



The Efficacy of a Homoeopathic Simillimum as Compared to a Homoeopathic Complex in the Management of Post-Traumatic Stress Disorder

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.



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Dedication

This research is dedicated to all the people who have lived all their lives thinking they were not good enough and that they were weak or deserved all the evil things that have happened in their lives. This research brings to light to those who live in the dark with the fear of being mocked, ridiculed and shamed for having being caught in a situation which they had no control over. For all the times that they have blamed themselves and stopped living and remained trapped in their past. With this research, I want to create hope; hope that there is life after trauma, there is indeed light at the end of the tunnel. You are not alone!

I also dedicate this research to God almighty. Thank you for sustaining me. You have been there for me when I couldn't be there for myself. You loved me even when I thought I didn't deserve it. To God be the glory.

My biological father, my first taste of disconnection. I didn't know how it felt not to know one's identity until that moment when I found out the truth about my real identity. Although I have never met you, I love you and I am thankful for the chance to live.

My sister Sindiswa Gumede, the reason I knew what PTSD was, I have been through a lot in my life, but losing you was by far the most painful of them all. I died when you died. All the plans that we sat down and spoke about for our future all disappeared when you passed on. I thought I was strong, but my strength was questionable when I lost you. In my pain, I found out how much strength I possessed. I had to dig deep inside of me and rise up once more from the ashes. You continue to inspire me even in death. I dedicate this entire work to you.

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Last but not least, my daughter Tuseka. When I reached my breaking point, you have been my motivation to fight. Without you, I would have given up. You have given me a new purpose. I love you.

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Abstract

This double-blind randomised controlled study aimed to determine the efficacy of a homoeopathic simillimum treatment as compared to a homoeopathic complex in the management of post-traumatic stress disorder (PTSD). PTSD belongs to a group of mental disorders that is caused by an intense stress or the inability to overcome stress. The DSM-5 (2013) categorises PTSD as a mental disorder that is debilitating to the person and occurs after experiencing or witnessing a traumatic, tragic or terrifying incident that results in the person having recurrent frightening thoughts and memories of the past incident and causes emotional numbness. This study aimed to manage and reduce PTSD symptoms through careful treatment of the mental, emotional and physical being of the individual.

Methodology

A sample size of 33 consenting participants between the ages of 18-65 years who met the inclusion criteria according to the DSM-5 (2013) completed the study. The duration of the study was eight weeks per participant. Measurements were taken during four consultations over the eight weeks period of the intervention. The participants were divided into two groups using a randomisation list arranged by the Durban University of Technology Homoeopathic Clinic technician, namely, the simillimum group and complex group. Because of the nature of the research, the researcher was not aware of who was in which group, this prevented biasness when treating the participants.

At each consultation a Clinician-Administered PTSD Scale (CAPS) (Weathers et al.2013), Post-Traumatic Stress Diagnostic Scale (PDS) (McCarthy 2008) and the Screen for Posttraumatic Stress Symptoms (SPTSS) (Carlson 2012) was filled out to measure the progress in each consultation.

Results

The results of the study showed no significant difference between the simillimum group and complex group, leading to the conclusion that homoeopathic simillimum treatment is no more effective than homoeopathic complex treatment in the management of PTSD. Each treatment group showed a reduction in scores in all the scales, and improvement in well-being, lifestyle and attitude towards life even though this improvement was not statistically significant. It was evident that the p-values were greater than 0.05. All three instruments showed of improvement of symptoms in the participants. However, there was no statistical significance between the simillimum and complex group

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List of Acronyms

Acronym	Full Name
ACTH	Adrenocorticotrophic Hormone
CAPS	Clinician-Administered PTSD
CH	Centesimal Dilution
CT	Cognitive Therapy
DSM	Diagnostic and Statistical Manual
DUT	Durban University of Technology
EFT	Emotional Freedom Technique
EMDR	Eye Movement Desensitisation and Reprocessing
GHP	German Homoeopathic Pharmacopoeia
HDC	Homoeopathic Day Clinic
PDS	Post-Traumatic Stress Disorder
PDSD	Prolonged Duress Stress Disorder
PTSD	Post -Traumatic Stress Disorder
SASH	South African Stress and Health study
SPTSS	Screen for Posttraumatic Stress Symptoms
SSRI	Selective Serotonin Reuptake Inhibitors

CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

The Diagnostic and Statistical Manual V (DSM-5) (2013) describes post-traumatic distress disorder (PTSD) as a debilitating mental disorder that occurs after experiencing or witnessing a traumatic, tragic or terrifying ordeal that leaves the person with recurrent frightening thoughts and memories of their past ordeal with the result that the person becomes emotionally numb.

Kinchin (1994) states that PTSD is a natural emotional reaction to a deeply shocking and disturbing experience, especially one that was life threatening. During the event, the person experiences intense fear, helplessness or horror. Studies have consistently indicated that violence is more likely than other forms of trauma to be associated with PTSD and evidence shows that over a third of the South African population have been exposed to some form of violence (Kaminer et al. 2008).

Although the introduction of democracy in 1994 reduced politically motivated violence, there are still reports indicative of very high rates of violent crime, sexual violence and domestic abuse in the current era. Political detention and torture is associated with men as a causation of a lifetime diagnosis of PTSD, while in women, rape has the strongest association with PTSD (Kaminer et al. 2008).

Because of the crippling effect of PTSD on people, treatment is very important to ensure a healthy life. There is evidence of many treatment options for PTSD, however none have claimed to completely cure the condition. According to Jeffreys (2009), PTSD symptoms improve only when psychotherapy is used in conjunction with medication, and not on its own. This further raises questions on the effectiveness of the current treatment options due to the fact that there is evidence of medication resulting in some severe side effects, some of which are the same as the symptoms of PTSD (Kinchin 1994). Thus, the researcher opted for a homoeopathic

simillimum and complex as treatments of choice due to their proven gentle and rapid cure.

1.2 PROBLEM STATEMENT

According to research conducted by Kaminer et al. (2008), over a third of the South African population has been exposed to some form of violence. The most common form associated with men are criminal and miscellaneous assaults, and with women physical abuse by partner, child physical abuse and criminal abuse. South Africa has the highest incidence of murder, armed robbery, rape and intimate partner violence, worldwide. According to Shaw (2002), this violence is a result of the South African socio-political history of apartheid and violent repression combined with ongoing socio-economic inequality. Children were impacted the most as a result of the destruction of families and communities during the Group Area Act which resulted in the victimisation of children, because of lack of security and social control due to the absence of their parents and the violence that was existing at the time (Emmett 2001: 6-7).

Some researchers came to the realisation that South Africa is in a state of violence and faces a possible increase in violence, because it is populated with children who have been socialised to find violence completely acceptable and lack knowledge of the worth of a human life (Chikane 1986: 344).

As a result of the above mentioned, many people undergo traumatic situations that they are unable to overcome and end up suffering from PTSD. According to the World bank group (2016), as a result of ineffective treatments, coverage and poor adherence to psychotropic drugs, psychiatric disorders have worsened with the cost being estimated to be approximately US \$2.5 trillion in 2010 and is expected to rise up to US \$6.0 trillion by 2030. As a result of medication non-adherence, indirect incurred economic cost such as Misplaced resources, vanished production, unemployment, absence from work, and premature mortality.

Although South Africa has taken some progressive steps towards the strengthening of its mental health system. Although there was a reformation of the legislation of mental health and there is some level of policy commitment to mental health, implementation, among others remains a challenge. There have been previous studies that have reported that there is no official endorsed mental health policy in South Africa, despite the existence of 1997 policy guidelines, (Draper et al., 2009). According to Lund et al (2011), some of the major challenges facing South Africa's mental health system are; Low priority of mental health, Limited inter-sectoral policy integration, Stigma and discrimination, Inadequate integration of mental with primary health and 'De-hospitalisation' rather than 'de-institutionalization'.

Because of the sensitivity of the disorder, the adherence or compliance rate and the side effects associated with psychotropic drugs, namely feeling sick, blurred vision, constipation and diarrhoea from Paraxetine as well as the associated withdrawal symptoms thereof, the researcher found it compelling to find a gentler treatment option effective in the management of PTSD. The homoeopathic simillimum and complex utilised in this study showed evidence of such a trait.

1.3 AIM OF THE STUDY

The aim of this double-blind, randomised clinical trial was to determine the efficacy of a homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD and determine whether any of the interventions were superior than the other.

1.4 RESEARCH QUESTION

Is there a significant difference between homoeopathic simillimum and a homoeopathic complex in the management of PTSD?

1.5 ASSUMPTIONS

- Participants regularly took their remedy as indicated on their script;
- Participants did not change their lifestyle; and
- Participants were truthful in completing the scales.

1.6 HYPOTHESES

1. It was hypothesised that the homoeopathic simillimum will decrease the signs and symptoms of PTSD.
2. It was hypothesised that the homoeopathic complex will decrease the signs and symptoms of PTSD.
3. It was hypothesised that there will be a significant difference between the treatment effect of the homoeopathic simillimum and homoeopathic complex.

1.7 OBJECTIVES

1. To determine the efficacy of homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD in terms of the Clinician-Administered PTSD Scales (CAPS) (Weathers et al. 2013).
2. To determine the efficacy of homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD in terms of the Post-Traumatic Stress Diagnostic Scale (PDS) (McCarthy 2008).
3. To determine the efficacy of homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD in terms of the Screen for Posttraumatic Stress Symptoms (SPTSS) (Carlson 2012).

1.8 THE SIGNIFICANCE OF THE STUDY

The significance of the study is that it highlighted the importance of homoeopathic treatments in the management of PTSD. The significance of the study is that it raises an awareness of mental illnesses in our community and also the lack of support that many traumatised victims face in their everyday lives. It also brings to light the

vulnerability of our children as most of the participants were violated at a tender age. The study further educated the participants and thus the community about homoeopathy and what it is able to achieve.

1.9 IMPLICATIONS OF THE STUDY

The implications of the study are that it brings into focus the area of PTSD and other mental illnesses and emphasises the need for clinical trials using complimentary medications in the management of mood disorders.

1.10 OPERATIONAL DEFINITIONS

Aggravation

A noticeable intensification of the disease symptoms previously observed. Often associated with the action of the correct homoeopathic remedy. Aphorisms 157-161, 247-249, 280, 282 of the Organon Hahnemann 1998).

Centesimal scale “cH”

A method of potentising based on the principle that the first potency contains one hundredth part of the base substance and each succeeding potency contains one hundredth of the one immediately preceding (Centesimal potencies are denoted by suffixing “C” to the numerical denoting the deconcentration stage of the drug) (Gaier 1991: 448).

Decimal

The first experiments with the decimal scale were performed by Constantine Hering in 1833. 1 part medicinal substance (dry or tincture), mixed with 9 parts diluents (lactose or alcohol), and then succussed (shaken), yields the 1X (D) potency. Taking 1 part of that potency mixed with 9 parts diluents, then succussed, yields the 2X (D) potency. This is continued until the desired potency is reached (Gaier 1991: 448).

Complex

Simultaneous prescription of two or more remedies to treat a particular disease. This form of prescription entails no individualisation, as many patients suffering from a condition will receive the same medicine (O'Reilly 1996).

Homoeopathy

Homoeopathy a systemic method of healing, based on the law of similars. It is also a healing art which is used to stimulate the body's own ability to heal itself (Banerjea 2003)

Materia medica

"Materials of medicine" in Latin. A reference that lists the curative indications and therapeutic actions of homoeopathic medicines. This information is derived from provings and clinical experience. A homoeopathic Materia Medica is a collection of "drug pictures", organised alphabetically by "remedy,". These entries describe the symptom patterns associated with individual remedies (Cook 1987). This is a systemic documentation of the description of the nature and the therapeutic repertoire of homoeopathic medicines, of the pathology, the symptoms and signs and their modifying factors, and general characteristics of the patient associated with them, derived from their toxicology, homoeopathic pathogenic trials and clinical experience of their use (Swayne 2000: 132-133).

Miasm

A miasm is any inherent weakness or tendency to disease, a mist indicating both it is dynamic and it's subtle and all-pervading nature. Miasms work deeply and over long periods of time, even over several generations. They work to change us so that we become more susceptible to diseases new and old (Roberts 1993: 38).

Plussed potency

Ten impregnated granules are added to a 25ml dropper bottle followed by 18mls of purified water. The bottle is then swirled to dissolve the granules and once completely dissolved 2,5mls of 96 percent alcohol is added. The bottle is then sealed and succussed ten times and fixed with a label with the appropriate instructions. This

selection of potency provides for little or no aggravation and can be taken more often (De Schepper 2001).

Potency

The power, vitality, strength, or dynamis which a homoeopathic remedy possesses, often represented as a number attached to the remedy name, either immediately before or after. The potency of the remedy comes as a result of the succession step in the remedy preparation process (Yasgur 1998:193). A Hahnemannian concept of increasing the 'medicinal power' (potency) by serial dilution and succussion (Swayne 2000: 168).

Proving

The most accurate method of ascertaining the action of medicines on human health. Medicines (usually potentised) are administered to healthy people to discover the symptoms they are capable of producing and thereby able to cure. Aphorisms 20, 21, 108, 121, 136, 141, 145 of the Organon (Hahnemann 2002).

Remedy

This term is usually used to refer to homoeopathic medicines because it implies both the more comprehensive remedial action which the prescription is expected to achieve, and the more purposive relationship to what is to be remedied in the patient than the more general term 'medicine' (Swayne 2000: 182-183).

Repertory

Systemic cross reference of symptoms and disorders to the homoeopathic medicines in the materia medica in order to identify the remedy during a process known as repertorisation (Swayne 2000: 183).

Rubric

A symptom as written in a homoeopathic repertory. The phrase used in a repertory to identify a symptom or disorder and its component elements, and to which a list of the remedies which are known to have produced that symptom or disorder in provings, or to have remedied it in clinical practice, is attached (Swayne 2000: 186).

Stress

Stress is a biological and psychological response experienced on encountering a threat that a person feels they do not have the resources to deal with (Bisbey and Bisbey 1998).

A stressor

Is the stimulus (or threat) that causes stress, e.g. exam, divorce, death of loved one, moving, loss of job (Bisbey and Bisbey 1998).

Succussion

The process of forcefully striking a homoeopathic remedy against a firm surface, with impact or 'elastic collision', carried out at each stage of dilution in the preparation of a homoeopathic potency (Swayne 2000: 201).

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Homoeopathy is a form of therapeutic system of medicine that is holistic and focuses on the totality of the person. When we refer to the totality of a person, it's a composition of the symptoms personality traits pathologies, inherited tendencies among a few things. (Van Wyk 2009). Homoeopathic medicine acts directly by stimulating the body's own innate ability to (Trivieri 2001). A German physician and chemist Samuel Hahnemann (1755-1843) developed homoeopathy in 1796. It is based on the Law of Similars, 'Like cures like', which alludes that in order to bring total healing or cure a disease, a substance that can create similar symptom when given to a healthy person should be considered (Vithoulkas 2009). Homoeopathy is a therapeutic system of medicine that emphasizes on a cure that is gentle, rapid and permanent and brings healing in the shorted and harmless way (Hahnemann 1998). Post-Traumatic Stress Disorder (PTSD) belongs to a group of anxiety disorders that some people get after experiencing a traumatic event and is associated with increased arousal of the person and avoidance of the stimuli that is associated with the trauma (American Psychiatric Association 2013).

2.2 ANXIETY DISORDERS

Anxiety is an abundant and adaptive phenomenon that is sometimes very unpleasant, although it has proven to enhance some people's performance. Recent epidemiological data has shown that anxiety disorders are extremely common and have been divided into several discrete conditions with different diagnostic criteria, including panic disorder, obsessive compulsive disorder, social phobias, post-traumatic stress disorder and generalised anxiety disorder (Robertson, Allwood and Gagliano 1995).

Thus, PTSD is a debilitating condition as a result of a very traumatic situation that leaves the person hopeless, fearful and helpless, among others. The trauma is so

stressful that the person is unable to overcome the stress and depletes all the biological resources that normally help them to deal with the stressor.

PTSD can be further defined as the normal reaction of normal people to events which, for them, are unusual or abnormal (Parkinson 1993). Usually, an individual is able to recover from a stressor with the use of their internal and external resources, but sometimes the stressor is so traumatic that the individual is unable to cope. It therefore can be said that trauma is an overwhelming input of information of sufficient magnitude to bypass an individual's capacity to selectively direct his or her attention (Bisbey and Bisbey 1998).

Stress can be experienced on a psychological and social level, and the types of stressors and responses can vary with the intensity of the impact of the stress varying depending on factors such as the nature of the stress, the perception of threat level of the stressor e.g. beliefs about ability to cope, stress tolerance of the individual, availability of external resources and support, as well as the period of time over which the stressor occurred (Bisbey and Bisbey 1998). Traumatic stress is a very specific type of stress, distinguishable from other forms of stress by the severity of both the stressor and the response.

