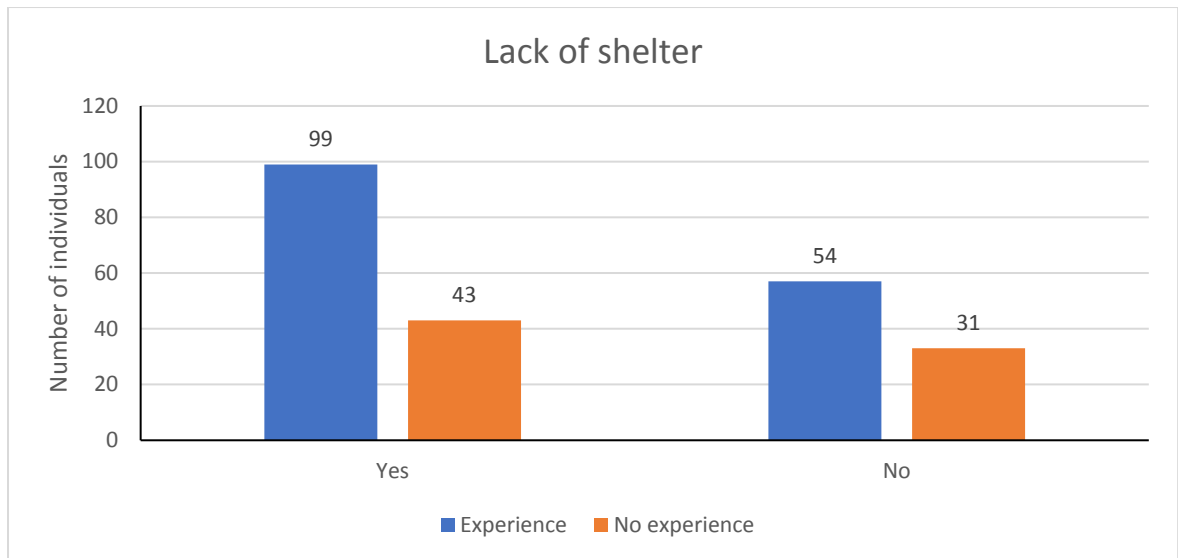


Figure 4.4.10. The number of refugees and asylum seekers at CSVR who screened positive (Yes) or negative (No) for depression that did or not experience lack of shelter.

4.5 Clinical outcomes and measures of change

Of 41 patients who initially screened positive for PTSD (Figure 4.3.1) and then seen by a psychiatrist, 30 (73%) were formally diagnosed with PTSD by the Psychiatrist. In comparison, all 34 patients initially screened positive for depression (Figure 4.3.2) were also formally diagnosed with Major Depressive Disorder by the psychiatrist.

A small number of patients had follow-up visits to the clinic and were assessed again for PTSD and depression. Ninety patients who screened positive for PTSD presented for follow up, and 70 patients who screened positive for MDD presented for follow up. They were assessed on whether there was an improvement (reduced HTQ and HADS-D scores) no worsening (low HTQ and HADS-D scores), no improvement (similar HTQ and HADS-D scores) or worsening (increased HTQ and HADS-D scores) following a second evaluation. Overall, there was not a statistically significant difference in terms of improvement/no worsening and no improvement/worsening in PTSD (Figure 4.5.1; $\chi^2 = 0.06$; $df = 1$; $p = 0.806$) and depression (Figure 4.5.2; $\chi^2 = 0.40$; $df = 1$; $p = 0.527$). Of note however, is that the number of patients were small therefore these results were not conclusive.

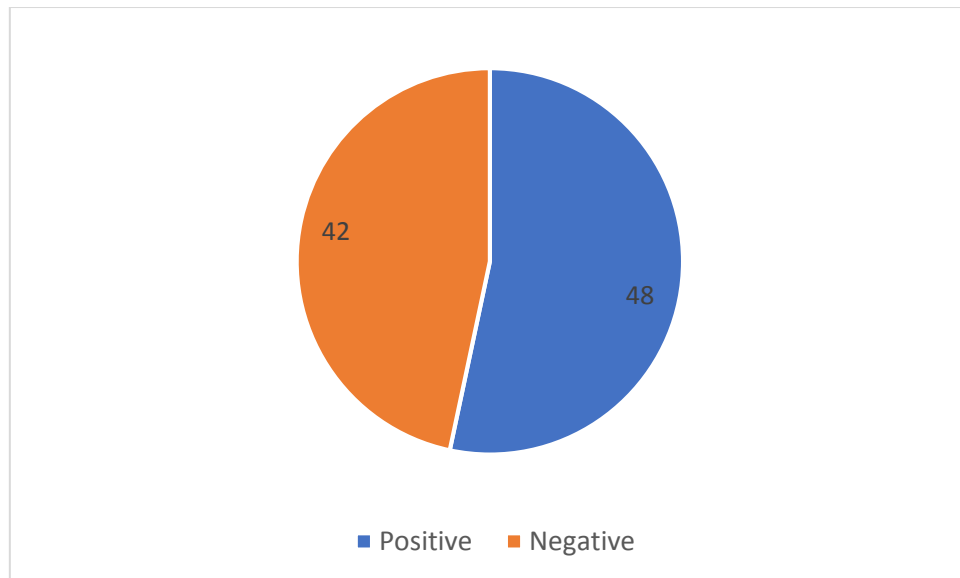


Figure 4.5.1 The number of refugees and asylum seekers at CSVR that presented a positive (improved or no worsening) and negative (worsened or no improvement) PTSD assessment after a follow-up

