Harvard Trauma Questionnaire Urdu Translation: The only cross-culturally validated screening instrument for the assessment of trauma and torture and their sequelae

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Abstract

Background and Objective: There is no valid clinical instrument in Urdu for assessing postpartum depressive disorders. This study was undertaken to translate into Urdu, validate and test the reliability of the Edinburgh postnatal depression scale (EPDS). At the same time various psychosocial dimensions of the presentation of postpartum depressive illness were studied.

Methodology: Randomly selected women after childbirth (n=66) underwent (on the tenth postpartum day) a semi-structured interview after first having answered the translated EPDS questionnaire. At the same time psychosocial profile was obtained through a structured checklist. The diagnosis of depressive disorder was made according to the ICD-10. For validation the results of the EPDS were compared with the clinical diagnosis of depression, based on the Mental Status Examination.

Results: The average age of the tested women was 26.86% years; 100% were married and 45.45% were primiparae: 27.27% and 25.57% reported Pre-Menstrual Tension and Dysmenorrhea respectively. Conflict with in laws was reported by 15.15% and 10.6% reported Domestic Violence or were Battered wives. For an EPDS total score, threshold value of >12 was, taken, which showed 39.39% depression in the study population.

Conclusion: The results of the study are alarming and indicates a grave public health issue which goes unrecognized and unacknowledged. The Urdu version of the EPDS with ten questions is “application friendly” as well as a valid and reliable method for the diagnosis of postpartum depression. It is suitable for both clinical and research use (JPMA 51:285;2001).

Introduction

The violence is on increase all over the world. However the method, manner and quantum of such actions remain little explored. The reasons could be rising expectations in a world of economic, political and territorial disputes or easy availability of weapons and their abuse. The common man has clearly received the message of ‘power through the barrel of gun’ today. The trauma needs definition in every culture and it is different for each individual, but the most common trauma involves either a serious threat to one’s life or physical integrity: a serious threat or harm to one’s children, spouse, or other close relatives and friends: sudden destruction of one’s home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one’s child has been kidnapped, tortured or killed.

In Pakistan the major battle field of ethnic, political, sectarian and communal conflicts were Sindh and Punjab. An entirely new phenomenon noticed in the nineties was not only institutionalised torture but also private torture and brutal killings among the political and/or ethnic divide. A seminar was organized by the Mental Health Organization of Pakistan in 1996 to review the impact of on-going brutalization in Karachi, it concluded that due to stress and insecurity there is an increase in psychiatric morbidity. In the absence of any scientific study there was no way to find out the extent of psychological trauma or any change in behaviour. At another workshop, later same year, it was decided
to conduct surveys to study any change in the behaviour of people in the four districts of Karachi. The preliminary report indicates that during 1996 there was definite change in the behaviour of the people of Karachi.

Trauma and torture leaves a permanent scar on the survivor, it has physical, psychological and social sequelae. The two major psychiatric illnesses associated with trauma and torture are major depression and posttraumatic stress disorder. The definition of posttraumatic stress disorder (PTSD) is modified in the DSM-IV to include the proposed criteria that “the person has been exposed to a traumatic event in which both of the following have been present: the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others, and 2) the person’s response involved intense fear, helplessness, or horror. Note: in children it may be expressed instead by disorganized or agitated behavior.”

This definition does not require that the stressor be “outside the range of usual human experience” and “markedly distressing to almost anyone.” Nonetheless, the diagnosis of post-traumatic stress disorder (PTSD) is not meant to apply to ordinary everyday stressor, which commonly occur in life or, even if unusual, are not seriously life threatening or traumatic.

To diagnose PTSD, other specific criteria must be met which fall under the broad categories of increased arousal, re-experiencing the event, and avoidance of stimuli associated with the trauma or numbing of general responsiveness.

There are no recognized tools to measure the extent of trauma or the resulting emotional disability, except the Urdu translation of DSM IV done by the Pakistan Association for Mental Health, which is very lengthy and difficult to execute on a multi-linguistic population of Pakistan.

There are many difficulties in evaluating, diagnosing and treating torture survivors. The cataclysmic impact of the trauma events on an individual’s personal life often impedes the ability of the survivor to share his or her experiences. Obtaining accurate knowledge of traumatic event and symptoms and properly classifying them into a diagnostic system is fundamental for providing effective treatment and good therapeutic intervention. In order to achieve this, clinicians have shifted from traditional open-ended psychiatric interview to structured and shorter interviewing methods where they collect necessary information through several questions, and test the accuracy of reporting over time.
An attempt to use Urdu translation of DSM IV with the torture survivors proved to be ineffective, time consuming and emotionally overwhelming for the patients. Therefore an attempt is made to translate the Harvard Trauma Questionnaire, the only cross-culturally validated screening instrument for the assessment of trauma and torture related to mass violence and their sequelae.
Harvard Trauma Questionnaire:
The HTQ was developed over a four year period by the Indochinese Psychiatric Clinic in Harvard for primary clinical purposes. The Harvard Trauma Questionnaire (HTQ) measures symptoms associated with diagnostic criteria for post traumatic stress disorder as defined by DSMIII R manual and symptoms. The Harvard Trauma Questionnaire is intended for use in both clinical and research settings with patients and community-based population of diverse cultural backgrounds. The HTQ was developed in order to document information about actual trauma events experienced by torture survivors, and to assess their physical, psychological and social sequelae. The format of HTQ was modeled after the Indochinese version of the Hopkins Symptom Checklist-25 (HSCL-25) 5-7.
The HTQ is a self-reporting checklist that inquires about a variety of trauma events and symptoms identified by clinical experience and treatment outcome studies conducted by the Indochinese Psychiatric Clinic. The questionnaire consists of four parts. Part I includes 17 items describing a range of trauma events and symptoms.
of traumatic events, such as Lack of food and water”. “ Forced separation from the family members”, and “being close to death”. For each item there are four categories of response: “Experienced”, “Witnessed”, “Heard about” and “No”. Multiple answers often emerge, allowing for a refined understanding of the different levels of exposure to trauma.