2.3 NORMAL STRESS RESPONSE

1. From previous situations or from memories of past situations and also sensory inputs and processing, the brain is able to judge whether a situation is stressful or not.
2. The hypothalamus is activated when a situation is seen as stressful.
3. The hypothalamus being the stress response, sends out signals to the pituitary gland and adrenal medulla.

These short-term responses are produced by the fight or flight response via the sympathomedullary pathway produces short term responses of flight and fight, while the hypothalamic pituitary-adrenal system regulates long term stress.

2.3.1 The hypothalamic pituitary-adrenal system

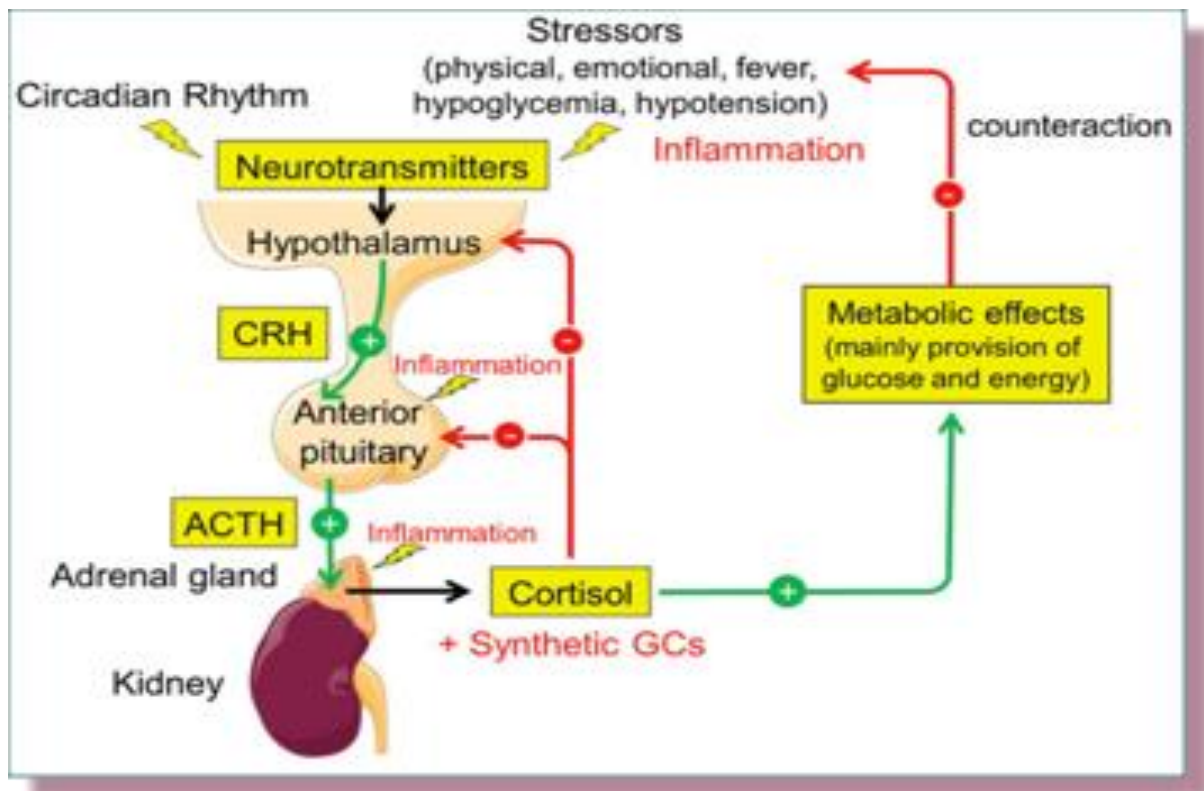


Figure 2.1: The hypothalamic pituitary-adrenal system

Figure 2.1 illustrates that:

- o The hypothalamic pituitary axis is activated by the stressor;
- o The pituitary glands get stimulated by the hypothalamus;
- o The adrenocorticotrophic hormone (ACTH) gets secreted by the pituitary gland;
- o A hormone called corticosteroid gets produced from the stimulation of the adrenal glands by ACTH;
- o Cortisol regulates the body's blood sugar level
- o With a steady blood sugar level, the person is able to cope with prolonged stress and normalise the body

The stress hormone cortisol gets released by the adrenal cortex. This enables the body to release stored glucose that is found in the liver and to control the swelling post injury. During this time, the immune system is

2.3.2 The sympathomedullary pathway

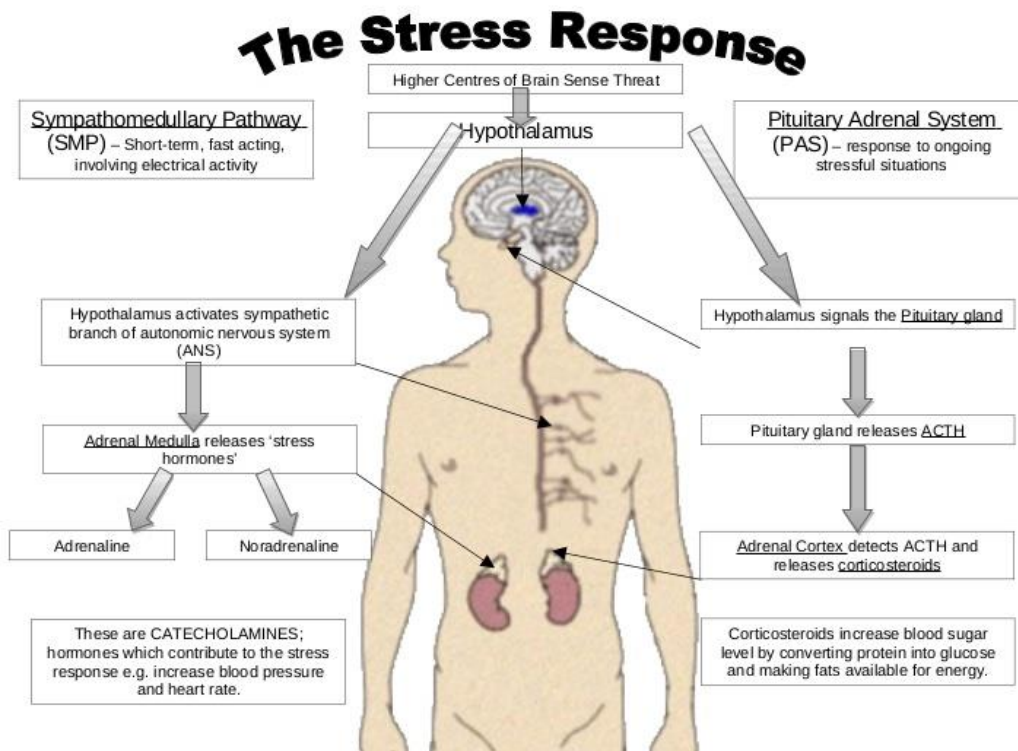


Figure 2.2: The sympathomedullary pathway (McLeod 2010)

Figure 2.2 shows the activation of the adrenal medulla by the hypothalamus. The autonomic nervous system comprises of the adrenal medulla.

The autonomic nervous system is a system that controls the maintenance of homeostasis in the body. These activities happen unconsciously

Adrenaline gets secreted by the adrenal and is control of the fight or flight response with an increased heart (McLeod 2010).

The sympathetic nervous system gets aroused by the adrenaline and reduces activity in the parasympathetic nervous system (McLeod 2010).

The body reacts by decreasing digestion and increasing sweating, and blood pressure due to adrenaline (McLeod 2010).

Usually the parasympathetic branch brings a balance to the body once the threat is over.

No ill effects are experienced from the short-term response to stress and has survival value in an evolutionary context (McLeod 2010).

2.4 PATHOPHYSIOLOGY OF PTSD

If the trauma is prolonged, extreme or repetitive, it can physically injure the brain. (Bailey, Cordell, Sobin and Neumeister 2013) states that it manifests as follows:

- The amygdala remains in an alert state;
- The neuron pathways in the amygdala lose their elasticity or ability to recover;
- The body still feels it is in danger therefore sends information to the hypothalamus to remain non-responsive to the hormones that are being released continuously;
- The liver releases more sugar for energy and the adrenals get burned out. This results in the body depleting its resources;
- During the trauma the cooling system remains weak, disrupting the proper memory process, leaving the person with fragmented memories without proper time frames;
- The body keeps thinking it is in the danger and the person keeps reliving the moments as if they had just occurred; and
- If this continues for a long duration, the person develops PTSD.

The person seems to suffer from symptoms even long after the original trauma ends. The person responds to 'this moment' even though 'this moment' may be a memory fragment from long ago. They cannot separate 'now and safe' from 'now and danger.' There is a higher change of a permanent damage with this vigilant. The cool hippocampus cannot get to the long-term memories. The amygdala keeps shutting them down. Because the PTSD sufferer lacks the ability to access the cool, cognitive solutions, they now cannot check the safety of the current event nor can they distinguish danger from safety. Flashbacks and other strange memory or emotional signals get triggered by current safe events. A hyper-alert state states keeps been retriggered by the brain. Each new encounter and event is perceived as dangerous

as the previous. This phenomenon is sometimes known as 'sensitisation'. The injury is real. The injury is physical. It is not mere confusion or misdirected thinking, or a sign of a weak character (Howard et al 2007).

2.5 DEFINITION AND CHARACTERISTICS OF PTSD

Sevak (2014) states that the development of PTSD is caused by a pre-exposure to one or multiple traumatic and terrifying events that were threatening or caused grave physical harm to a person and is classified as an anxiety. The extreme physical trauma causes a continuous emotional reaction that is severe. This stressor may involve someone's actual death, a threat to the patient's or someone else's life, serious physical injury, or threat to physical or psychological integrity, overwhelming the psychological defences.

The DSM-5 (2013) further states apart from any physical harm, PTSD can arise from intense psychological and emotional trauma. You can distinguish PTSD from traumatic because traumatic stress is less intense and far lesser in duration and from combat stress reactions, which is momentary.

Oxford text book of Psychiatry (2016) concurs that PTSD may be seen following very traumatic that everyone would find very traumatic, such as assault, rape, combat, torture, natural catastrophe. There is significant amount of impairment within the social, occupational or other important areas of functioning (e.g. problems with work and relationships) due to the long duration of the symptoms (six months) (Yehuda 2002).

2.6 PTSD SYMPTOMS

During an event/episode of PTSD, the person experiences intense fear, helplessness, or horror. Further diagnostic symptoms include re-experiencing (flashbacks and nightmares), avoidance of stimuli associated with the trauma, hyper-arousal (difficulty falling or staying asleep), hyper-vigilance, impaired concentration and memory, anger, and depression, may be experienced by an individual (Carson, Butcher and Minika 1996: 135).

2.7 PREVALENCE

PTSD is increasingly recognised as common with a lifetime prevalence of 1-3% in the general population, with much higher prevalence in high-risk groups whose members have experienced trauma such as with soldiers having experienced combat or torture and women having experienced rape and battery (Oxford textbook of Psychiatry 2016). Studies estimates that 5-6% of men and 10-12% of women in the general population have experienced PTSD at some point in their life (Resick 2001: 97).

2.8 AETIOLOGY

Oxford textbook of Psychiatry (2016) states that there is increased understanding of the neurobiology of PTSD, with the neurochemistry of the disorder characterised by the sensitization of a number of symptoms, namely:

- The hypothalamic-pituitary-adrenal axis manifestation of enhanced negative feedback.
- Sensitization of the noradrenergic system which may play a role in the symptom of hyper-arousal.
- The opiate system which may be important in mediating the symptom of numbing.
- The amygdala which is involved in the acquisition and expression of conditioned fear responses and may also play an important role in PTSD.

- The hippocampus which has been found to be shrunken in patients with PTSD (Oxford textbook of Psychiatry 2016).

2.9 DIAGNOSIS OF PTSD

The detailed diagnosis of PTSD is laid out fully in Appendix G, as per DSM-5 (2013).

2.10 DIFFERENTIAL DIAGNOSIS

According to DSM-5 (2013), there is a varied course of PTSD. Research shows that 50% PTSD sufferers will recover within a space of three month (this is called Acute PTSD). For those with Chronic PTSD their symptoms will appear and disappear for months, sometimes years after their trauma, however some may experience a delay in the development of PTSD, to a total of six months or even more after their trauma (Delayed PTSD).

There are many other disorders that are triggered by traumatic event besides Post-traumatic stress. Differential disorders (and indicators) to be considered are:

- Depression (prevalence of low temperament, lethargy, loss of interest, suicidal thoughts).
- Specific phobias (fear and avoidance restricted to certain situations).
- Adjustment disorders (less severe stressor, different pattern of symptoms).
- Enduring personality changes after catastrophic experience (prolonged extreme stressor, different pattern of symptoms).
- Dissociative disorders.
- Neurological damage due to injuries sustained during the event.
- Psychosis (hallucinations, delusions).

PTSD may also coexist with many of the above disorders, in particular, depression and anxiety disorders.

2.11 RISKS AND COMPLICATIONS

In most cases trauma is considered as a single event that is life-threatening, however, instead of a single major incident, trauma can manifest and arise from a build-up of smaller incidents. Examples include: a constant and repetitive exposure to dreadful scenes at accidents or fires, repeated involvement with serious crime, exposure to news of bereavement caused by accident or violence, especially if young people are involved, continual abuse (verbal, physical, or sexual), consistent intrusion and defilement of one's physical or psychological space (bullying, stalking, harassment, domestic violence), etc. People who are especially vulnerable to these events are emergency workers (e.g. police, fire, and hospital workers), crime scene investigators, children, and soldiers. Prolonged Duress Stress Disorder (PDSD) is a term that some mental health professionals use when the symptoms are the result of a sequence of events (Howard et al 2007). PTSD can lead to phobias about certain situations or activities that resemble or symbolise the original trauma. Frequent mood swings, depression, and guilt may lead to substance abuse, self-defeating behaviour, or suicidal actions. Other complications can include aggression and violence as well as their consequences (Hales et al. 1995: 280).

2.12 TREATMENT AND MANAGEMENT OF PTSD

The effectiveness of treatment of stress related psychological problems is when early interventions are applied, especially immediately after the traumatic event (Carson, Butcher and Minika 1996: 152).

2.12.1 Conventional treatment

➤ Psychotherapy

This form of treatment can help to reduce the effect of the intrusive and avoidance symptoms experienced by PTSD sufferers (Kinchin 1994: 123-124). According to the University of Maryland Medical Centre (2013), many forms of psychotherapy have been promoted for trauma-related problems. Basic counselling for PTSD includes

teaching about the ailment and establishment of safety and support. The psychotherapy programmes with the strongest demonstrated efficacy include:

- Cognitive behavioural programmes, including alternatives of exposure therapy.
- Stress inoculation training, a variant of Cognitive Therapy (CT).
- Eye movement desensitisation and reprocessing (EMDR), this done by rapidly moving your eyes from side to side while eliciting the traumatic. This motion causes a reduction of distress for many patients with PTSD.
- Psychodynamic psychotherapy, although is used while wildly, has not been sufficiently tested as a form of treatment for PTSD.

➤ **Biofeedback**

Initially a machine is used to see autonomic and involuntary body functions such as heart rate and temperature. As you observe your body's reaction to stress, you are able to control those reactions. After a period of time you can develop the technique that allows you to control the reaction without relying on the machine.

➤ **Hypnosis**

Historically, hypnosis has been used to treat war-related post-traumatic conditions. In most recent times, cases of sexual assaults, including rape, failure of anaesthesia, survivors of the holocaust and motor vehicle accidents have used hypnosis as a form of therapy. Hypnosis encourages a deep state of relaxation, which reduces anxiousness of people with PTSD and make them feel safer, reduces intrusive thoughts, and creates an active involvement in daily activities once more. Hypnosis is usually used in conjunction with psychotherapy and requires a trained, licensed hypnotherapist.

➤ **Emotional Freedom Technique (EFT)**

A process that combines tapping on acupuncture points while calling to mind traumatic events, has shown great promise in helping patients suffering with PTSD. More studies need to be done, but anecdotal evidence has been very encouraging.

➤ **Acupuncture**

Acupuncture may aid with symptoms of PTSD, including insomnia, anxiety, and depression. In one case involving a Vietnam War veteran, acupuncture and relaxation with guided imagery reportedly reduced insomnia, nightmares, and panic attacks over a treatment period of 12 weeks. One study for anxiety (not PTSD-related) found that benefits lasted as long as one year after treatment.

Acupuncturists treat people based on an individualised assessment of the excesses and deficiencies of qi located in various meridians in the body.

Other forms of treatment according to the VA Centre for PTSD 2010

➤ **Group therapy**

Many people find it easier to talk about their trauma with others who have had similar experiences. In group therapy, participants share their experiences within a group, with people who also have been through a trauma and who have PTSD. Sharing story with others allows the participant to be more comfortable talking about their trauma. This can help them cope with symptoms such as, memories, and other parts of one's life. Group therapy encourages victims to build relationships with others who understand what they have been through. They learn to deal with emotions such as shame, guilt, anger, rage, and fear. Sharing with the group also can help to build self-confidence and trust.