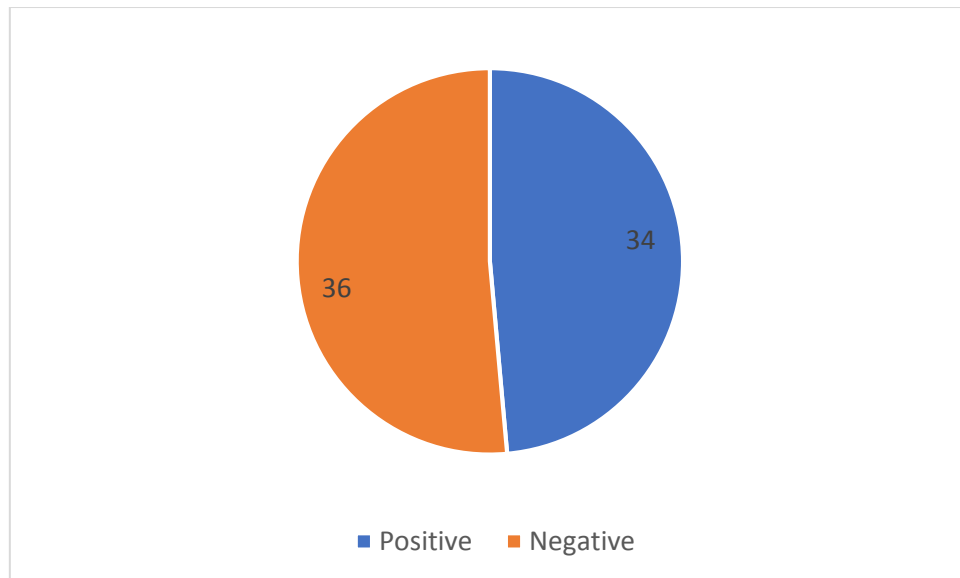


Figure 4.5.2 The number of refugees and asylum seekers at CSV that presented a positive (improved or no worsening) and negative (worsened or no improvement) depression assessment after a follow-up

CHAPTER 5 - DISCUSSION

5.1 The demographic profile of patients

Of the 232 patients considered for the study, 227 were included (97.84%). In the first part of the analysis, demographic parameters were analysed. Demographic factors reviewed were: age, gender, marital status, highest level of education, employment, country of origin and number of children. The majority of patients that were seen in this sample were male (51%). This was in keeping with other studies conducted in various parts of the world: one study in Ireland (Duffy, et al., 2016), a multicenter study of refugees in Egypt, South Africa, Honduras, Mexico and Gaza (McColl, et al., 2010) and a study of refugees in Turkey (Kaya & Kocaman, 2010).

Half of the patients in the sample were married and 30% were single. With regards to education level, 49% of the sample had a secondary level education or higher. High levels of education were seen in other African studies. A study by Idemudia and colleagues, conducted on Zimbabwean refugee's found that 85% of their sample had a secondary school level education (Idemudia, et al., 2013). In a study conducted at the Forced Migration Study Programme at the University of the Witwatersrand by Dalton-Greyling in 2008, a high level of tertiary education was found in refugees (30,7%) (Dalton-Greyling, 2008). The majority of the current sample were from DRC (37%), Somalia (19%) and Ethiopia (19%).

Various factors may contribute to depression developing in an immigrant. Immigration is a stressful process in itself. The Merriam-Webster dictionary defines acculturation as "cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture" (Merriam-Webster, 2018). A study on Korean immigrants found that acculturation in itself was not associated with depression, in fact acculturation was found to decrease stress in immigrants. Stress was found to be associated with an increased likelihood of depressive symptoms (Ayers, et al., 2009). Once arriving in their new country, immigrants often face discrimination which has been found to contribute to the development of a depressive disorder. (Yussuf, 2015). In the case of the current study, one can expect that the population studied would have similar stressors that an immigrant would face, but with the compounded burden of fleeing persecution and traumatic events experienced.

The correlation between demographic factors and having screened positive for PTSD (with part IV of the HTQ) and depression (with HADS) was reviewed. Statistically significant associations were made between depression and marital status ($p=0.007$), employment status ($p=0.002$) and country of origin ($p=0.043$). A high unemployment rate was found in this sample, with 67% of the whole sample being unemployed. Furthermore, unemployment was associated with depression, and this association was statistically significant. In the general population itself unemployment is associated with worse mental health outcomes in terms of Depression. (Pharr, et al., 2011). Other factors that significantly predicted Depression in this sample was being widowed. Other studies have demonstrated that marriage is a protective factor against depression while being divorced is a risk factor for developing depression (Akhtar-Danesh & Landeen, J, 2007). Furthermore to this, depression is more likely to occur in a widower than a divorcee (Manjul, 2017).

A statistically significant association was made between country of origin and depression. Patients originating from DRC, Somalia or Ethiopia were more likely to be depressed in this study. The nationalities of the individuals affected in this study is largely representative of the ongoing conflicts in the African continent. It is important to note that 75% of the current sample were from these 3 countries. The association made between country of origin and Depression is likely a reflection of experiences of these political conflicts in these countries. Between 2010 and 2016 the highest number of politically violent events occurred in Somalia, Nigeria, Egypt, South Africa, Sudan and the Democratic Republic of the Congo (DRC) (Aucoin, 2017).