Part II of the HTQ is a personal description which includes two open-ended questions asking respondents for subjective descriptions of the most traumatic event(s) they experienced in both their countries of origin and resettlement, own understanding of the relative effects of his/her experience, and clarify the relationship between Part I and Part 4 of the questionnaire.
Part III includes a few brief questions about traumatic experiences that may involve head injury, drowning, suffocation, beating to the head and loss of consciousness. Clinicians should be alerted to the frequent occurrence of head trauma among populations who underwent mass trauma. Such injuries are often associated with impairment in social functioning and with neuropsychological deficits. It is essential to remember that psychological symptoms reported by survivors of trauma and torture may be secondary to organic central nervous system dysfunction rather than to the psychological impact of the trauma experience.
Part IV of the HTQ includes thirty symptom items; the first sixteen items were derived from the DSM-III-R criteria for post-traumatic stress disorder, and specify a cluster of symptoms that are associated with overwhelming environmental stress. These symptoms are arranged along three dimensions: re-
experiencing traumatic events, avoidance and numbing, and physiological arousal\textsuperscript{10}.

The Harvard Trauma Questionnaire (HTQ) measures symptoms associated with diagnostic criteria for post-traumatic stress disorder as defined by DSM-III-R manual and symptoms that are associated with Indochinese refugee experience\textsuperscript{4}. Therefore, in order to be applied to other groups of trauma and torture survivors it cannot be simply translated into another language but rather it has to be adopted and revised. Modification of the HTQ requires extensive knowledge of the cultural background, the life events and the culture specific symptoms of each new target population\textsuperscript{9}.

**Methodology**

The Harvard Trauma Questionnaire (HTQ) was translated into Urdu by a team of psychiatrists and linguistic experts proficient in national languages belonging to different ethnic backgrounds. Each member translated HTQ independently and subsequently a workshop was arranged to develop the standard translation, both conceptual and linguistic equivalence were considered during the workshop, so as to make the questionnaire sensitive to the local dialect and culture, and finally it was approved. Subsequently back translation of the approved questionnaire was carried out by independent multilingual psychiatrist to test the accuracy of the approved translation. Once the accuracy was established the translated version was formally accepted.

**Cross Cultural Validation of the Questionnaire,**

The cross-cultural validation of a screening instrument requires a consideration of the following dimensions\textsuperscript{11}.

- **Content equivalence:** each item has a content relevant to each culture.
- **Semantic equivalence:** the meaning of each item is the same in each language.
- **Technical equivalence:** the manner in which the data is collected is unaffected by the cultural differences.
- **Criterion equivalence:** the interpretation of the results remains the same when compared against a norm in each culture.
- **Conceptual equivalence:** responses to the instrument indicate the measurement of the same underlying theoretical construction across cultures.

**Reliability of the questionnaire:** Reliability depends on the extent to which a measure repeatedly yields the same results on repeated trials. It is a measure of consistency - the more consistent the results given by repeated measurements, the higher the reliability of the instrument.

The reliability of the HTQ was determined by three methods: inter-rater reliability, test-retest and internal consistency.

Inter-rater reliability is the degree to which there is agreement among several raters regarding the meaning of the items in a questionnaire.

Test-retest reliability is a measure of the stability of performance over time.

Reliability was also assessed by the method of internal consistency. Cronbach’s coefficient alpha, measures the degree to which items on a questionnaire are inter-correlated.

Validity of a the questionnaire\textsuperscript{12}. Validity of a screening instrument is understood as the degree to which the instrument measures what it purports to measure.

**Traditionally, there are three types of validity:**

- **Content validity:** the degree to which items on an instrument represent the universality of items that define the variable or behavior to be measured.
- **Criterion validity:** the degree to which the instrument corresponds with some other criterion that is external to the measuring instruments itself.
- **Construct validity:** the degree to which a test can be interpreted as a measure of some theoretical attribute or quality (i.e., depression, anxiety) otherwise operationally undefined.
In validating instruments for psychiatric assessment, it is hard to conceive the determining validity by correlating the test with a criterion without first confirming that the test can stand by itself as an adequate measure of what it is supposed to measure. Therefore, it is common to view criterion validity as related to or dependent on content validity.

Although a measuring instrument can be validated merely in terms of its content and criterion validity, establishing construct validity is important especially for measures of abstract psychological variables that do not constitute an observable dimension of behaviour. The construct validity of the HTQ relies on the construct validity of PTSD as a disease entity that is separate and distinguishable from other psychiatric disorders.

Guidelines for the Use of the Questionnaire: The following guidelines have been developed over a period of years for the use of the HTQ: In general, the discussion about when to introduce HTQ should be based on the clinical assessment of the adoptive role of denial from the client. The client-therapist relationship and the existence or absence of suicidal and psychotic phenomena. When the HTQ is administered in a research sitting it should be presented at the beginning of therapy and again after six months or whichever time frame is dictated by the study’s research questionnaire. Guaranteeing the confidentiality of the information by the torture survivor is an essential prerequisite for the successful administration of HTQ. Clinicians are also advised to make it clear to their patients that answering the question is optional. Privacy and sufficient time (50 to 60 minutes are essential). No friends or relatives should be present in the room at the time of administration and under no circumstances should they be used as a translator.

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References

9. Mollica RF, Wyshak G, Lavelle J. The psycho-social impacts of war trauma and torture on South East