➤ **Brief psychodynamic psychotherapy**

In this type of therapy, one learns ways of dealing with emotional conflicts caused by their trauma. This therapy helps the victim understand how their past affects the way they feel now. The therapist can help you:

- Identify what triggers your stressful memories and other symptoms.
- Find ways to cope with intense feelings about the past.
- Become more aware of your thoughts and feelings, so you can change your reactions to them.
- Raise your self-esteem.

➤ **Family therapy**

PTSD can impact your whole family. Your family may not understand why you get angry sometimes, or why you're under so much stress. They may feel scared, guilty, or even angry about your condition. Family therapy is a type of counselling that involves your whole family. A therapist helps you and your family communicate, maintain good relationships, and cope with tough emotions. Your family can learn more about PTSD and how it is treated. You can talk about your PTSD symptoms and what triggers them. You also can discuss the important parts of your treatment and recovery.

2.12.2 Allopathic treatment

The primary drug for PTSD are antidepressants such as selective serotonin reuptake inhibitors (SSRIs), including sertraline (Zoloft), fluoxetine (Prozac), fluvoxamine (Luvox), or paroxetine (Paxil), benzodiazepines, and a group of medications sometimes used for anxiety, including lorazepam (Ativan) and alprazolam (Xanax). The symptoms of the sufferer can improve when these treatments are combined. Symptoms such as depression and anxiety can be aided by these medications; however, they are not without side effects and these drugs have anaesthetising properties and may cause drowsiness, constipation, or nausea (Carson, Butcher and Minika 1996: 152).

2.12.3 Homoeopathy

Homoeopathy considers the totality of a person mental emotional and physical state as it is a holist therapy that doesn't only focus on the treatment of the physical complaints of the individual to allow for a complete healing and treatment process

(Gray 2000). To reduce symptom of PTSD and improve functioning, one needs to receive effective treatment as soon as symptoms develop.

The materia medica and repertories are the two references that practitioners rely on when prescribing (Lockie 1998).

From a homoeopathic point of view, the frequency of mental illness in society is not simply directly linked to stresses of society nor the very fast pace in which it moves, but a large number of mental illness cases come as a result physical suppression of various illnesses because the medical care system treats symptoms as 'causes' rather than "effects"; this suppression of symptoms pushes the disease process even deeper into the organism and manifest itself as a more severe physical pathology and severe psychological disorder (O'Reilly 1996).

Homoeopaths recognise that living organisms respond to stresses in ways that primarily allow for survival. The most vital processes are protected by the organism first. The mental state of the person is assumed to be vital for survival as it administers the state of awareness that makes decisions on how to respond to stressful or life-threatening situations. An externalization of various superficial emotion will take place while the organism most strongly protects the deepest psychological level. Likewise, the most vital organs such as the brain and the heart will be protected before others at a physical level (O'Reilly 1996). Psychological symptoms, too, are thought of as ways in which a person is trying to adapt to biological and psychosocial stresses. Unless medically essential, such symptoms should not be suppressed, a homoeopathic medicine should be individually prescribed based on the totality of the person's symptoms. The correct homoeopathic medicine will catalyse a healing process that will raise the person's overall level of health (De Schepper 2001).

Ullman (2007) further articulates that homoeopathy has been shown to be efficacious and has a history of successful treatment of various psychological disorders.

Mismanagement of trauma may result in potentially devastating effects because trauma invades all three spheres of an individual's life (Foa, Dancu and Hembree 1999). Homoeopathy is a therapeutic intervention that treats holistically, and cures rapidly, yet gently and permanently restores one's health (O'Reilly 1996). In this light, it is anticipated that homoeopathy can be used in the management of PTSD.

In addition to this De Schepper (2001) states that the Homoeopathic consultation is thorough and focuses on a patient as an individual. De Schepper goes on to say that during the consultation the patient dominates, allowing them to impart information in their own words without interruptions. Nell (2004) reports that good communication is important and entails listening to and understanding the patient as well as communicating that understanding back to the patient. Nell further states that allowing patients to express themselves may bring improvement to their health. As stated in Dube (2015) that there is healing through talking. In her study the Homoeopathic consultation had a positive impact, which could be due to treating the suppressed emotions whether from their childhood experiences or walks of life – these emotional wounds may manifest physically. According to Street et al. (2009) talking gives people the chance to explore their thoughts and feelings in order to be aware and make positive changes. The reason why the patients found the Homoeopathic consultation to have had a positive impact could be because talking can be therapeutic in a sense that it speeds recovery.

2.13 PRINCIPLES OF HOMOEOPATHY

2.13.1 Law of similars

Homoeopathic medicines act cathartically in patients whose clinical picture is closely resembling the pathological effects of the source material of the medicine (Swayne 2000 17). The effective remedy will be that constituent which is proficient in eliciting an immune response most similar to that of the sick person, thus, 'let likes be cured by likes' (Lilley 1998: 120-128).

2.13.2 Law of simplex – the single remedy

According to Hahnemann (Hahnemann 1998: 296-297), Aphorism 273 states that “In no case under treatment is it necessary and therefore not permissible to administer to a patient more than one single, simple medicinal substance at one time ... it is absolutely not allowed in homoeopathy, the one true, simple and natural art of healing, to give the patient at one time two different medicinal substances” (Hahnemann 1998: 296-297).

2.13.3 Law of minimum

It is not the quantity of the drug that is important, but the quality of a carefully selected drug used that is important (Corea 1998: 36). The transformation of a homoeopathic remedy is so dynamic, that a minute quantity of the potentised drug is capable of curing various ailments (Chatterjee 1993: 3). Aphorism 275, according to Hahnemann, states that “...a medicine given in too large a dose, though completely homoeopathic, will still harm the patient by its quantity and unnecessarily strong action on the vital force” (Hahnemann 1998: 298-299).

2.13.4 Doctrine of drug proving

In homoeopathy, medication whose properties are known through drug proving is prescribed. Drug proving is a systematic investigation of the pathogenic (disease-producing) power of medicine on healthy human beings of different ages, both sexes and of various constitutions. These recordings of drug provings give the only reliable knowledge of medicines which is essential to cure disease homoeopathically. Different medicines must be proved thoroughly in order to obtain full details of their curative properties.

2.13.5 Theory of chronic disease

During the early age of homoeopathic practice Hahnemann observed that chronic diseases are caused by chronic miasms. The miasms are Psora, Syphilis and Sycosis.

2.13.6 Theory of vital force

The human organism is a triune entity consisting of body, mind, and spirit. This spirit which is responsible for different manifestations of life was termed by Dr Hahnemann as 'vital force'. Hahnemann speaks of the vital force in Aphorism 10 of his Organon of Medicine as "The material organism without the vital force is capable of no sensation, no function, no self-preservation. It derives all sensations and performs all functions of life solely by means of the immaterial being (the vital force) which animates the material organism in health and disease" (Hahnemann 2002).

2.13.7 Simillimum

A homoeopathic simillimum is a remedy indicated in a certain case because the same drug, when given to a healthy person, will produce the symptom complex most nearly approaching that of the disease in question (Gray 2000). For a remedy to be selected as simillimum, it needs to match the dynamic planes of the disease at the instance that the patient themselves for treatment (Weiner and Gross 1989). It is the single remedy whose picture best fits the patient's totality of symptoms. This single remedy is attained by taking the individual patient's case and noting the mental, emotional, physical and peculiar symptoms and ranking them in the order of intensity that they present (O'Reilly 1996:130). Simillimum treatment is effective in chronic diseases as it is based on a full evaluation of the patient's physical, emotional and mental characteristics (Lockie and Geddes 1995:14). Research conducted by Louw (2003) showed that homoeopathic simillimum in conjunction with rational behaviour therapy proved to be statistically superior to placebo and rational behaviour therapy in patients with dysthymic and adjustment disorder.

De Schepper (2001) states that the homoeopathic approach is to treat the mental and emotional state of the individual and not to just treat the physical complaint.

Lockie (1998) states that the homoeopathic treatment approach differs from the more conventional forms of medicine in that it is highly individualised, holistic, safe and gentle and effective in managing mental, emotional and physical symptoms. As stated in the Organon, “the highest ideal of cure is rapid, gentle and permanent restoration of the health, or removal and annihilation of the disease in its whole extent, in the shortest, most reliable, and most harmless way, on easily comprehensible principles” (O'Reilly 1996).

As stated earlier, the homoeopathic similimum is that remedy which produces the set of symptoms most like that which the disease produces; ideally exactly congruent. A similimum remedy is best adapted for the treatment of any special condition in accordance with the fundamental therapeutic principle of homoeopathy. A homoeopathic complex is the admixture of two to ten homoeopathic remedies known to be effective against a particular condition with the hope that one will have an effect on the symptoms affecting the patient (Kayne 1997).

Bonne et al. (2003) conducted a randomised, double-blind, placebo-controlled study of classical homoeopathy in generalised anxiety disorder and found a significant ($p < .05$) improvement in most measures. Ngobese (2006) conducted a double-blind placebo-controlled study investigated the relative efficacy of homoeopathic similimum treatment as compared to psychological counselling (cognitive therapy combined with behavioural therapy), in the management of generalised anxiety disorder and found a significant change in the symptoms. Lankesar (2004) conducted a clinical trial regarding the effectiveness of the homoeopathic similimum in the treatment of PTSD. The results showed a general improvement in PTSD frequency, severity and intensity in each patient and there was an indication of improvement in energy levels, sleep patterns, appetite, general well-being, attitude and outlook on life. A study by Honnorat (2012) on the efficacy of a homoeopathic complex (Pegasus t.r.s 200C®) in the treatment of PTSD in women concluded that the complex significantly improved the overall severity and intensity of PTSD

symptoms over a six weeks period ($p=0.01$) and significantly improved 10 specific symptoms of PTSD in the experimental group when compared to the placebo. These studies therefore support the use of a homoeopathic simillimum and homoeopathic complex in the management of mental disorders.

2.13.8 Complex

Cook (1987:73) describes complexes as being a combination of as many as 10 homoeopathic remedies, often in low potencies. One of the reasons why some homoeopaths choose to use complex remedies in treating patients, is when the prescriber is uncertain as to which remedy is most appropriate, thus a complex is given to increase the chances of correct prescription, and others use it for its convenience, and, lastly to treat more than one symptom at a time (Kayne 1997: 105). Homoeopathic complex treatment in the current study contained *Aconitum napellus* 30CH, *Arnica montana* 30CH, *Ignatia amara* 30CH, *Delphinium staphysagria* 30CH and *Datura stramonium* 30CH. These remedies were chosen because they are the remedies that came up highest on repertorisation for PTSD symptoms (Vermeulen 1994).

The constituents of a complex are usually made up in middle range potencies, which range from 9-12CH and have proved to be more effective in influencing tissue and organ function at lower potencies (Gaier 1991: 433). The chosen potency for the complex is 30CH.

2.14 MEASUREMENT TOOLS

2.14.1 Clinician-Administered PTSD Scale

Although there are several measurement tools to assess PTSD, the Clinician-Administered PTSD Scale (CAPS) appears to satisfy these standards most homogeneously (Weathers et al. 2013) (Appendix H). The CAPS is an organised interview for assessing essential and associated symptoms of PTSD. It assesses the regularity and intensity of each symptom using standard prompt questions and

explicit, behaviourally-anchored rating scales. The CAPS yield both continuous and dichotomous scores for current and lifetime PTSD symptoms (Blake et al. 1995).

Preliminary studies indicate that the CAPS possess excellent internal consistency, and high convergent and discriminant validity. The findings also indicate excellent utility with high specificity and sensitivity (Blake et al. 1995).

2.14.2 Post-Traumatic Stress Diagnosis Scale

The Post-Traumatic Stress Diagnosis Scale (PDS) (McCarthy 2008)] (Appendix I) scale is intended for the screening the presences of PTSD in patients who have undergone trauma or to assess symptoms severity and functioning in patients already identified as suffering from PTSD. The test is very simple to administer and takes about 15 minutes to fill out. Test items reflect DSM IV criteria for PTSD and are framed in easy to understand language. Questions relate to the frequency of distressing and intrusive thoughts, post-traumatic avoidance and hyper-arousal (McCarthy 2008).

2.14.3 The Screen for Posttraumatic Stress Symptoms

The Screen for Posttraumatic Stress (Carlson 2012) (Appendix J) is a 20-item self-report measure that assesses symptoms of PTSD. Respondents rate items on a 5-points scale ranging from 0-5. It is recommended for screening for PTSD symptoms in clinical or research settings. This scale is usually useful for clients with a history of multiple traumatic events or whose trauma history is unknown as it does not key symptoms to any single traumatic event. Items scores can be used to make a preliminary determination about whether client's symptoms meet DSM criteria for PTSD (Carlson 2012).

Caspi, Carlson and Klein (2007) conducted a study to evaluate the performance of the SPTSS in the assessment of a high-risk ethnic minority sample in a culturally distinct setting with a community sample of Bedouin members of the Israel defence forces. Findings showed that not only was the SPTSS readily accepted and easy to

administer, but also highly accurate in identifying participants with PTSD. In another study by Carlson (2001), with a sample of 136 psychiatric inpatients, the SPTSS showed good internal consistency, a high sensitivity rate and a moderate specific rate. The concurrent and construct validity of the SPTSS were supported by strong correlation with symptom and trauma experience measures and by comparison of SPTSS scores of groups with different trauma history.

2.15 CONCLUSION

PTSD as a debilitating mental disorder that occurs after experiencing or witnessing a traumatic, tragic or terrifying ordeal that leaves the person with recurrent frightening thoughts and memories or their past ordeal with the result that the person becomes emotionally numb. According to the University of Maryland Medical Centre (2013), the common medications are antidepressants and anxiolytics. These medications can help relieve symptoms of depression and anxiety, however they are associated with side effects. Homoeopathy on the other hand is an exclusive and complete system of medicine based on a principle of similars and has a holistic approach to treatment, in which an individual is treated including their psychological, emotional and physical states as part of the complete healing and treatment process (Gray 2000).

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology is the systematic process of collecting, interpreting and analysing data in order to increase one's understanding and to resolve the problem or a question that initiated the study. In this study the aim was to determine the efficacy of a homoeopathic simillimum as compared to a homoeopathic complex in the management of post-traumatic stress disorder. Thirty-three consenting participants who met the inclusion criteria for PTSD, were selected and underwent four consultations where they received treatment and had to fill out questionnaires to monitor their progress. The questionnaire helps to diagnose and evaluate the progress made. The participants were randomly divided by an independent person who also would make up the remedy according to the randomization list, with those in the simillimum group, receiving the simillimum and those in the complex group, receiving the complex. The researcher was not involved in dispensing of medication.

3.2 STUDY DESIGN

This was a randomised double-blind clinical study which included both quantitative and qualitative methods of analysis.

3.3 SETTING

The study was conducted at the Durban University of Technology (DUT), Homoeopathic Day Clinic (HDC) under the supervision of a qualified and registered Homoeopath after being granted permission by the ethics committee of the DUT (Appendix A) and the Clinic Director, for the use of the facilities over the clinical trial period. Each participant was seen for a period of eight weeks.

3.4 DATA COLLECTING PROCESS

This was double-blind study, with neither the researcher nor the supervisor knowing which participant belonged to which group, since participants were allocated to two different groups by means of randomisation. The researcher had no access to the randomisation list, only the homoeopathic laboratory technician and clinician on duty had access to the list and allocated medication accordingly.

There was no placebo group in this study, because it was unethical to allow people who have been suffering for years with PTSD to be part of a clinical trial without actually giving treatment. The two groups were divided into the simillimum group and complex group. Each participant was their own control.

3.5 SAMPLE METHOD

A non-probability convenience sampling method was used. The sample size was 33 consenting male and female participants with PTSD, between the ages of 18-65 years and who met the inclusion criteria. Based on previous Homoeopathic clinical trial studies done at DUT by Megan Jones (2009), Carla Swan (2003), Shada Ismail (2003), Julia Elderidge (2000), and Maureen Dos Ramos (2000) among the few, which have used 30 participants in their trial, a sample size of 30 will be statistically significant.

Sampling bias was avoided as participants were randomly and evenly distributed between the treatment and control groups. Ideally, people participating in a research study should be chosen randomly while still adhering to the criteria of the study. When researchers fail to select their participants at random, they run the risk of severely impacting the validity of their results and findings because their sample does not accurately reflect the population of interest. This was a randomised double blind clinical study where inclusion and exclusion criteria were followed which ensures that any individual with the PTSD may be recruited if they met the criteria.

One of the most effective methods that can be used by researchers to avoid sampling bias is simple random sampling, in which samples are chosen strictly by chance and that is how the researcher conducted the study.

3.6 DURATION OF THE STUDY

The duration of the study was 2 months. There were four consultations in which the measurement tools were applied.