5.2 Symptomatology

This study found that most of the people that presented to the CSVr screened positive for PTSD and depression. The majority of the patients presenting to the CSVr screened positive for PTSD with 72.2% ($n=164$) of the whole sample having PTSD symptoms. This study showed high rates of PTSD symptoms, this was in keeping with the study that showed higher rates of PTSD in Turkey versus Sweden

(Chung, et al., 2018). A potential reason could be that better health facilities are available to refugees and asylum seekers in Sweden. It is important at this point to note there is an overlap in symptomatology of PTSD and Depression. Rates of Depression in this study were higher than those found in studies of Syrian Refugees, Al Nuaimi and colleagues found rates of Depressive Disorders of 22.5% % (Al-Nuaimi, et al., 2018). This study found that 62.6% (n=142) of the sample screened positive for Depression.

5.3 Psychiatric Outcomes of PTSD and MDD

Despite these high screening rates for PTSD and Depression, only 21.2% (n=48) of the total sample were referred to the psychiatrist. That is, only 29.3% of the sample that screened positive for PTSD were referred, and only 33.8% of the sample that screened positive for depression were referred. This low rate of referral was in keeping with Subramaney's 2006 study and Raghubir's findings in 2014, possibly suggesting a gap in service delivery to this population, lack of resources or lack of knowledge on the referring person's part. It is evident from this study, that not all patients who screen positive for PTSD and depression are referred on to the psychiatrist, a factor could be that only the patients who are severely unwell on clinical impression are referred. This could be due to inadequate referral guidelines and protocols available at the clinic. A contributing factor to this low rate is a high dropout rate of patients at this clinic. A similar trend is seen elsewhere. One study that surveyed health care providers working in a Palestinian refugee camp found that professionals often underestimated and underdiagnosed mental illness. All the participants in the study expressed that more specialists and better referral pathways would improve rehabilitation (McKell, et al., 2017). Another important factor to consider is a lack of resources. In Gauteng alone, 67% of the mental health budget is channeled into mental health hospitals (WHO, 2007), while many refugees and asylum seekers suffering from Depression and PTSD are more likely to be seen in an outpatient setting, such as the CSVr. Furthermore to this, the WHO-AIMS Report on Mental Health System in South Africa found that there were merely 0,28 psychiatrists per 100 000 people in South Africa.

All of the patients who screened positive for Depression and were referred to the psychiatrist were formally diagnosed with Depression. This indicates a high sensitivity of the HADS in this study, with a pick-up rate of 100%, higher than what was reviewed in the literature. Of the patients who screened positive for PTSD and were referred to the psychiatrist, 73% were formally diagnosed with PTSD.

Of the patients reviewed by the psychiatrist, 10 were not placed on pharmacotherapy. Reasons for this were due to other pathology. Two patients were diagnosed with epilepsy, four were found to be psychotic; these patients were referred for further assessment. Notably, one patient who was not placed on medication was breastfeeding. Whilst some drugs are safer than others in lactation, it can be speculated that breastfeeding was the reason for omission of medication in this case.

In terms of the drugs of choice, a SSRI was most often prescribed at the clinic, this is in keeping with the treatment guidelines for both PTSD and MDD (NICE, 2009)

5.4 Effects of different forms of trauma

For this study, different forms of trauma were considered. Personally experiencing torture, personally experiencing rape or sexual abuse and being deprived of shelter were included. Witnessing torture or rape was considered a form of psychological torture. This study found that personal experiences of rape/sexual assault significantly predicted depression. This is expected, as it is estimated that approximately 30% of all persons who have been raped will develop a Major Depressive Episode in their life (Kilpatrick, 2000). It has been argued that witnessing torture is a form of psychological torture (Berliner, et al., 2004). This study found a tendency of witnessing torture and the development of Depression. This is similar to Feyera and colleagues findings that witnessing trauma is a determinant of future Depression (Feyera, et al., 2015).

As mentioned, all the patients who screened positive for Depression and were then referred to the psychiatrist, were formally diagnosed with Major Depressive Disorder by the psychiatrist. Despite the low referral rate, this indicates that the HADS screening tool for depression is a highly sensitive tool. 62,5% of those who screened

positive for PTSD symptomatology and referred for psychiatrist review, were diagnosed formally by the psychiatrist as having PTSD. This tells us that not everyone exposed to a traumatic event will go on to develop PTSD. Furthermore, the HTQ is a screening tool and not a diagnostic tool, this result indicates that clinician assessment is required to confirm or exclude the diagnosis of PTSD.

5.5 Clinical Outcomes and Measures of Change

With regards to follow up, a small proportion of patients presented for follow up appointments. Just over half that screened positive for PTSD (n=90), and just under half who screened positive for depression (n=70). Logistical barriers may be attributed to part of the dropout rate, such as poor access to facilities such as transportation, as well as financial restrictions. Ninety patients who initially screened positive for PTSD presented for a follow up assessment. 42 (46,6%) of these patients showed worsening of symptoms while 48 (53,3%) showed either improvement or no change in symptoms. Seventy patients who screened positive for Depression presented for a follow up. Of these, 34 (48,5%) showed improvement of symptoms while 36 (51,4%) showed worsening of symptoms. Analysis of these assessments at this stage showed an equal chance of improvement, no change or worsening of symptoms.

CHAPTER 6 - CONCLUSION

6.1 Conclusion

This study looked at a population of asylum seekers and refugees that presented to the CSV. All of these patients had faced trauma and the majority had experienced torture. The majority of the patients screened positive for PTSD and depression. Depression was significantly predicted by country of origin, being unemployed, being widowed and personal experiences of sexual assault or rape. A small proportion of the patients were referred to the psychiatrist, despite high screening rates. Most of these patients were then formally diagnosed with PTSD and/or depression, thus confirming the usefulness of the HTQ and HADS-D as screening tools.

6.1 Strengths and Limitations

This study was unique in that, according to the researchers' knowledge, it is the first of its kind to be conducted at this particular setting, the CSV, that utilized HTQ as a screening tool in a population of refugees and asylum seekers within South Africa. The statistical analysis conducted in this study found strong evidence for the development of depression in people who have been tortured. This study also found strong evidence that rape, sexual abuse and witnessing torture leads to the development of MDD. There were also significant associations between being widowed, unemployed and country of origin (Congo, Ethiopia and Somalia) and the development of depression. In essence, what this study does show is a large amount of patients that have been exposed to traumatic events are in need of psychiatric care and intervention, but are not receiving it. This is evident by the low referral rate for specialist psychiatric care.

There were a number of limitations to this study. Firstly, the study was a retrospective record review and as such the data collected was dependant on the availability of information in the electronic records. Some of these records were incomplete. Differences in record keeping between individuals may influence the data collected. Due to various interviewers that are involved in the patient interviews, the data collected and available was inconsistent at times.

Secondly, much of the information gathered on the assessment tool relies on patients' retrospective recollection of events, which may not be accurate for various reasons. Their recollection of events may also be influenced by their current mental state.

Thirdly, the screening tool used at the CSVr to elicit the symptoms related to PTSD and MDD are not necessarily based on DSM IV-TR or DSM5 criteria for PTSD or MDD, and as such the assessment of PTSD is not a clinical diagnosis, rather an estimation of PTSD and Depression. Clarity of the diagnosis is dependent upon a further assessment by the psychiatrist. It is important to note that all the patients suspected of having MDD that were referred to the psychiatrist went on to be formally diagnosed with MDD, indicating that in this sample at least, the HADS is a sensitive screening tool. Seventy three percent of the patients who were screened for PTSD and referred, were formally diagnosed with PTSD, making the HTQ a less sensitive screening tool when compared to the HADS. Of note, much of the symptomatology for PTSD and depression overlap.

Fourthly, the high attrition of the patients in this study was a limitation in assessing progression of symptoms, and as such a much smaller sample was available to assess follow up scores. This resulted in that portion of the analysis being equivocal.

Lastly, refugees and asylum seekers in South Africa have faced extreme xenophobia in the past years, with significant attacks in 2008 and 2015 (Mohamed, et al., 2016). In 2008 alone 62 people were killed as a result of xenophobic attacks in South Africa (Dalton-Greyling, 2008). This could be contributory to the development and maintenance of both PTSD and MDD. Post-Traumatic factors have an allostatic role to play in the pathogenesis of PTSD and MDD. Allostasis is the body's physiological ability to maintain homeostasis while adapting to the environment, by utilising various systems. These include the immune, endocrine and nervous systems. Allostatic load refers to chronic psychological stress that results in impaired adaptation of these systems (Danese and McEwen, 2012)

6.2 Recommendations

The course of the illnesses studied are often dynamic, therefore this study population requires a longitudinal study. A longitudinal, prospective study would be useful to assess the effectiveness of treatments prescribed to this population.

There is a dearth of information regarding each individual patients' personal experiences. A qualitative study, looking at these experiences may give more credence to the question of specific torture experiences leading to psychiatric morbidity.

Another recommendation is that a study be conducted that looks at the number of torture and trauma experiences that an individual experiences and their psychiatric outcomes, as well as whether these traumatic experiences took place in their country of origin or their country of settlement.

This population requires more services, as despite the high number screening positive, few were referred. Both the conditions studied in this research report are treatable with readily available pharmacologic agents as well as psychotherapy interventions. The morbidity of both Depression and PTSD have been documented over the years. Depression alone is associated with severe impairments in social and occupational facets of patients' lives (Fawcett, 1993). Therefore, the author suggests implementation of training of staff at all levels to screen for and recognise signs and symptoms of mental illness in refugees and asylum seekers. Part of this training should focus on education about referral systems in place, as this study found that few patients were referred for psychiatric assessment. A series of protocols should be developed to assist all levels of staff triaging those who need urgent victim support. Training should be an ongoing process.

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APPENDICES

List of Appendices

1. Permission to conduct research at the CSVR
2. CSVR assessment tool (which includes part of the HTQ and HADS).
3. Guide to scoring the HTQ and HADS
4. Ethics Clearance form
5. Data Collection Sheet
6. Turn- It-In Report

Appendix 1: Permission to conduct research at the CSVR



CSV The Centre for the Study of
Violence and Reconciliation

Reg. No.: 1998/000544/08 Section 21 Reg. No.: Welfare 007-428 NPO

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Permission for Dr. Preethi Jayrajh to conduct studies at CSVR

To Whom it May Concern

The Centre for the Study of Violence and Reconciliation (CSV) grants permission to Dr. Preethi Jayrajh to conduct research for her Masters of Medicine degree at our organisation. She has proposed to conduct a retrospective record review of the files at the CSV's trauma clinic in Braamfontein, focusing on Posttraumatic Stress Disorder.