3.7 RECRUITMENT

On receiving approval from the DUT Institutional Research Ethics Committee, participants were recruited through advertisements that were placed on notice boards at DUT, other tertiary institutions, health shops, shopping malls, around local public clinics, hospitals, libraries and churches. Participation was voluntary and there is was no coercion to participate. Participants were also recruited by word of mouth. The researcher advertised at places such as police stations, hospitals, trauma centres and fire stations (Appendix K).

Potential participants responded to the advertisement by means of a phone call to the researcher and which is when the inclusion and exclusion criteria were accessed. If participant met the criteria, a meeting was set by the researcher in which the study was explained to the participant and a consent form was signed. Once a consent form was signed, the participants were given two scales to fill out, the PDS scale and SPTSS scale and the researcher filled out the CAPS scale and took the case concurrently so as to get baseline data. A standard physical examination was conducted.

All candidates not included in the research study were referred to the Ukuba Homoeopathic Clinic or Lifeline. At the end of the research period, participants were also referred to Ukuba Homoeopathic Clinic should they need further assistance and those who could afford, were referred to the Homoeopathic Day Clinic in DUT.

3.8 INCLUSION CRITERIA

Individuals between the ages of 18-65 years who met the inclusion criteria for PTSD according to the DSM5 (2013) (Appendix G) were included in the study. Additional inclusion criteria:

- Participants must be between the ages 18-65 years.
- Participants must be living in the vicinity of Durban, KwaZulu-Natal.
- Participants must be willing to follow study requirements.
- Participants must be able to read and understand English.

3.9 EXCLUSION CRITERIA

- Participants who do not meet the inclusion criteria for PTSD as stated by DSM-5 (2013).
- Participants who are on any recreational drugs.
- Participants who are on any treatment for PTSD.
- Participants are having a, co-existing, chronic, medical or mental conditions.
- Participants who are pregnant or intending to conceive for the duration of the study.
- Participants who have had surgery in the past six weeks.
- Participants who are not willing to maintain their normal lifestyle during the study.
- Participants who are illiterate.

3.10 RANDOMISATION

Randomisation was arranged by an independent person and the researcher was not aware of what treatment group each participant was placed in until the completion of the study.

3.11 MANUFACTURING PROCESS OF REMEDIES

The simillimum was prepared according to the German Homoeopathic Pharmacopoeia (GHP) (Appendix Q). A 30++ potency was used for both the homoeopathic simillimum as well as the homoeopathic complex.

The homoeopathic complex was prepared in the following method:

1. Wash, dry and flame 1000ml beaker.
2. Measure out 52ml granules via measuring cylinder.
3. Pour granules into beaker.
4. $52\text{ml granules} \times \frac{1}{100} \times 86 = 44.72/5 = 8.944$ drops of each remedy.
5. 9 drops *Aconitum napellus* 30CH in granules, swirl till dry.
6. Repeat for *Arnica montana* 30CH, *Ignatia amara* 30CH, *Delphinium staphysagria* 30CH and *Datura stramonium* 30CH in the same granules.
7. Transfer to 100ml glass bottle and label.

3.12 INSTRUMENTS

3.12.1 Clinician-Administered PTSD Scale

Several interviews are available for assessing PTSD. These interviews vary in merit when compared to stringent psychometric and utility standards. Of all the interviews, the Clinician-Administered PTSD Scale (CAPS) appears to satisfy these standards most uniformly (Weathers et al. 2013) (Appendix H). The CAPS is a structured interview for assessing core and associated symptoms of PTSD. It assesses the frequency and intensity of each symptom using standard prompt questions and explicit, behaviourally-anchored rating scales. The CAPS yield both continuous and dichotomous scores for current and lifetime PTSD symptoms (Blake et al. 1995).

Preliminary studies indicate that the CAPS possess excellent internal consistency, and high convergent and discriminant validity. The findings also indicate excellent utility with high specificity and sensitivity (Blake et al. 1995).

3.12.2 Post-Traumatic Stress Diagnosis Scale

The Post-Traumatic Stress Diagnosis Scale (PDS) (McCarthy 2008)] (Appendix I) scale is intended to screen for the presence of PTSD in patients who have identified themselves as victims of a traumatic event or to assess symptoms severity and functioning in patients already identified as suffering from PTSD. The test is self-administered and can usually be completed within 10-15 minutes and requires a reading age of 13 years. Test items mirror DSM IV criteria for PTSD and are framed in easy to understand language. Questions relate to the frequency of distressing and intrusive thoughts, post-traumatic avoidance and hyper-arousal (McCarthy 2008).

3.12.3 The Screen for Posttraumatic Stress Symptoms

The Screen for Posttraumatic Stress (Carlson 2012) (Appendix J) is a 20-item self-report measure that assesses symptoms of PTSD. Respondents rate items on a 5-points scale ranging from 0-5. It is recommended for screening for PTSD symptoms in clinical or research settings. This scale is usually useful for clients with a history of multiple traumatic events or whose trauma history is unknown as it does not key symptoms to any single traumatic event. Items scores can be used to make a preliminary determination about whether client's symptoms meet DSM criteria for PTSD (Carlson 2012).

The duration of the study was eight weeks. There were four consultations in which the measurement tools were applied. The CAP (Appendix H) was applied by the researcher at the beginning of the consultation and the PDS (Appendix I) and SPTSS (Appendix J) were given to the participant to fill in before each consultation.

3.13 STUDY PROCEDURE

The first consultation was regarded as baseline, thereafter the participants were seen for the second consultation which was a first follow up after two weeks of treatment. The participants were given treatment according to the randomisation list (Appendix L). The third consultation which was the second follow up was two weeks after the first follow up. Thereafter the participant came for their fourth consultation which was the last consultation which was four weeks after the third consultation.

Consultation 1: BASELINE

1. The participant was fully informed about the study. The participant was given the information letter (Appendix F) and had the opportunity to ask questions about the study.
2. The participant signed the consent form (Appendix F) to participate on the study.
3. On both the information letter and consent form there was information about participants not being forced to participate in the study and that there would be no remuneration for taking part in the study. Participants were informed that they may withdraw at any time during the study without any prejudice.
4. The researcher applied the past month version of the CAPS (Weathers et al. 2013) (Appendix H), PDS (McCarthy 2008) (Appendix I) and the SPTSS (Carlson 2012). (Appendix J).
5. A detailed case history was taken (Appendix M).
6. A full physical examination was performed and a SOAPE note was completed by the researcher (Appendix O).
7. Medication was dispensed according to the randomisation list drawn by an independent person (Appendix L).
8. Participants in the simillimum group received an individualised simillimum and the participants in the complex group received a complex.
9. The participant proceeded to the Clinic reception area where the dispenser on duty dispensed fully labelled allocated medication with instructions on when and how to take homoeopathic medication (Appendix R).

The researcher called the participants to remind them of their next consultation after 2 weeks of treatment.

Consultation 2: FIRST FOLLOW UP

1. The researcher applied the past week version of the CAPS (Weathers et al. 2013) (Appendix H), PDS (McCarthy 2008) (Appendix I) and the SPTSS (Carlson 2012). (Appendix J).
2. A detailed follow up case history was taken (Appendix N).
3. A full physical examination was performed and a SOAPE note was completed by the researcher (Appendix O).
4. Participants either were prescribed the same medication or if not satisfied with their recovery, were prescribed a different remedy.
5. The participant proceeded to the Clinic reception area where the dispenser on duty dispensed fully labelled allocated medication with instructions on when and how to take homoeopathic medication (Appendix R).

Consultation 3: SECOND FOLLOW UP

1. The researcher applied the past week version of the CAPS (Weathers et al. 2013) (Appendix H), PDS (McCarthy 2008) (Appendix I) and the SPTSS (Carlson 2012) (Appendix J).
2. A detailed follow up case history was taken (Appendix N).
3. A full physical examination was performed and a SOAPE note was completed by the researcher (Appendix O).
4. Participants either remained on the same medication or if not satisfied with their recovery, received a different remedy.
5. The participant proceeded to the Clinic reception area where the dispenser on duty dispensed fully labelled allocated medication with instruction on when and how to take homoeopathic medication details (Appendix R).

Consultation 4: THIRD FOLLOW UP/ last follow up

1. The researcher applied the past month version of the CAPS (Weathers et al. 2013) (Appendix H), PDS (McCarthy 2008) (Appendix I) and the SPTSS (Carlson 2012) (Appendix J).
2. A detailed follow up case history was taken (Appendix N).
3. A full physical examination was performed and a SOAPE note was completed by the researcher (Appendix O).
4. There was no medication prescribed on this final follow up.
5. The participants were thanked for their participation in the study and were informed that they would be welcome for further treatment at the Clinic should they need it.

3.14 DATA ANALYSIS

All data captured was analysed using SPSS version 22. Pie charts, bar graphs and tables were used to illustrate and compare results and non-parametric and inferential analysis of data were performed.

3.15 CONCLUSION

The study was guided by the research problem. Data was collected, organised, and interpreted to give meaning to the data which led to a resolution of the problem, thus testing the hypotheses and providing an answer to a question. The aim of the study was to determine the efficacy of a homoeopathic simillimum as compared to a homoeopathic complex in the management of post-traumatic stress disorder.

CHAPTER 4: PRESENTATION OF RESULTS

4.1 INTRODUCTION

Following the methodology described in Chapter 3, the study produced raw data in the form of completed data sheets. This chapter presents the results and discusses the findings obtained from the questionnaires in this study. The questionnaires were the primary tool that was used to collect data and were distributed to 33 participants, divided into two groups, homoeopathic simillimum and homoeopathic complex. The data collected from the responses was analysed with SPSS version 24.0. The descriptive statistics are presented in the form of graphs, cross tabulations and other figures for the quantitative data that was collected. Inferential techniques include the use of correlations and chi square test values which were interpreted using p-values.

The specific objectives of the analysis were as follows:

1. To determine the efficacy of homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD in terms of the CAPS (Weathers et al. 2013).
2. To determine the efficacy of Homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD in terms of the PDS (McCarthy 2008).
3. To determine the efficacy of Homoeopathic Simillimum as compared to a Homoeopathic complex in the management of PTSD in terms of the SPTSS (Carlson 2012).

4.2 OVERVIEW OF THE RESULTS

4.2.1 The sample

The sample size consisted of 33 consenting male and female participants with PTSD between the ages of 18-65 years who met the inclusion criteria. Participants were randomly and evenly distributed between the treatment and control groups.

4.3 RELIABILITY OF THE QUESTIONNAIRES

The two most important aspects of precision are reliability and validity. Reliability is computed by taking several measurements on the same subjects. A reliability coefficient of 0.70 or higher is considered as 'acceptable'.

Table 4.1 reflects the Cronbach's alpha score for all the items that constituted the questionnaires.

Table 4.1: Cronbach's alpha score for all the items on all the questionnaires

		Visit	N of Items	Cronbach's Alpha
CAPS	SEV	1	23	0.821
		2	23	0.938
		3	23	0.940
		4	23	0.971
	SX	1	23	0.694
		2	23	0.921
		3	23	0.911
		4	23	0.954
PDS		1	22	0.817
		2	22	0.915
		3	22	0.971
		4	22	0.983
SPTSS		1	20	0.888
		2	20	0.924
		3	20	0.967
		4	20	0.980

The reliability scores for all sections exceed the recommended Cronbach's alpha value. This indicates a degree of acceptable, consistent scoring for these sections of the research.

4.4 SECTION A: BIOGRAPHICAL DATA

This section summarises the biographical characteristics of the respondents. Figure 4.1 shows the gender, age and racial composition of the sample.

4.4.1 Gender

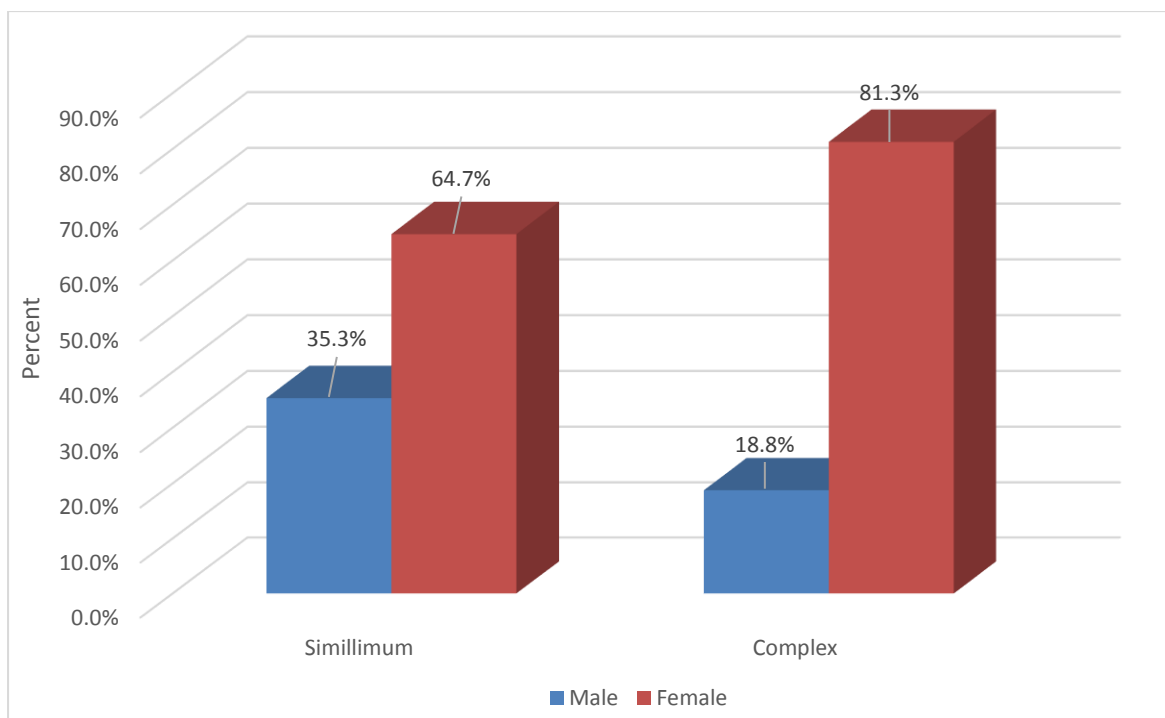


Figure 4.1: Bar graph: gender distribution (%)

The ratios of males to females is similar for both the groups. In both cases, there were more females than males, with the complex group having the larger number. The difference in the gender by grouping was not significant (Fisher's Exact Test p-value = 0.438).

Table 4.2: Age distribution

Group	N	Mean	Std. Deviation
Simillimum	17	33.43	8.600
Complex	16	32.00	9.868
Total	33	32.71	9.112

As can be seen from Table 4.2, the mean age was approximately 33 years for both groups. The differences observed were not significant ($p = 0.686$).

4.4.2 Race

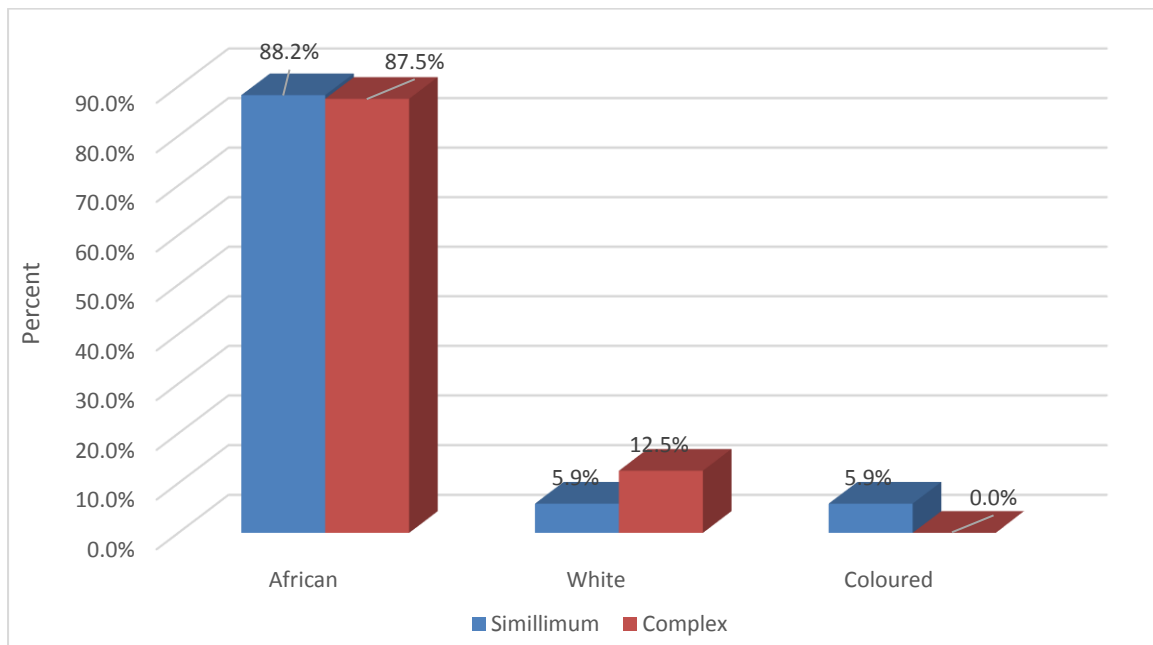


Figure 4.2: Race distribution (%)

Figure 4.2 shows that the ratio of the racial compositions were similar ($p = 0.995$). In both the groups, African people have the highest percentage of participants

Since the demographic factors are not different between the groups, they would not have had a major effect on the result sets observed.

4.4.3 Trauma type

Table 4.3: Trauma type (%)

			Group		Total
			Simillimum	Complex	
TRAUMA TYPE	Abuse	Count	1	0	1
		% within Group	5.9%	0.0%	3.0%
	Accident	Count	0	1	1
		% within Group	0.0%	6.3%	3.0%
	attempted murder	Count	1	1	2
		% within Group	5.9%	6.3%	6.1%
	chronic disease	Count	0	1	1
		% within Group	0.0%	6.3%	3.0%€
	Loss	Count	6	3	9
		% within Group	27.3%	18.8%	27.3%
	Multiple	Count	5	2	7
		% within Group	29.5%	12.5%	21.3%
	natural disaster	Count	0	1	1
		% within Group	0.0%	6.3%	3.0%
	Rape	Count	4	7	11
		% within Group	23.5%	43.8%	33.3%
Total		Count	17	16	33
		% within Group	100.0%	100.0%	100.0%

From Table 4.3, rape seems to be the highest trauma type with 33.3%, followed by loss with 27.3% and multiple trauma with 21.3%. This reflects the literature, where sexual abuse is identified as one of the major factors that causes PTSD.

4.5 ANALYSIS OF EACH INSTRUMENT

The results presented in the following sections are a summary of the patterns observed. Due to the numerous options per variable, graphical representations are used to present mean scores.

4.5.1 CAPS

This section looks at the frequency and intensity of each symptom using standard prompt questions and explicit, behaviourally-anchored rating scales. The CAPS yield both continuous and dichotomous scores for current and lifetime PTSD symptoms

Table 4.4 and Figure 4.3 show the mean scores.

Table 4.4: CAPS mean scores

		SEV	
		Simillimum	Complex
CAPS 1	B	13.3	13.9
	C	7.1	6.3
	D	20.6	21.8
	E	13.9	14.4
	G	8.6	7.5
CAPS 2	B	4.4	5.5
	C	4.2	3.1
	D	10.1	10.0
	E	6.6	6.0
	G	3.5	3.9
CAPS 3	B	2.5	3.6
	C	2.4	1.2
	D	6.1	5.9
	E	4.9	2.4
	G	2.4	2.0
CAPS 4	B	2.2	2.3
	C	1.7	1.1
	D	3.6	4.8
	E	2.4	2.9
	G	1.4	1.7

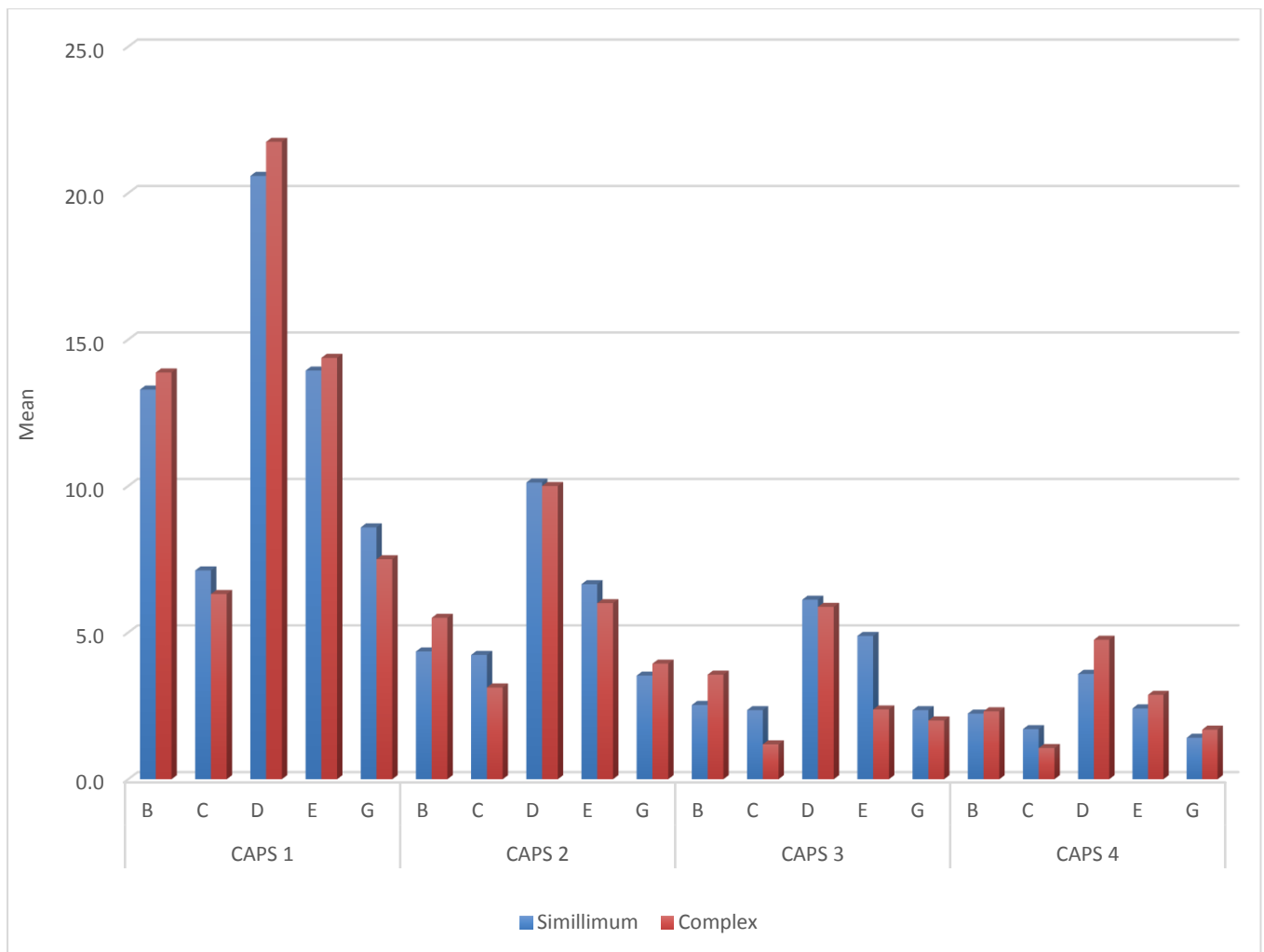


Figure 4.3: CAPS mean scores

The following patterns are observed:

- Some statements show higher levels simillimum while others show higher values for the complex.
- The significance of the differences is tested below.

4.5.1.1 Comparison between means score of CAPS 1-4 within the simillimum group

The CAPS scale was administered to determine if there was any significant improvement within the simillimum group between consultations 1-4, labelled as CAPS 1 BCDEG, CAPS 2 BCDEG, CAPS 3 BCDEG and CAPS4 BCDEG, using their mean value.

Table 4.5: CAPS similitum group mean totals

	CAPS1	CAPS2	CAPS3	CAPS4
TOTAL	63.3	28.8	18	11.3
DIFFERENCE	0	34.5	10.8	6.7

Table 4.5 shows that there was a drop in the symptoms from first visitation to last. The participants moved from a score of 63.3-11.3 within eight weeks of treatment.

4.5.1.2 Comparison between CAPS 1-4 within the complex group

The CAPS scale was administered to determine if there was any significant improvement within the complex group between consultations 1-4, labelled as CAPS 1 BCDEG, CAPS 2 BCDEG, CAPS 3 BCDEG and CAPS4 BCDEG using their mean values

Table 4.6: CAPS complex group means totals

	CAPS 1	CAPS 2	CAPS 3	CAPS 4
TOTAL	63.9	29.9	16.2	14.2
DIFFERENCE	0	34	13.7	2

Table 4.6 shows that there was a significant drop in the symptoms from first visitation to last. The participants moved from a score of 63.9-14.2 within eight weeks of treatment.

To determine whether the scoring patterns were significantly different between the two groups, a Mann-Whitney U test was used. The null hypothesis claims that the central values are similar. Table 4.7 is a summary of the Fisher's Exact Test p-values.

Table 4.7: Fisher's Exact Test p-values

Test Statistics^a										
	B-SEV	B-SX	C-SEV	C-SX	D-SEV	D-SX	E-SEV	E-SX	G-SEV	G-SX
Mann-Whitney U	127.000	134.500	113.500	110.000	105.500	97.500	131.500	128.000	111.500	114.500
Wilcoxon W	280.000	287.500	249.500	246.000	258.500	250.500	284.500	281.000	247.500	250.500
Z	-.326	-.056	-.866	-1.507	-1.105	-1.472	-.163	-.294	-.892	-1.035
Asymp. Sig. (2-tailed)	.744	.955	.387	.132	.269	.141	.871	.768	.373	.300
Exact Sig. [2*(1-tailed Sig.)]	.763 ^b	.958 ^b	.423 ^b	.363 ^b	.276 ^b	.168 ^b	.873 ^b	.790 ^b	.382 ^b	.444 ^b
a. Grouping Variable: Group										
b. Not corrected for ties.										

In all instances, the p-values are greater than 0.05, the level of significance. Hence, the mean (median) values are not that different. However, there is a decreasing trend from visit 1 to visit 4 for both groupings.

4.5.2 PDS

Table 4.8 and Figure 4.4 show the mean scores.

Table 4.8: PDS mean scores

	Simillimum				Complex			
	Visit 1	Visit 2	Visit 3	Visit 4	Visit 1	Visit 2	Visit 3	Visit 4
Q1	2.65	0.76	0.53	0.41	2.69	1.56	0.56	0.69
Q2	1.24	0.59	0.24	0.24	1.38	1.06	0.56	0.44
Q3	2.24	0.82	0.41	0.24	2.44	1.06	0.63	0.44
Q4	2.65	1.24	0.76	0.71	2.69	1.50	0.69	0.75
Q5	1.94	1.12	0.47	0.35	2.19	1.19	0.63	0.50
Q6	3.00	2.59	0.82	0.47	2.88	2.00	0.56	0.69
Q7	3.06	2.00	1.65	0.88	2.88	1.50	0.56	0.69
Q8	1.35	1.18	0.71	0.71	1.88	1.13	1.63	0.88
Q9	2.94	1.35	1.06	0.82	3.00	1.63	0.69	0.75
Q10	2.47	0.88	0.53	0.35	2.56	1.19	0.63	0.31
Q11	2.94	1.59	1.12	0.65	2.88	1.56	0.56	0.50
Q12	2.41	1.06	0.59	0.59	1.69	1.19	0.69	0.69
Q13	2.53	1.35	0.82	0.53	2.44	1.25	0.44	0.38
Q14	2.71	1.35	0.94	0.47	2.63	1.31	0.63	0.44
Q15	2.35	1.12	0.76	0.53	3.06	1.00	0.56	0.56
Q16	2.82	0.53	0.71	0.29	1.69	0.38	0.19	0.50
Q17	2.29	1.71	0.82	0.76	2.50	1.25	0.44	0.56
Q18	2.18	1.47	0.76	0.41	1.69	1.06	0.56	0.56
Q19	2.71	1.41	0.88	0.41	2.56	1.44	0.75	0.88
Q20	1.65	1.35	0.76	0.35	1.88	1.25	0.69	0.56
Q21	3.24	1.41	0.94	0.65	3.00	1.50	0.69	0.75
Q22	3.06	1.53	1.00	0.53	3.13	1.50	0.88	0.81

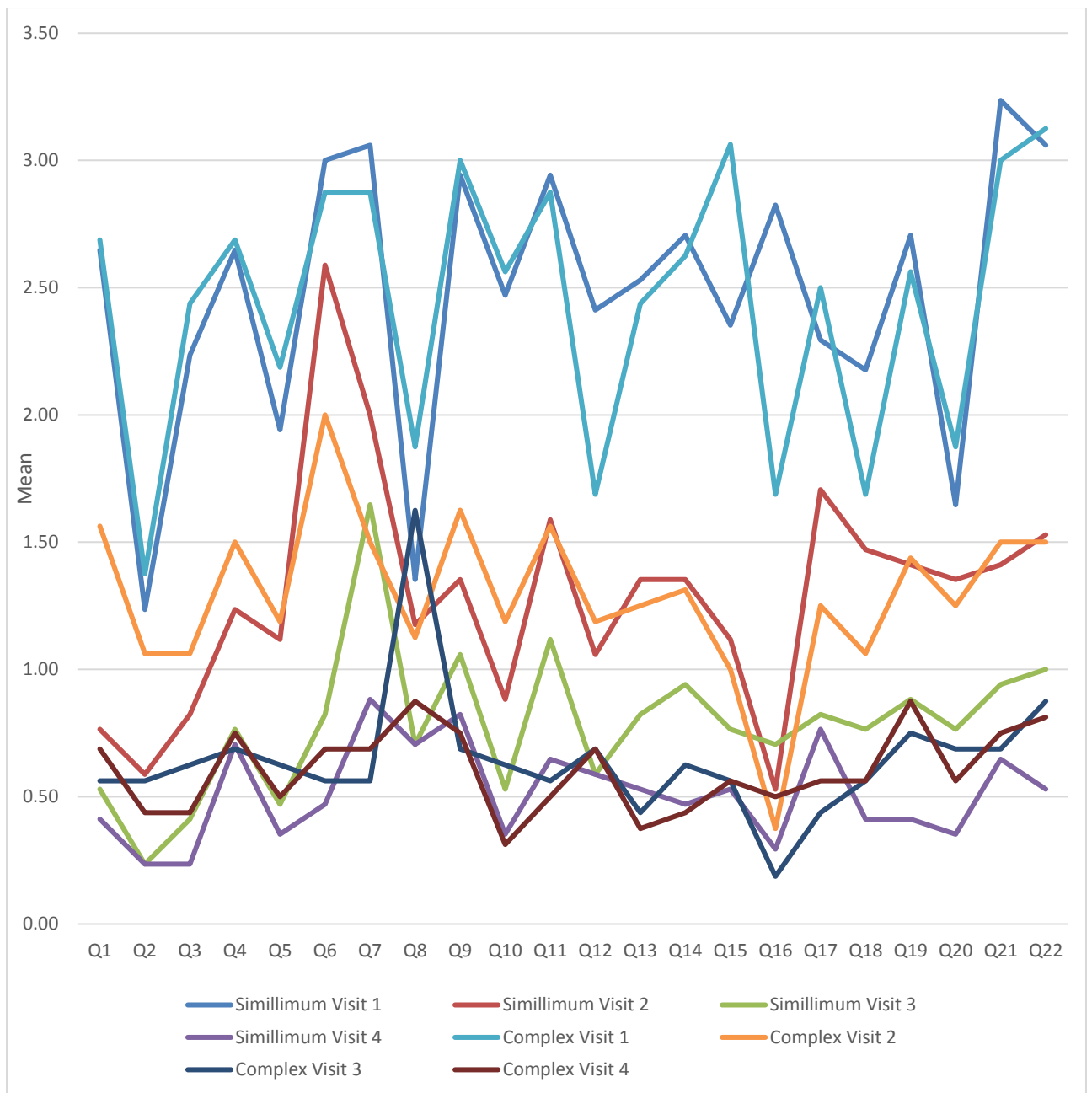


Figure 4.4: PDS mean scores

There is evidence of improvement from first visit to last visit on both the simillimum and complex group.

Table 4.9 is a summary of the Mann-Whitney U scores.

Table 4.9: PDS Mann-Whitney U scores

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2-tailed)	Exact Sig. [2*(1-tailed Sig.)]
Q1	5.000	15.000	-0.866	0.386	0.486
Q2	5.000	15.000	-0.871	0.384	0.486
Q3	5.000	15.000	-0.866	0.386	0.486
Q4	8.000	18.000	0.000	1.000	1.000
Q5	5.000	15.000	-0.866	0.386	0.486
Q6	7.000	17.000	-0.289	0.773	0.886
Q7	4.000	14.000	-1.155	0.248	0.343
Q8	4.000	14.000	-1.162	0.245	0.343
Q9	7.000	17.000	-0.289	0.773	0.886
Q10	7.000	17.000	-0.289	0.773	0.886
Q11	5.000	15.000	-0.866	0.386	0.486
Q12	6.000	16.000	-0.584	0.559	0.686
Q13	5.000	15.000	-0.866	0.386	0.486
Q14	6.000	16.000	-0.577	0.564	0.686
Q15	8.000	18.000	0.000	1.000	1.000
Q16	5.000	15.000	-0.866	0.386	0.486
Q17	6.000	16.000	-0.577	0.564	0.686
Q18	7.000	17.000	-0.290	0.772	0.886
Q19	7.500	17.500	-0.145d	0.885	0.886
Q20	8.000	18.000	0.000	1.000	1.000
Q21	8.000	18.000	0.000	1.000	1.000
Q22	8.000	18.000	0.000	1.000	1.000

From Table 4.9 it is evident that all of the p-values are greater than 0.05. This implies that there is no difference between the groups in terms of the central measures.