Given the usefulness and importance of this work for our clients and for CSV's trauma clinic, we have agreed that this research should go ahead. This permission is conditional on her agreement to take the necessary measures to ensure client confidentiality and anonymity, to ensure the security of client information. She will also share any findings and draft publications arising from the research with CSV for comment prior to publication.

Yours sincerely

Dr Hugo van der Merwe
Director of Research, Knowledge and Learning

Appendix 2: CSVR assessment tool

ASSESSMENT FORM

ADMINISTRATIVE INFORMATION:

- 1) Client code: _____

- 2) Date of assessment: _____

- 3) Assessment Number: _____

- 4) Number of sessions completed to date: _____

- 5) Name of person doing assessment: _____

Ensure that the client is comfortable and offer him/her a cup of tea or coffee. Provide the client with a copy of the intake form to follow. Explain the process in the following way.

*Kindly ensure that each item is completed (check this at end of interview in case you skipped one). On the tables please **tick** the correct option clearly. In some of the items we have included follow-up or clarification questions that can be used if the client does not understand the initial question. Only use the follow-up questions if the client does not understand the first question. Should they still not understand after the follow-up question then you may attempt to explain in other ways. The N/A choice will also apply to unknown information.*

Today we will be doing what we call an assessment. This involves me asking you a number of questions about yourself, how you are managing, and about ways in which you may be affected by what happened to you. This helps us see how you are and check if this changes over time. It also helps me to plan what you and I may need to work on together. I will ask you the same questions again after 6 sessions. Because there are many questions we will do this at your pace, so if you would like to have a break or go slower we will. You can let me know at any time if you need a break. These questions focus on how you are doing and not on what happened to you. We will cover that in more detail at a later time. Do you have any questions?

6) **DEMOGRAPHIC INFORMATION:**

First I will ask you some basic information that we did not get during the screening.

Currently living with	Living alone		Living with strangers	
	Living in a shelter		Living with partner / spouse	
	Living with children / family		Other (specify)	
	Other			
Do you feel safe in your current living conditions?		Yes / No		
Legal status in SA	Citizen		Permanent resident	
	Temporary resident		Work visa	

	Study visa		Tourist	
	Refugee		Asylum seeker	
	Undocumented		Other (specify)	
	Other legal status:			
Current employment	Minor		Student	
	Unskilled labour		Semi-skilled labour	
	Skilled labour		Highly skilled/professional	
	Unemployed		Unknown	
	Other (specify)			
	Other employment:			

7) **EVENT INFORMATION**

Event		Happened to someone I know	Happened to me	Have not experienced
1.	Imprisonment	(1)	(2)	(0)
2.	Being close to death	(1)	(2)	(0)
3.	Forced Separation from family members	(1)	(2)	(0)
4.	Ill health without access to medical care	(1)	(2)	(0)
5.	Lack of Shelter	(1)	(2)	(0)
6.	Combat situation (e.g. war or armed conflict)	(1)	(2)	(0)
7.	Unnatural death of family member or friend. This includes murder, suicide, or accidents)	(1)	(2)	(0)
8.	Any other situation that was very frightening or you felt your life was in danger Specify:	(1)	(2)	(0)

Please indicate if the following events have ever happened to you directly and/or if you have witnessed them.

Event		Experienced personally		Witnessed	No
1.	Rape or sexual abuse	(2)	and/or	(1)	(0)
2.	Serious injury	(2)	and/or	(1)	(0)
3.	Loss of a family member or friend through murder	(2)	and	(1)	(0)
4.	Torture	(2)	and/or	(1)	(0)

CONNECTIONS TO OTHERS:

I would like to ask you some questions about your connections with others.

- 8) Please indicate for each of the 6 statements, the extent to which they apply to your situation, the way you feel now. Please, circle the appropriate answer¹.

Statement					
1. I experience a general sense of emptiness. <i>Like you feel empty inside or like something is missing inside.</i>	Strongly Yes!	Yes	More or less	No	Strongly No!

¹ De Jong Gierveld Loneliness Scale 6-Item (Short)

2. There are plenty of people I can rely on when I have problems. <i>Many or a lot of people that will help you if you have a problem.</i>	Strongly Yes!	Yes	More or less	No	Strongly No!
3. There are many people I can trust completely.	Strongly Yes!	Yes	More or less	No	Strongly No!
4. There are enough people I feel close to. <i>If they say a number ask them if they feel that is enough.</i>	Strongly Yes!	Yes	More or less	No	Strongly No!
5. I miss having people around	Strongly Yes!	Yes	More or less	No	Strongly No!
6. I often feel rejected. <i>Not welcome or not accepted.</i>	Strongly Yes!	Yes	More or less	No	Strongly No!

COPING OR MANAGING:

I would now like to ask you some questions about how you are coping or managing things in your life. *Note down general coping patterns.*

- 9) How well have you managed or coped with family-related stressors or difficulties in the last month?

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
Comments:						

- 10) How well have you managed or coped with external stressors or difficulties in your life (not related to family) in the last month? *Examples include difficulties with: accommodation, money, and securing safety.*

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
Comments:						

- 11) How well have you managed or coped with a situation(s) that made you angry in the last month?

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
Comments:						

12) Locus of Control²

Instructions: Following is a series of attitude statements. Each represents a commonly held opinion. There are no right or wrong answers. You will probably agree with some items and disagree with others. We are interested in the extent to which you agree or disagree with such matters of opinion.

Read (or listen to) each statement carefully. Then indicate the extent to which you agree or disagree using the following responses (read from table). First impressions are usually best. Read/listen to each statement, decide if you agree or disagree and the strength of your opinion, and then respond accordingly. Please give your opinion on every statement. If you find that the numbers to be used in answering do not adequately reflect your own opinion, use the one that is closest to the way you feel. Thank you.

Note down general trends for client, not for specific events (Epi coding in brackets. Analysis coding out of brackets)

Statement	agree strongly (6) +3	agree somewhat (5) +2	agree slightly (4) +1	disagree slightly (3) -1	disagree somewhat (2) -2	disagree strongly (1) -3
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² Items extracted from the Levenson Multidimensional Locus of Control Inventory

1. (P) I feel like what happens in my life is mostly determined by powerful people. <i>This could be anyone you feel has power in your life.</i>	6	5	4	3	2	1
2. (C) It is not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune. <i>Or luck.</i>	6	5	4	3	2	1
3. (I) When I get what I want, it's usually because I worked hard for it.	6	5	4	3	2	1

At this stage, check that the client is still comfortable. Ask if it will be okay to continue a little longer and then take a break after the next set of questions (after the Harvard Trauma Questionnaire).

13) HARVARD TRAUMA QUESTIONNAIRE³ PART IV: TRAUMA SYMPTOMS

Instructions: The following are symptoms that people sometimes have after experiencing terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

		Not at all	A little	Quite a bit	Extremely
1.	Recurrent thoughts or memories of the most hurtful or terrifying events	(1)	(2)	(3)	(4)
2.	Feeling as though the event is happening again	(1)	(2)	(3)	(4)
3.	Recurrent nightmares. <i>Or bad dreams.</i>	(1)	(2)	(3)	(4)

³ Harvard Program in Refugee Trauma (who have kindly given us permission to use the HTQ).

4.	Feeling detached or withdrawn from people. <i>Feeling like you do not want to be with people or want to be alone. Or even when you are in a crowd you feel alone.</i>	(1)	(2)	(3)	(4)
5.	Unable to feel emotions. <i>That you cannot feel sad, or happy, or angry when things happen that should make you feel these ways.</i>	(1)	(2)	(3)	(4)
6.	Feeling jumpy or easily startled. <i>For example if there is a loud sound or someone touches you, you jump up or feel afraid.</i>	(1)	(2)	(3)	(4)
7.	Difficulty concentrating	(1)	(2)	(3)	(4)
8.	Trouble sleeping	(1)	(2)	(3)	(4)
9.	Feeling on guard. <i>Always looking around or feeling like something is about to happen to you.</i>	(1)	(2)	(3)	(4)
10.	Feeling irritable or having outbursts of anger. <i>Losing your patience or feeling frustrated.</i>	(1)	(2)	(3)	(4)
11.	Avoiding activities that remind you of the hurtful or traumatic event. <i>For example</i>	(1)	(2)	(3)	(4)

	<i>doing anything that reminds you of what happened.</i>				
12.	Inability to remember parts of the most hurtful or traumatic events	(1)	(2)	(3)	(4)
13.	Less interest in daily activities	(1)	(2)	(3)	(4)
14.	Feeling as if you don't have a future	(1)	(2)	(3)	(4)
15.	Avoiding thoughts or feelings associated with the traumatic or hurtful events. <i>Trying not to think about what happened.</i>	(1)	(2)	(3)	(4)
16.	Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events	(1)	(2)	(3)	(4)

		Not at all	A little	Quite a bit	Extremely
17.	Feeling that you have less skills then you had before. <i>Like you are less able to do things than before.</i>	(1)	(2)	(3)	(4)
18.	Having difficulty dealing with new situations	(1)	(2)	(3)	(4)
19.	Feeling exhausted. <i>Feeling very or extremely tired.</i>	(1)	(2)	(3)	(4)
20.	Bodily pain	(1)	(2)	(3)	(4)
21.	Troubled by physical problem(s)	(1)	(2)	(3)	(4)
22.	Poor memory. <i>Like you cannot remember things or keep forgetting things.</i>	(1)	(2)	(3)	(4)
23.	Finding out or being told by other people that you have done something that you cannot remember	(1)	(2)	(3)	(4)
24.	Difficulty in paying attention. <i>Concentrating or keeping focused.</i>	(1)	(2)	(3)	(4)
25.	Feeling as if you are split into two people and one of you is watching what the other is doing. <i>People who experience terrible things sometimes during the experience</i>	(1)	(2)	(3)	(4)

	<i>may almost step back and feel like they are watching it happen, not experiencing it.</i>				
26.	Feeling unable to make daily plans	(1)	(2)	(3)	(4)
27.	Blaming yourself for things that have happened	(1)	(2)	(3)	(4)
28.	Feeling guilty for having survived	(1)	(2)	(3)	(4)
29.	Hopelessness	(1)	(2)	(3)	(4)
30.	Feeling ashamed of the hurtful or traumatic events that have happened to you. <i>Feeling embarrassed.</i>	(1)	(2)	(3)	(4)
31.	Feeling that people do not understand what happened to you	(1)	(2)	(3)	(4)
32.	Feeling that others are hostile to you. <i>Dangerous to you.</i>	(1)	(2)	(3)	(4)
33.	Feeling that you have no one to rely on. <i>Depend on or lean on.</i>	(1)	(2)	(3)	(4)
34.	Feeling someone you trusted betrayed you	(1)	(2)	(3)	(4)

35.	Feeling humiliated by your experience. <i>Embarrassed.</i>	(1)	(2)	(3)	(4)
36.	Feeling no trust in others	(1)	(2)	(3)	(4)
37.	Feeling powerless to help others	(1)	(2)	(3)	(4)
38.	Spending time thinking why these events happened to you	(1)	(2)	(3)	(4)
39.	Feeling that you are the only one who suffered these events	(1)	(2)	(3)	(4)
40.	Feeling a need for revenge	(1)	(2)	(3)	(4)

Take a short break here (5 – 10 minutes). Offer the client something else to drink.