4.5.3 SPTSS

This section looks at frequency of the symptom of PTSD per week. 0 being 0 times, 1 being 1-2 times a week, 2 being 3-4 times a week, 3 being every day, 4 being twice a day.

The instrument consists of 20 statements. To avoid duplication, the graph for Q1 is done completely (Figure 4.5). All other questions can be represented in a similar manner.

However, the Fisher's Exact test below provides a summary as to whether differences are significant (Table 4.10).

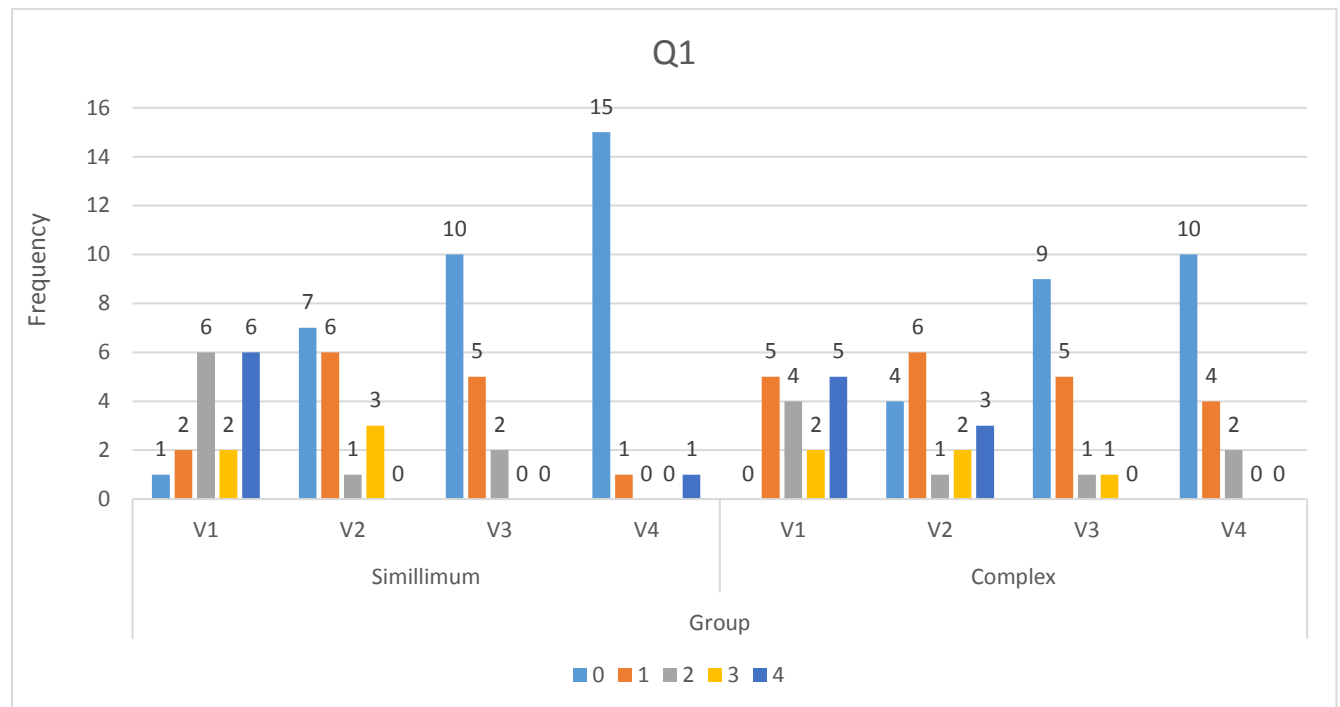


Figure 4.5: SPTSS frequency of symptoms Q1

The following patterns are observed:

- The frequency of the symptoms of PTSD showed great improvement from first to last visit in both the groups. Many symptoms were not occurring at all in most of the participants at their last visit. A huge difference is noted from the third visit.
- The simillimum group's improvements are greater than the complex group's.

To determine whether the differences between the two groups were significant, a chi square test was done, with the Fisher results being reported in the table below.

Table 4.10: SPTSS Fisher's Exact Test p-values

	Exact Sig. [2*(1-tailed Sig.)]			
Statement	Visit 1	Visit 2	Visit 3	Visit 4
1	0.665	0.440	1.000	0.081
2	1.000	0.900	0.447	1.000
3	0.384	0.490	0.810	0.838
4	0.683	0.922	0.467	0.784
5	0.825	0.933	0.595	0.691
6	0.859	0.195	0.600	0.062
7	0.733	0.323	0.024	1.000
8	0.617	0.764	0.219	0.139
9	0.523	0.242	0.832	0.358
10	0.842	0.065	1.000	1.000
11	0.382	0.122	0.516	1.000
12	0.788	1.000	0.618	1.000
13	0.641	0.832	1.000	0.584
14	0.878	0.715	0.673	1.000
15	0.084	0.770	0.284	0.840
16	0.550	0.838	1.000	0.193
17	0.870	0.567	0.430	0.562
18	0.646	0.317	0.528	0.071
19	0.707	0.842	0.631	0.070
20	0.710	0.356	0.705	0.086

The null hypothesis states that there is no difference between the two groups. The alternate states that the differences are significant.

It is noted that there is only a single value (highlighted in yellow) which shows a significant difference.

For the most part, the differences are not significant.

4.6 CONCLUSION

All three instruments showed of improvement of symptoms in the participants. However, there was no statistical significance between the simillimum and complex group.

CHAPTER 5: DISCUSSION OF THE RESULTS

5.1 INTRODUCTION

The study aimed to compare and determine the efficacy of a homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD by means of the CAPS scale, PDS scale and SPTSS scale. PTSD is defined as an anxiety disorder triggered by a traumatic event and characterised by symptoms of re-experiencing the trauma, avoidance and numbing and hyper-arousal (Tolin and Foa 2006).

5.2 DISCUSSION

The frequency of the symptoms of PTSD showed improvement from first to last visit in both groups. Many symptoms were not occurring at all in most of the participants at their last visit. However, the results showed that there was no statistically significant improvement between the groups.

Literature is informing us of a high fraction of people who will undergo a traumatic experience at some point of their lives, with a fraction as high as two thirds of the total population, this show just how common trauma is (Galea and Vlahov, 2005). Although comparable international data is limited, large proportions of populations in many countries have been exposed to terrorism, forced relocation, and violence, which suggests that the overall prevalence of exposure to traumatic events worldwide may be even higher than that in the United States (Galea and Vlahov, 2005).

Demographics in this study showed that there were more women participants than men. The literature states that on average, males will experience more traumatic situations than females, yet females are more likely to meet diagnostic criteria for PTSD) with rape being the most common form of trauma that occurs (Tolin and Foa 2006). Tolin and Foa (2006) further state that because of their cognitive and

emotional response to a traumatic situation, women are more likely to be diagnosed with PTSD. So even though men may experience more traumas, they do not seem to have the same emotional responses to traumatic events. Furthermore, when confronted with a new trauma, those participants who experienced multiple traumas may be at more risk to re-experiencing old PTSD symptoms. These findings were consistent regardless of the population and age examined and the type of study and assessment tool used (Tolin and Foa 2006).

Tolin and Foa (2006) propose that the fact that men's symptoms manifest differently is the reason why many of them do not fit the current diagnosable criteria for PTSD. The male participants examined in their review were more likely to report drug and behavioural problems rather than anxiety or depression. They were also more likely to become violent, angry or irritable after traumas. To help better determine whether a person has experienced trauma one needs to understand that responses to trauma can be varied, however it is important to note that some literature does not concur with this review. It is important to note that the incidence of trauma and PTSD in South Africa is not disseminated according to the socio-demographic factors or trauma types observed in other countries. The prevailing role of witnessing in contributing to PTSD may reflect the public settings of trauma exposure in South Africa and highlight the importance of political and social context in shaping the epidemiology of PTSD (Atwoli et al. 2013).

The South African Stress and Health Study (SASH) documented lower lifetime (2.3%) and 12-month (0.6%) prevalence rates, although PTSD was among the anxiety disorders with the highest proportion of severe cases (36% of all individuals diagnosed with PTSD were severely ill). From the patients who are attending primary healthcare clinics in South Africa, a rate as high as (19.9%) of people diagnosed with PTSD has been documented (Swain, Pillay and Kliwer 2016). The authors further state that in the USA, prevalence rates for the general population is 5.0% for males and 10.4% for females. In Europe, the general population prevalence rates range from 0.5% for males and 0.7% for females in Iceland, to 0.56% in Spain, 0.76% in Belgium, 3% in the UK (0%) and 3.3% in the Netherlands.

The lifetime prevalence rates of PTSD in the general South African population have been found to be 2.3% for all ages and 1.8% for ages between 18 and 34 with the 12-month prevalence rate being 0.6% – 0.7%; sex, age and education were largely unrelated to PTSD risk (Swain, Pillay and Kliwer 2016). PTSD and its associated sequelae are, therefore, a major public health concern in South Africa, particularly for youth who are understood to be experiencing high levels of trauma stemming from discrimination, abuse, interpersonal violence and traumatic events, often against a backdrop of socioeconomic disproportion, reflecting the widening gap between the rich minority and the large proportion of poor in South Africa (Swain, Pillay and Kliwer 2016).

South Africa has reached a pandemic when it comes to rape. Despite all the efforts of the civil society, government and non-government institutions, the incident of rape doesn't decrease. South Africa is a traumatised nation with 400 rapes a day, along with the mass of other violent crimes. It is estimated that approximately 70% of the people living in Soweto are suffering from PTSD. There is thus a huge discrepancy between the number of rapes occurring and those being prosecuted. This is a result that many women out of fear of being humiliated and exposed to the society, a very few of them report rape. South Africa is a country of diversity – a melting pot of cultures, religions and ethnic groups. Each of these cultures and religions have their own view of women and of sexuality and are run by a patriarchal system. The black South African population makes up a huge majority, and in many cases, there is still a fairly strong tie to the traditional gender roles. In the black culture, like most patriarchal cultures, a woman does not have autonomy over her own body, but her husband or boyfriend has ownership of her body. It has been found that a contributory factor to the rape statistics is the belief that, once aroused, a man cannot control his sexual urges and is henceforth not responsible for his actions. In fact, rape is blamed almost entirely on the dress code of young girls who 'ask for it' if they wear tight clothing. We are living in what is commonly known as a 'rape-supportive culture', where the blame for the rape is diverted away from the rapist and shifted to the victim.

This notion concurs with the findings of the current research shows that there are more black people effected by PTSD as compared to other races, due to the environment that they grow up in. However; having said this the current study did not do statistical comparisons between black participants and other race participants to see if they had statically significant differences in their levels of PTSD, and the current study did not correlate results with environment. According to the South African Depression and Anxiety Group (2017) rape has long term. Although the incident of rape cannot be forgotten, with some time and support, the victim can accept their reality and form a coping mechanism that will be suitable for them to process the trauma. All victims of this crime will experience the rape differently. Culture, class, religion, sexual orientation and attribution styles are examples of the different characteristics that could influence how the person feels about being raped. Their symptoms will also depend on the type and amount of support they receive from their friends, families and communities (South African Depression and Anxiety Group 2017).

The group analysis data obtained from all three scales using a Mann-Whitney U test, with the Fisher results being reported to compare the results of each intervention. The results showed no significant statistical difference between the two groups, which means that the homoeopathic simillimum was not more effective that the homoeopathic complex in the management of PTSD.

The researcher did not find any other research on the management PTSD using homoeopathic interventions where similar measuring tools were used. However, research conducted by Lankesar (2004) indicated that a homoeopathic simillimum is effective in the management of PTSD, and this current research is evidence that homoeopathic simillimum is effective.

As previously alluded to, apartheid played a major role in the attitudes and behaviours of South African people. The traumas from that era have left scars that have crippling effects. It created an environment of violence and anger. Children were exposed to that violence, which has caused the post-apartheid generation to find it normal to be violent. With black South Africans being the most affected, it is

understandable that they will be the most likely to have PTSD compared to other races. The demographics of this study were that 80% of participants were black South Africans compared to other races. The location of the study where the majority of the people of KwaZulu-Natal are black South Africans could have contributed to this proportion.

Research participants all displayed symptoms of PTSD such as avoiding of trauma, hyper-arousal, sensitivity and replay of their ordeals, as per DSM-5 (2013). The researcher encountered these symptoms during the consultations with the participants. The researcher is of the view that culture, and insufficient parental skills, play a role in how well one is able to heal. Most households, especially black households, do not allow a space for mood disorders. They are unable to understand, or provide the right kind of support, resulting in their children suffering from PTSD when they are adults. The researcher has encountered the perception in the black South African community that those with PTSD are 'weak' and are unable to cope with traumatic events in the same way as everyone else. The fact is that PTSD can affect anyone who has experienced trauma, and involves specific chemical changes in the brain, occurring in response to the experience of a traumatic event. Therefore, lack of knowledge of pathophysiology may be a factor underlying this thinking behaviour and attitude. It is therefore vital for survivors of any trauma and those suffering from PTSD to be well educated with correct information that PTSD is associated with high levels of comorbid mood, anxiety and substance related disorders. In addition, there may be significant impairment in occupational and social functioning as seen in participants in this study.

Regarding the non-statistical significance between the two groups, the researcher notes that the simillimum group showed a quicker response to the treatment compared to the complex group and lesser recurrence of symptoms. This could be due to accurate simillimum selection and Hahnemann's notion that the best treatment comes in a single remedy and that this form of treatment acts gently and brings rapid results. It could be that the well selected remedies of the homoeopathic complex could not act quickly as these remedies were competing for reaction by the vital force. Even though the selected remedies were not anti-doting each other, it

could be that the vibrational energy needed, was either too general or did not match the frequency needed of the patient. The improvement that is evident in the results could have been brought on by the consultation itself as a significant number of participants were sharing their stories for the first time, and that alone is purported to have healing properties and would concur with research conducted by Dube (2015) which found that the homoeopathic consultation has a positive impact, which could be due to treating suppressed emotions whether from childhood experiences or current life experience –emotional wounds which often manifest physically. According to Street et al. (2009) talking gives people the chance to explore their thoughts and feelings in order to become aware and make positive changes. This can speed up recovery.

Healing can also be promoted through safe forms of touching. After the case taking the researcher conducted a physical examination and communicated the findings to the patient. According to Non-Verbal Communication (2008), touch (palpation) is a form of communication. It provides security, solace, expresses intimacy and affection, creates and maintains a bond between patient and practitioner, builds trust and can even be therapeutic. This could be another reason why the respondents perceived a positive impact from the homoeopathic consultation.

Below is the list of remedies prescribed in both the groups with their frequency. Each prescription was determined after taking a detailed homoeopathic case. Rubrics were then carefully selected in order to get to one remedy. Because the researcher was blinded as to who was getting which intervention method, every case was treated as a similimum case. Table 5.1 is a list of remedies prescribed.

Table 5.1: Frequency of remedies prescribed

	NAME OF REMEDY	PARTICIPANTS IN THE SIMILIMUM GROUP	PARTICIPANTS IN THE COMPLEX GROUP
1	NAT MUR	8	3
2	ANARCADIUM	4	3
3	ACONITE	1	1
4	AURUM MET	1	0
5	THERIDION	1	1
6	STAPH	2	1
7	SEPIA	1	0
8	LAC CAN	3	2
9	LACHESIS	1	0
10	MERC SOL	1	0
11	PLATINA	2	0
12	MUREX	1	0
13	ARSENICUM ALB	0	1
14	IGNATIA	0	2
15	CUASTICUM	0	1
16	THUJA	0	1
17	ARG NIT	0	1

Table 5.2: Remedies prescribed in the simillimum group

PARTICIPANT IN SIMILLIMUM GROUP	VISIT 1	VISIT 2	VISIT 3
1	NUT MUR	CONTINUE	NUT MUR
4	ANACARDIUM	CONTINUE	CONT
6	NAT MUR	LAC CAN	LAC CAN
7	AUR MET	CONT	CONT
9	THERIDION	CONT	CONT
11	STAPH	CONT	ANACARD
12	SEP	CONT	NAT MUR
15	STAPH	CONT	CONT
17	LAC CAN	NAT MUR	CONT
20	MUREX	PLATIN	CONT
22	ANARC	PLAT	CONT
25	NAT MUR	CONT	CONT
27	LACHESIS	CONT	NAT MUR
29	NAT MUR	CONT	CONT
30	MERC SOL	CONT	CONT
31	LAC CAN	CONT	CONT
32	ACONITE	CONT	CONT

5.3 ANALYSIS

5.3.1 Simillimum group

It is evidence from the quantitative results shown in Chapter 4 that the majority of the participants had some improvement in their symptoms, with some showing a greater and faster improvement than the rest. Having said that, this study was also qualitative in its approach. The researcher took a homoeopathic case with each participant, whether they were in the simillimum or complex group.