14) Hospital Anxiety and Depression Scale (HADS)⁴

Instructions: We are aware that emotions are important. If we know about these feelings we will be able to help you more. This questionnaire is designed to help us know how you feel. I will read each item and then place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought out response.

1. I feel tense or 'wound up': <i>Illustrate with body being tense, say you cannot relax.</i>		A	2. I feel as if I am slowed down: <i>You take longer to do things.</i>	D	
Most of the time		3	Nearly all of the time	3	
A lot of the time		2	Very often	2	
Time to time, occasionally		1	Sometimes	1	
Not at all		0	Not at all	0	
3. I still enjoy the things I used to enjoy:	D		4. I get a sort of frightened (scared or afraid) feeling like 'butterflies in the stomach' (like a funny feeling in your stomach):		A
Definitely as much	0		Not at all		0

⁴ Hospital Anxiety and Depression Scale, copyright: nferNelson. Authors: Dr Phillip Snaith and Anthony S Zigmond

Not quite so much	1		Occasionally		1
Only a little	2		Quite often		2
Not at all	3		Very often		3
5. I get a sort of frightened feeling like something awful (bad) is about to happen:		A	6. I have lost interest in my appearance: <i>In how I look.</i>	D	
Very definitely and quite badly		3	Definitely	3	
Yes, but not too badly		2	I don't take as much care as I should	2	
A little, but it doesn't worry me		1	I may not take quite as much care	1	
Not at all		0	I take just as much care as ever	0	
7. I can laugh and see the funny side of things:	D		8. I feel restless as if I have to be on the move		A
As much as I always could	0		Very much indeed		3

Not quite so much now (<i>less than I used to</i>)	1		Quite a lot		2
Definitely not so much now (<i>much less than I used to</i>)	2		Not very much		1
Not at all	3		Not at all		0
9. Worrying thoughts go through my mind:		A	10. I look forward with enjoyment to things <i>Getting excited about doing something, like you cannot wait.</i>	D	
A great deal of the time		3	As much as I ever did	0	
A lot of the time		2	Rather less than I used to	1	
From time to time but not too often		1	Definitely less than I used to	2	
Only occasionally		0	Hardly at all	3	
11. I feel cheerful <i>Happy or excited.</i>	D		12. I get sudden feelings of panic		A

Not at all	3		Very often indeed		3
Not often	2		Quite often		2
Sometimes	1		Not very often		1
Most of the time	0		Not at all		0
13. I can sit at ease and feel relaxed		A	14. I can enjoy a good book or radio or TV programme <i>Or a good conversation.</i>	D	
Definitely		0	Often	0	
Usually		1	Sometimes	1	
Not often		2	Not often	2	
Not at all		3	Seldom	3	

15) How well have you managed or coped with the psychological or emotional difficulties or symptoms you have just mentioned, in the last month?

(1) Managed very well	(2) Managed well	(3) Managed more or less	(4) Managed poorly	(5) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
Comments:						

16) Do you currently experience any pain? *For each pain identified by the client tick the number on the left and ask and record if this pain is due to torture in the corresponding column on the right hand side. This information is based on client self-report.*

Area of pain:	Tick if present	Due to torture:	
(1) No pain exists	(0) Yes		
(2) Shoulder region	(1) Yes	(1) Yes	(0) No
(3) Upper extremity (<i>arms, hands</i>)	(1) Yes	(1) Yes	(0) No
(4) Genitalia	(1) Yes	(1) Yes	(0) No
(5) Abdomen	(1) Yes	(1) Yes	(0) No
(6) Chest	(1) Yes	(1) Yes	(0) No

(7) Lower extremity (<i>legs, feet</i>)	(1) Yes	(1) Yes	(0) No
(8) Head and neck region	(1) Yes	(1) Yes	(0) No
(9) Back	(1) Yes	(1) Yes	(0) No
(10) Generalised pain	(1) Yes	(1) Yes	(0) No
(11) Other. Specify:	(1) Yes	(1) Yes	(0) No
Comments:			

17) In general, to what extent has the pain you are experiencing impacted on your ability to function *in the last month (for intake) or since the last assessment (for on-going assessments)*?

(0) No impact or completely able to function	(1) Mild impact or very able to function	(2) Moderate impact or more or less able to function	(3) Severe impact or poorly able to function	(4) Complete impact or not able to function	Has not had pain	N/A (unknown)
Comments:						

Before the client leaves run through the intake to ensure that each question is answered. Thank the client for their time and patience. Allow the client to ask any questions they may have.

CLINICIAN SECTION

- 1) General clinician comments on assessment:

Comments:

- 2) How well has this client managed or coped with family-related stressors or difficulties in the last month?