A total of 12 remedies were selected in the simillimum group, out of 17 participants. The majority of the participants received *Nat mur* as their Simillimum, followed by *Lac can* and *Anacardium*.

The researcher will concentrate on the cases with the most frequently prescribed remedy, *Nat mur*, as it is one of the more universal remedies.

5.3.1.1 *Natrum Muriaticum*

The remedy picture has many heartbreaks; the person turns to silent grief, never crying except perhaps when alone listening to classical music. They do not want to talk about their depression (except maybe with their very best friend). They feel worse when people try to console them because they just want to be left alone. These people are easily offended, never forget what was done to them, and often dwell on the painful event, sometimes with great vindictiveness. Rather than committing suicide, they tend to crusade for a worthy cause as this improves their moods.

Participant1

A 35 year old black male.

CONSULTATION 1:

A man came into the room with a face like he did not need to be here and was forced by his wife. He sat down and begin to narrate his story about the loss of his mom. Growing up he did not have a very close relationship with his mom, as she was always absent. It was only in the year 2000 that he came to be close to her. His eyes lit up every time he mentioned her and their relationship. In 2006 she sadly passed away in hospital. He felt lonely and as if his world had turned upside down. He gets emotional when he thinks about her and always goes away to cry alone. He was filled with anger, especially when he didn't get what he wanted, and compared his wife to his mom. He explained how his wife lacked the same kind of love his mom showed him. He believed that no one was able to love him as his mother did. He often wanted to be alone to think about his mom.

RUBRICS

MIND: AILMENTS FROM - grief

MIND: AILMENTS FROM - silent grief

MIND: AILMENTS FROM - love, disappointed

MIND: ANGER - love, from disappointment

MIND: FORSAKEN - feeling

MIND: DELUSION - neglected - he is

MIND: DELUSION - appreciated he is not

CONSULTATION 2

He came in today looking a lot happier. The scores on his scales have reduced a bit. He was more open to speak about his mother and her death. He was even able to open up to his wife about how he felt about his mom. There was an overall improvement even in his work place. He appeared more relaxed and at ease.

CONSULTATION 3

Scales dropped even further. Maintained wellness.

CONSULTATION 4

No issues.

Participant 6

A 43 year old black female.

CONSULTATION 1

She walked in the room looking very fearful, with lots of emotions on her face. In 2010 she had an incident that left her running for her life. She was accused of witchcraft and her family attempted to kill her, with her mom leading the mob. She has been fleeing for her life since then. She is very fearful and paranoid. She questions why she is alone, yet she prefers being alone because she has become short tempered. She does not want to be controlled, because she does not know what the person will do or is up to. She feels better to talk about issues, otherwise she can't get over them. Does not have love, does not want anything to do with love. If her own mother has failed to love her, no one else can.

She is very fearful, always looking out the window to see if anyone is trying to harm her. She has become hypersensitive to noise, scared of cockroaches and rats. She feels she is surrounded by accidents.

RUBRICS

MIND: AILMENT REJECTIONS

MIND: AILMENTS FROM ABANDONMENT

MIND: AILMENT FROM UNRETURNED LOVE

CONSULTATION 2

She is still very fearful and paranoid, but the researcher chose to continue with the remedy as she felt strongly that she fit the remedy picture well.

CONSULTATION 3

Much improvement from previous consultation, fears are still there, but not as intensified. Most of the PTSD symptoms have subsided.

CONSULTATION 4

She walked in very happy today. Said she feels alive. She felt like a new person.

Participant 25

A 43 year old coloured female.

CONSULTATION 1

A 43 year old coloured female walked into the consultation room. She looked very pleasant and well-kept together, in a very good mood. She smiled throughout the consultation. About a year ago, her mother passed away from organ failure after she refused to take medication for her sickness. This was a very difficult time for the participant, as she has to watch her mother die every day. What stressed her the most during this time was that she would have too much responsibility if her mother passed away. As the eldest in the family, everything would have to be taken care of by her.

When her mom passed away, she found it very difficult to believe as it felt like a dream. Now she did not have anyone.

She wants to be alone, just to relax her mind, to distress, she even switches off her phone to escape from everyone and just sits and feels tears rolling out. She has no issue of crying in front of people as she is very sympathetic, she is moved by the sight of another person crying as she carries the person's pain.

However, she has a big fear of being alone, scared that someone might come in and rape her. She has a lot of anger, does not know why, but notices that it gets worse when she sees her family members. Her life now has to stop, and she has to take care of them. They are a burden and she does not like the responsibility. If it was up to her, she would just let them be, but now it is her duty to take care of them.

RUBRICS

MIND: AILMENT FROM GRIEF

MIND: AILMENT FROM, GRIEF, SILENT

MIND: DUTY - EVERSION TO

MIND: DUTY - TOO MUCH SENSE OF

MIND: FEAR - ALONE BEING

MIND: COMPANY - AVERSION TO

MIND: WEEPING - ALONE, WHEN

CONSULTATION 2

She walked in a little bit sad today, but tried her best to keep her emotions in. Her eyes were glassy the whole consultation, yet she said she was ok. Symptoms of PTSD were still visible, however the scales reduced dramatically. Her brother is also sick and will pass away soon and her sister also. They have kids who she now also will have to take care of. Her whole life is ruined now because they might die. She wanted to fix her house, but she feels guilty because her siblings need money.

CONSULTATION 3

She walked in looking happier today. Her PTSD scales have decreased dramatically. She renovated her home like she wanted to and she didn't care what anybody said. She had the right to spend her money as she feels like because she worked hard for it.

CONSULTATION 4

There were no issues reported today. She is very happy and wants to focus on herself from now on.

Participant 29

A 30 year old black female.

A 30 year old female came in today. She looked very well kept together. She showed no expression throughout the consultation, but just smiled.

In the year 2004 she was physically assaulted by her then boyfriend's other girlfriend. On her way from the shop, the girlfriend confronted her and she tried to talk back to her, but the girlfriend cut her with a glass on her legs. It left her with a huge scar and a limp when she walked. At the time of the assault, she felt no pain,

she became numb, she only remembers seeing lots of blood and clots and that made her scream. After that all she remembers is waking up in hospital.

On waking up, she was very angry, she didn't want to ever see her boyfriend again.

In 2005 her mother passed away and she also had an ectopic pregnancy which resulted in her not being able to have any more children. It was the most difficult time of her life. Too much was happening. Every time she sees her scar, all the memories come back. She feels like a failure. She blames herself for everything that goes wrong.

She is very fearful of what might happen to her on an everyday basis, she thinks she might get involved in an accident. She believes that everyone is against her. She wants to let go, but she cannot. The only thing that can make her better is revenge.

RUBRICS

MIND: AILMENTS FROM ABUSE

MIND: REPROACHING ONESELF

MIND: HATRED - REVENGEFUL

MIND: SUSPICIOUS

CONSULTATION 2

She walked in very angry today. I proceeded to find out what the problem was. She said the girl that attacked her sent her a friend request on Facebook. It made her very angry. She began to cry. "Why would she torture me like this". Seeing the picture of that girl upset her very much. She said the two weeks were fine until she got that friend request. Everything seems so fresh.

CONSULTATION 3

She walked in very happy today. Her PTSD scales seemed to have decreased. She began to explain her sudden mood change. She accepted the Facebook request from the girl who asked her if they could meet. At first she was not sure what to do, but accepted the invite and met her. The girl felt really bad about what she had done

and wanted to apologise as she had found Christ. As a Christian, she forgave her. She feels better, and the scar does not hurt that much when she sees it anymore.

CONSULTATION 4

No complaints.

Patients that needed *Natrum muriaticum*. later

Participant 12

A 36 year old black female

CONSULTATION 1

A 36 year old very emotional female came in, she seemed very laden with pain and sorrow. She looked and sounded angry as she told her story.

In 2011 she lost her baby after 2 days of delivery. The baby was fine, then suddenly she passed away.

In 2014 she had a miscarriage.

In 2016 she lost her baby one month after him being born. The baby was born fine, but a few days later, the liver swelled, and she had to endure one month of finding hope and then losing it again.

“I have three kids...but I can’t even see them...I have nothing to show, just scars and graves.”

She keeps having dreams that she gave birth to another child, but then it passes away and dogs eat the body and leave only the legs. She does not want another baby, because it will also pass away. She feels better when she speaks about the deaths. It upsets her very much every time she sees other kids, because she can’t

help but think that how old her kids would be. "I cannot have children, something is wrong with me, why did I lose three children."

She hates being consoled. Her husband is very supportive, but it just makes her even angrier when he is supportive. She wants to scream every time he touches her. She is a very dedicated Christian, but she finds herself doubting God and angry at Him.

RUBRICS

MIND: AILMENTS FROM DEATH OF LOVED ONE

DREAMS: DOGS, BITTEN BY DOGS

DREAMS: DEATH

MIND: COMPANY DESIRED

MIND: FEAR - BABY WILL DIE IN UTERO

MIND: ANXIETY - PREGNANCY IN

MIND: DELUSION - FORSAKEN

Prescription: *Sepia officinalis*.

CONSULTATION 2

She walked in very depressed today. She said she is still very sad about the death of her babies and cannot even look at other children. Remedy was changed to *Nat mur*.

CONSULTATION 3

She looked and sounded more hopeful than previous consultations. Her face glowing and she smiled. She played with kids for the first time since the babies' passing and she didn't feel as hurt as before. She no longer closed herself in the room and interacted with family. She feels grateful for her husband's support.

CONSULTATION 4

She felt a relief, applied for a preschool teacher position and although not ready for a baby, she is able to play and look at other kids without being emotional.

5.4 CONCLUSION

The main themes of the diagnosis of PTSD include:

- Escape (e.g., unconsciousness, numbness, disassociation)
- Hyper-vigilance (e.g., suspiciousness, insomnia, hypersensitivity to noise)
- Excessive defensiveness (e.g., rage, promiscuity, pushing others away)
- Stuck in the past (e.g., flashbacks, recurring nightmares, brooding on past)

These are the themes that were observed by the researcher during case taking from the participants. They varied in frequency and intensity and also by presentation depending on the participant's constitution. Although the presentation of the remedy was different, but the themes were constant, and these were used to repertorise to find the simillimum. The scales that were used during this research was the CAPS scales. Its focus was to diagnose as well to continuously measure the frequency and intensity of each core symptom for PTSD; the PDS scales focused on severity of the symptom and functioning of the participants who are diagnosed with PTSD; and the SPTSS scales was focused at the frequency of the symptoms in a more detailed manner.

From the CAPS scales the overall mean score for the simillimum group, improved from 13.3 in initial consultation for intrusion symptoms to 2.2 and from 13.9-2.3 for the complex group; 7.7 for persistent avoidance to 1.7 in simillimum group and from 6.3-1. In complex group; 20.6 for negative emotions to 3.6 in simillimum group and from 21.8-4.8 in complex group; 13.9 for hyper-arousal to 2.4 in simillimum group and 14.4-2.9 in complex group.

There was an overall reduction in the mean score from the PDS scale, from visit 1-4 which shows a decrease in severity of the symptoms of PTSD and increase in the function of the participants.

The number of PTSD episodes also decreased per month week and day as evident from the reduction of the SPTSS scales from visit one to four, from both simillimum and complex group. This research has shown how Homoeopathic remedies can

manage the symptoms of PTSD, using similimum and complex as a mode of intervention.

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CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter is concluding the outcome of research question which was to determine the efficacy of a homoeopathic simillimum as compared to a homoeopathic complex in the management of PTSD. The study focused on a sample of patients suffering from PTSD. The study has helped to highlight the benefits of the homoeopathic consultation and homoeopathic interventions even though the results showed no statistical significance between the two groups.

6.2 CONCLUSION

The value that this study may be to sensitise the community to consider homoeopathy as a treatment for PTSD. This form of treatment will improve victim's quality of life as well as physical and psychological health. A collaboration of health practitioners can be established when treating PTSD, including nutrition and mental health professionals.

The results show a general reduction in frequency, severity, and intensity of PTSD symptoms amongst participants in both groups. Results also showed an increased energy level, improved sleeping patterns, improved appetite and healthier nutritional choices. Participants showed a more positive outlook on life and an improved sense of general wellbeing. This is because homoeopathic remedies stimulate the vital force, and the stronger the vital force is, the faster the body is able to heal itself.

Some participant improved faster than others; they did not need more prescriptions, especially those in the simillimum group who received the right remedy the first time. Participants in the complex group needed more prescriptions.

From this observation, the researcher suggests that a time frame should not be considered when treating patients with PTSD, and that the frequency and dosage

should depend on the participant's vitality and response to the remedy. This will ensure that an individual is treated and not the disease.

During the examination of the case studies the researcher noted something interesting from the participants. Participants had a sudden craving for food rich in nutrients, like fruits and vegetables. Those that had been disappointed with love, started dating again. Those that had lost their children had a desire to conceive again. One of the results of trauma is the loss of control and was echoed in some of the cases observed by the researcher. The researcher was pleased to see a dynamic shift in the mind-set of the participants, with an increase in self-realisation and understanding of the self.

The researcher is a firm believer in a vital force that is believed to bring healing to the body or is associated with the body healing itself. Thus, in her view, the task of the homoeopath is to facilitate the healing process while the remedy enhances the vital force.

The researcher concludes that PTSD is one of the most under diagnosed mental disorders, especially with black people and their cultural belief that say men do not cry or that it is shameful to share your problems with people. It became evident in this study that at the base of this disorder was the belief that participants were not good enough and that the world was against them. This study showed that homoeopathic remedies can bring relief to such people, especially when prescriptions are holistic and individualised. These findings have instilled faith in the researcher in this system of therapy that is gentle and effective yet poorly recognised.

6.3 LIMITATIONS OF THE STUDY

6.3.1 Time

The study was eight weeks long per patient and there were only four consultations of one-hour duration each. The researcher felt that not enough time was given to each

participant and longer consultation times would have been more appropriate to find out deeper underlying issues of the participant.

The last follow up was one month after the last dosage of medication. The researcher feels that it would have been interesting to also do another follow up one month after that follow up, and perhaps every month after that for six months to determine whether the treatment effect was long lasting.

6.3.2 Venue

The researcher believes that a different venue or clinic outside of DUT should be used to perform clinical trials which can be available at all times.

6.3.3 Potency

The researcher only used a 30++ potency. Some participants showed only slight improvement, not because the simillimum chosen was incorrect, but because it was not a high enough potency. A higher potency that would be able to treat on a deeper level should have been used.

6.4 RECOMMENDATIONS

- Change of research venue. As stated in the limitations, a different venue that is open throughout the day and throughout the year would be a better place to conduct research without being affected by university disturbances.
- A more flexible dosage method for the potency of the simillimum.
- Conducted the research over a longer period, for example six months, to get a bigger picture of each case.
- A higher number of participants – 60 participants or more.

- Conduct a similar study to this but use different measurement tools.
- Conduct a study in which the homoeopathic similimum is compared to other types of trauma treatments.

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APPENDICES

Appendix A: IREC approval REC 64/15



12 September 2017

IREC Reference Number: **REC 64/15**

Ms A S Z Gumede
202 Clarendon Court
4 Smith Street
Durban
4001

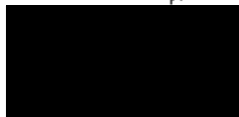
Dear Ms Gumede

The efficacy of a homeopathic simillimum as compared to a homeopathic complex in the management of post-traumatic stress disorder

The Institutional Research Ethics Committee acknowledges receipt of the late **submission** of your gatekeeper permission letters. Provisional approval was granted to you on 23 June 2015. Please be advised that you were required to submit the necessary gatekeeper permissions to the IREC before commencing with data collection, failure to do so could result in penalty.

Please note that **FULL APPROVAL** is granted to your research proposal.

Yours Sincerely,



Professor J K Adam
Chairperson: IREC



Appendix B: Permission Application Letters

(a) Permission Application Letter to use Homoeopathic Day Clinic (HDC) Clinic (HDC)

HOD: Homoeopathy Department

202 Clareridge Court
4 Anton Lembede (Smith Street)
Durban
4001

Faculty of Health Sciences
Department of Homoeopathy
Head of Department
P.O. BOX 1334
Durban
4000

Dear Dr Hall

Permission Application Letter to use the Homoeopathic Day Clinic (HDC)

Thank you for reading this letter. My name is Ms. Aphelele Gumede (20701201). I am currently registered for M. Tech. Homoeopathy and I am requesting to conduct my research study at the Homoeopathic Day Clinic (HDC). The title of my study is: The efficacy of a Homoeopathic Simillimum as compared to a Homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD).