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
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Comments:

- 3) How well has this client managed or coped with external stressors or difficulties in your life (not related to family) in the last month? *Examples include difficulties with: accommodation, money, and securing safety.*

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
Comments:						

- 4) How well has this client managed or coped with a situation(s) that made you angry in the last month?

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
Comments:						

- 5) How well has this client managed or coped with the psychological or emotional difficulties or symptoms in the last month?

(5) Managed very well	(4) Managed well	(3) Managed more or less	(2) Managed poorly	(1) Managed very poorly	(0) Have not had any such difficulties	N/A (unknown)
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Comments:	
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- 6) Rate the client's progress for each of the impacts present since the last assessment completed. *For BASELINE we will only mark presence or not of each.*

		MARK ONE OF THESE FOR EACH IMPACT PRESENT				
Impact	(1) Tick if present	(-2) Great regression	(-1) Some regression	(0) No progress or regression	(+1) Some progress	(+2) Great progress
Accommodation difficulties, economic difficulties, and concern for employment opportunities	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Anger	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Bereavement	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Coping difficulties and stress	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Difficulties with service providers	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Distress	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Family breakdown	(1)	(-2)	(-1)	(0)	(+1)	(+2)

Family-related stressors	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Isolation	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Loss of status, recognition, position in society	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Mood disturbances	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Pain	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Safety concerns and Repeated victimisation	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Traumatic responses and Intrusions	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Other (specify):	(1)	(-2)	(-1)	(0)	(+1)	(+2)
Other (specify):	(1)	(-2)	(-1)	(0)	(+1)	(+2)

TREATMENT GOALS /PLANS / RECOMMENDATIONS

Client Code: _____

Clinician: _____

Date: _____

Identified problem	Treatment goal	Plan for therapeutic intervention	Review

Clinician Impressions

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Appendix 3: Guide to scoring the HTQ and HADS

HADS

Questions relating to anxiety are indicated by an 'A' while those relating to depression are shown by a 'D'.

Scores:

0-7 = normal

8-10 = borderline

11 or over = clinical

HTQ

Questions:			Number of questions answered:	Total score
1 – 16	PTSD Score	≥ 2.5 are considered symptomatic for PTSD		add scores for 1-16 and divide by number answered
17 – 40	Self-perception of Functioning	No cut-off just a guideline to check progress over time		add scores for 17-40 and divide by number answered
1-40	Trauma score	≥ 2.5 are considered symptomatic for trauma		add scores for 1-40 and divide by number answered

Total	Total Trauma	Indication of trauma level again no cut-off		add scores for all items
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Appendix 4: Ethics Clearance Form



R14/49 Dr Preethi Jayrajh

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M160508

NAME: Dr Preethi Jayrajh
(Principal Investigator)
DEPARTMENT: Psychiatry
Centre for the Study of Violence and Reconciliation (CSVR)

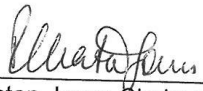
PROJECT TITLE: A Study of Torture Victims at the Centre for the Study of Violence and Reconciliation (CSVR), Using the Harvard Trauma Questionnaire (HTQ) as an Assessment Tool

DATE CONSIDERED: 27/05/2016

DECISION: Approved unconditionally

CONDITIONS:

SUPERVISOR: Dr A Pillay and Prof U Subramaney

APPROVED BY: 
Professor P Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 30/05/2016

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 Research Office Secretary in Room 10004, 10th floor, Senate House/2nd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. 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.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in May and will therefore be due in the month of May each year.

Principal Investigator Signature _____

Date _____

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 5: Data Collection Sheet

Sample number

Demographics

Gender: 1.Male: ☐ 2.Female: ☐

Age: _____

Marital status: 1.Single ☐ 2.Married ☐ 3.Divorced ☐
4.Widowed ☐ 5.Co-habitation ☐

Highest level of education: 0.No school ☐ 1.Primary ☐ 2.Secondary ☐
3.Tertiary ☐

Current employment: 0.Unemployed ☐ 1.Formally employed ☐ 3.Student ☐
2.Informally employed ☐

Documentation: 1.Refugee ☐
2.Asylum Seeker ☐
3.Undocumented ☐

Country of origin _____

Number of children _____

Referral source (UNHCR, LHR, JRS/Walk in) _____

Torture experience:

1. Personal experiences	1.1. Physical	☐	1.2. Psychological	☐	1.3. Deprivation	☐
2. Witnessed	2.1. Physical	☐	2.2. Psychological	☐	2.3. Deprivation	☐
3. Relative/ Friend/Other	3.1. Physical	☐	3.2. Psychological	☐	3.3. Deprivation	☐

Rating
scales:

	First Presentation		First follow up		Second follow up
HTQ score					
PTSD	Yes	☐	No	☐	
	Presentation		First f/ u		Second f/u
HADS-D score					

Outcomes:

1. Ref. Psychiatrist	1.1. Yes	☐	1.2. No	☐
2. Pharmacotherapy	2.1. Yes	☐	2.2. No	☐
3. Psychotherapy	3.1. Yes	☐	3.2. No	☐
4. Both	4.1. Yes	☐	4.2. No	☐
Diagnosis	1. PTSD	☐	2. MDD	☐
	3. Other	☐		

Appendix 6: Turn-It-In-Report

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ORIGINALITY REPORT

2%
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