Outline of the Procedures: The consultations where data relating to PTSD will be collected will take place at the Durban University of Technology (DUT), Homoeopathic Day Clinic (HDC). The total duration of the study is 2 months (8 weeks) with only 4 consultations. The Initial consultation will be about an hour long and thereafter the follow up consultations will be about 30 minutes long. Participants

will be requested to complete the consent form before they may participate in this study. On consenting to participate participants will be requested to complete the scales that will be explained to them. The completion of the scales may take 15-20 minutes. These scales will be completed before each consultation. A sample size of 30 consenting participants will be evenly distributed between the Simillimum and Homoeopathic Complex (*Aconitum napellus* 30CH, *Arnica montana* 30CH, *Ignatia amara* 30CH, *Delphinium staphysagria* 30CH and *Datura stramonium* 30CH) groups. Homoeopathic remedies treat holistically and cures rapidly, yet gently and permanently restores health.

Yours sincerely.

Ms. Aphelele Gumede (20701201)-Researcher
072 472 4447

Dr. J. Ngobese-Ngubane (Supervisor) – 031 373 2484 (jabulilen@dut.ac.za)

Dr. A. Essack (Co-supervisor) - 031 536 2112 (arianaessack@gmail.com)

(b) Permission Application Letter to use Homoeopathic Day Clinic (HDC)
Homoeopathic Clinic Director & Coordinator:

202 Clareridge Court
4 Anton Lembede (Smith Street)
Durban
4001

Faculty of Health Sciences
Clinic Director and Coordinator of Homoeopathic Day Clinic
P.O. BOX 1334
Durban
4000

Dear Dr Nienaber & Dr Korporaal

Permission Application Letter to use the Homoeopathic Day Clinic (HDC)

Thank you for reading this letter. My name is Ms. Aphelele Gumede (20701201). I am currently registered for M. Tech. Homoeopathy and I am requesting to conduct my research study at the Homoeopathic Day Clinic (HDC). The title of my study is: The efficacy of a Homoeopathic Simillimum as compared to a Homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD).

Outline of the Procedures: The consultations where data relating to PTSD will be collected will take place at the Durban University of Technology (DUT), Homoeopathic Day Clinic (HDC). The total duration of the study is 2 months (8 weeks) with only 4 consultations. The Initial consultation will be about an hour long and thereafter the follow up consultations will be about 30 minutes long. Participants will be requested to complete the consent form before they may participate in this study. On consenting to participate participants will be requested to complete the scales that will be explained to them. The completion of the scales may take 15-20 minutes. These scales will be completed before each consultation. A sample size of

30 consenting participants will be evenly distributed between the Simillimum and Homoeopathic Complex (Aconitum napellus 30CH, Arnica montana 30CH, Ignatia amara 30CH, Delphinium staphysagria 30CH and Datura stramonium 30CH) groups. Homoeopathic remedies treat holistically, and cures rapidly, yet gently and permanently restores health.

Yours sincerely.

Ms. Aphelele Gumede (20701201)-Researcher
072 472 4447

Dr. J. Ngobese-Ngubane (Supervisor) – 031 373 2484 (jabulilen@dut.ac.za)

Dr. A. Essack (Co-supervisor) - 031 536 2112 (arianaessack@gmail.com)

(c) Permission Application Letter to use Homoeopathic Day Clinic (HDC)

Director: Research and Postgraduate Support

202 Clareridge Court
4 Anton Lembede (Smith Street)
Durban
4001

Director: Research and Postgraduate Support
Tromso Annex, 1st Floor
Gate 1, Steve Biko Campus
P.O. BOX 1334
Durban
4000

Dear Professor Moyo

Application letter for permission to use the DUT facility and DUT Students as well as staff as participants

Thank you for reading this letter. My name is Ms. Aphelele Gumede (20701201). I am currently registered for M. Tech. Homoeopathy and I am requesting permission to conduct my research study at the Homoeopathic Day Clinic (HDC) and use DUT students and staff as participants. The title of my study is: The efficacy of a Homoeopathic Simillimum as compared to a Homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD).

Outline of the Procedures: The consultations where data relating to PTSD will be collected will take place at the Durban University of Technology (DUT), Homoeopathic Day Clinic (HDC). The total duration of the study is 2 months (8 weeks) with only 4 consultations. The Initial consultation will be about an hour long and thereafter the follow up consultations will be about 30 minutes long. Participants will be requested to complete the consent form before they may participate in this study. On consenting to participate participants will be requested to complete the

scales that will be explained to them. The completion of the scales may take 15-20 minutes. These scales will be completed before each consultation. Randomisation list will be drawn up by an independent staff member who is a qualified and registered homoeopath and technician for the Homoeopathy department. A sample size of 30 consenting participants will be evenly distributed between the Simillimum and Homoeopathic Complex (*Aconitum napellus 30CH*, *Arnica montana 30CH*, *Ignatia amara 30CH*, *Delphinium staphysagria 30CH* and *Datura stramonium 30CH*) groups. Homoeopathic remedies treat holistically, and cures rapidly, yet gently and permanently restores health.

Yours sincerely.

Ms. Aphelele Gumede (20701201)-Researcher
072 472 4447

Dr. J. Ngobese-Ngubane (Supervisor) – 031 373 2484 (jabulilen@dut.ac.za)

Dr. A. Essack (Co-supervisor) - 031 536 2112 (arianaessack@gmail.com)

(d) Application Letter to use Notice Boards to paste advert for research

Faculty of Health Sciences
Department of Homoeopathy
P.O. BOX 1334
Durban
4000

To whom it may concern.

Dear Sir/ Madam

Permission Letter to use Notice Boards for pasting research advert

Thank you for reading this letter. My name is Ms. Aphelele Gumede (20701201). I am currently registered for M. Tech. Homoeopathy and I am requesting permission to paste my research advert to recruit participants for my research. The title of my study is: The efficacy of a Homoeopathic Simillimum as compared to a Homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD).

Outline of the details of research advert: The advert outlines the symptoms of PTSD, location of the study, name of the researcher, contact details of the researcher and location of the study and that participation is free.

For further information regarding this study please contact the researcher or supervisors of the study.

Thanking you in advanced for your assistance in the above request.

Yours sincerely.

Ms. Aphelele Gumede (20701201)-Researcher
072 472 4447

Dr. J. Ngobese-Ngubane (Supervisor) – 031 373 2484 (jabulilen@dut.ac.za)

Dr. A. Essack (Co-supervisor) - 031 536 2112 (arianaessack@gmail.com)

Appendix C: Gatekeeper permission – Clinic Director

MEMORANDUM

To : Prof Puckree
Chair : RHDC

Prof Adam
Chair : IREC

From : Dr Charmaine Korporaal
Clinic Director : FOHS Clinic

Date : 27.07.2015

Re : Request for permission to use the Homoeopathic Day Clinic for research purposes

Permission is hereby granted to :

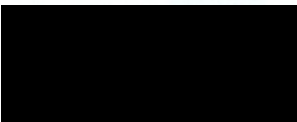
Ms Aphelele Gumede (student number 20701201).

Research title : "The efficacy of a Homoeopathic Simillimum as compared to a Homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD)."

It is requested that Ms Gumede submit a copy of her RHDC / IREC approved proposal to the Clinic Co-ordinator (Dr Nienaber) before she starts with her research in order that any special procedures with regards to her research can be implemented prior to the commencement of data capture.

Thank you for your time.

Kind regards



Dr Charmaine Korporaal
Clinic Director : FOHS Clinic

Cc: Dr Nienaber : Clinic Co-ordinator
Dr. J Ngobese-Ngubane : Supervisor
Ms A Essack : Co-supervisor
Dr C Hall : Co Supervisor

Appendix D: Gatekeeper permission – Director for Research and Postgraduate Support



Directorate for Research and Postgraduate Support
Durban University of Technology
Tromso Annexe, Steve Biko Campus
P.O. Box 1334, Durban 4000
Tel.: 031-3732576/7
Fax: 031-3732946
E-mail: moyos@dut.ac.za

27th July 2015

Ms Aphelele Sibahle Zodumo Gumede
c/o Department of Homoeopathy
Durban University of Technology

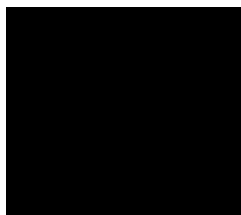
Dear Ms Gumede

PERMISSION TO CONDUCT RESEARCH AT THE DUT

Your email correspondence in respect of the above refers. I am pleased to inform you that the Institutional Research Committee (IRC) has granted permission for you to conduct your research "The efficacy of a homoeopathic Simillimum as compared to a homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD)" at the Durban University of Technology.

We would be grateful if a summary of your key research findings can be submitted to the IRC on completion of your studies.

Kindest regards.
Yours sincerely



PROF. S. MOYO
DIRECTOR: RESEARCH AND POSTGRADUATE SUPPORT

Appendix E: Permissions to use scales

From: "Carlson, Eve" <Eve.Carlson@va.gov>
Date: Mon, 23 Feb 2015 17:53:46 -0800
To: <aphelegmd@yahoo.com>
Subject: RE: Re: SPTSS request

Sorry, no visual analog scales. They were a nightmare to score.

I will send a couple of measures that may be of interest.

Best,
Eve Carlson

Eve B. Carlson, Ph.D.

National Center for PTSD, VA Palo Alto Health Care System

(650) 493-5000, 1, 2, 24058

eve.carlson@va.gov

From: aphelele [mailto:aphelegmd@yahoo.com]
Sent: Friday, February 20, 2015 12:11 AM
To: Carlson, Eve
Subject: Re: SPTSS request

Good day dr Carlson. May I please take you on your offer for sending me other measurement tools for posttraumatic stress disorder. If a Visual analogue scale is one of them, I will be very much pleased. Thank you

Sent via my BlackBerry from Vodacom - let your email find you!

From: "Carlson, Eve" <Eve.Carlson@va.gov>

Date: Thu, 19 Feb 2015 13:21:10 -0800

To: <aphelegmd@yahoo.com>

Subject: RE: SPTSS request

Dear Colleague,

In response to your request, I am attaching a copy of the SPTSS. An article that describes its psychometrics is attached. The full reference for the article is Carlson, E. (2001). Psychometric study of a brief screen for PTSD: Assessing the impact of multiple traumatic events. *Assessment*, 8, 431-441. Another psychometrics paper that compares SPTSS scores in an ethnic minority sample of combat veterans to responses on a structured interview is also attached.

<<Carlson 2001 SPTSS brief screen paper.pdf>><<Caspi SPTSS validation 2007.pdf>>

Also attached is a version of the SPTSS that has a different (I think much better!) response scale and assesses a one-week period. Scores for this version are the total of all item responses. Psychometric support for the new version has been obtained, and the measure appears to perform well to assess PTSD symptoms. We have also gathered data on norms in nonclinical samples for this measure. I

suggest follow-up for a total score of 20 or more. That score is 1.5 standard deviations above the mean of scores of those with no prior traumatic stressors (high magnitude stressors associated with persisting distress) in an adult community sample. In a sample of 40 adult survivors of traumatic injury of self or a loved one, a score of 20 predicted diagnosis on the [CAPS](#) (Clinician-Administered PTSD Scale) with a sensitivity of .90 and a specificity of .80.

Because many people ask about scoring and cut off scores for the SPTSS, I will make a few comments about those issues. The cut off score described above is derived from an adult community sample and a sample of survivors of traumatic injury and family members of traumatically injured patients. If a client comes from a population that is different from the community sample in important ways (age, culture, treatment-seeking, etc.), this cut off score might not be applicable. This is true for any measure – cut off scores don't necessarily generalize across different populations. Generalization is particularly problematic across cultures and gender. For clinical use, cut off scores can give you a general idea of what score might be clinically significant, but they should be used with caution because they are not definitive and cannot be used alone to diagnose or plan treatment. Available cut off scores, norms, or means for particular samples can be used in conjunction with additional information from interviews and other measures to inform diagnosis and treatment decisions. For these reasons, I suggest clinicians first use clinical judgment to determine how accurately the self-reports reflect the symptoms of PTSD (e.g., is the client reporting actual intrusive thoughts or something that sounds more like rumination?) and then follow-up with a structured interview if there seems to be enough PTSD symptoms to disrupt functioning or cause significant distress.

Lastly, an update of the SPTSS to include new symptoms in the DSM-5 diagnostic criteria is attached. Validation data collection is underway for this version and will likely be available in late 2014 or 2015. This version includes all of the SPTSS items, 3 new items for DSM diagnostic criterion of negative alterations in cognitions and mood associated with the traumatic event, and 8 items to assess dissociation. Researchers should note that the item numbers for this version do not correspond to the item numbers on prior versions of the SPTSS. Items 1-20 assess the DSM-5, ICD-10, and proposed ICD-11 diagnostic criteria. Items 21-28 assess dissociation with the brief version of the Dissociative Symptoms Scale (Carlson & Waelde) (available upon request from Eve Carlson).

Feel free to use the SPTSS in research or clinical work at no cost. Please note that because the SPTSS was designed as a screening instrument and does not key items to a single, identified trauma, quantification of trauma symptoms may differ from other types of measures (e.g., those that inquire about symptoms related to a single trauma).

If you have any need for a very brief, well-validated screening measure for trauma exposure or a new measure of posttraumatic dissociation, please let me know, and I can send those as well.

Lastly, may I suggest you visit <http://www.istss.org/Home.htm> and consider joining the International Society for Traumatic Stress Studies? ISTSS's publications and training programs are an ongoing source of information about traumatic stress.

Best,
Eve Carlson

<<SPTSS.pdf>><<One Week SPTSS v.3.pdf>><<SPTSS for DSM & ICD.pdf>><<SPTSS for DSM-5.pdf>>

Eve B. Carlson, Ph.D.

National Center for PTSD

795 Willow Rd.

Menlo Park, CA 94025

phone: (650) 493-5000, 1, 224058

NC-PTSD assessment web pages are at:

<http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp>

Fw: PDS measurement

aphelele [aphelelegmd@yahoo.com]

Sent: Thursday, February 19, 2015 8:28 PM

To: Threethambal Puckree

Cc: Jabulile Cresancia Ngobese; Ariana@Essack

Attachments:  PDS 5 instructions.docx (13 KB)[Open as Web Page];  PDS-5 Manual FINAL.pdf (236 KB)[Open as Web Page];  PDS-5.pdf (209 KB)[Open as Web Page]

Good day prof and dr's. One of the people have responded to my email regarding the scales. I have one of the scales now.
Sent via my BlackBerry from Vodacom - let your email find you!

From: "Ellen Kubis" <ekubis@mail.med.upenn.edu>

Date: Wed, 18 Feb 2015 14:40:01 -0500 (EST)

To: <aphelelegmd@yahoo.com>

Subject: PDS measurement

I have attached the PDS-5 measurement, manual, and instructions from Dr. McLean.

Thank you,

Ellen

Appendix F: Participant Information letter and consent form

Participant Information letter



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

LETTER OF INFORMATION

Dear Participant

Thank you for agreeing to participate in this study.

Title of the Research Study: The efficacy of a homoeopathic Simillimum as compared to a homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD)

Principal Investigator/s/researcher: Ms Aphelele Gumede, B.Tech. Homoeopathy

Co-Investigator/s/supervisor/s: Dr. J. C. Ngobese-Ngubane, M. Tech. Hom.(Supervisor)

Dr. Ariana Essack, M.ED (ED PSYCH) (Co-supervisor)

Brief Introduction and Purpose of the Study: The purpose of this proposed randomised, double-blind randomised controlled study is to determine the efficacy of a homoeopathic Simillimum treatment as compared to a homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD). PTSD is defined as a debilitating mental disorder that follows experiencing or witnessing an extremely traumatic, tragic, or terrifying event. People with this condition usually have persistent frightening thoughts and memories of their ordeal and feel emotionally numb. This condition can occur at any age and can be accompanied by depression, substance abuse, or anxiety. Symptoms may be mild or severe and people may become easily irritated or have violent outbursts. In severe cases, you may have trouble working or socializing.

Outline of the Procedures: The consultations where data relating to PTSD will be collected will take place at the Durban University of Technology (DUT), Homoeopathic Day Clinic (HDC). The total duration of the study is 2 months (8 weeks) with only 4 consultations. The Initial consultation will be about an hour long and thereafter the follow up consultations will be about 30 minutes long. You will be requested to complete the consent form before you may participate in this study. On consenting to

participate you will be requested to complete the scales that will be explained to you. The completion of the scales may take 15-20 minutes. These scales will be completed before each consultation.

Non-participation: You are not forced to participate in this study. Participation in this study is voluntarily. If you don't participate in this study, it will not affect the service offered to you by the HDC.

Risks or Discomforts to the Participant: Homoeopathic consultation is an in-depth questioning of the patient as a whole may trigger re-experiencing and due to the nature of PTSD, hyper-arousal symptoms, flashbacks, reliving the trauma over and over, including physical symptoms like a racing heart or sweating, frightening thoughts may be aroused during the consultation however, patients will not be pressured into continuing with the consultation if they feel it is unbearable.

Benefits: The information given by you will help to draw conclusions about the efficacy of a homoeopathic Simillimum as compared to a homoeopathic complex in the management of Post-Traumatic Stress Disorder (PTSD). You may also experience the ease of PTSD symptoms.

Reason/s why the Participant May Be Withdrawn from the Study: You are free to withdraw from the study at any time without any form of penalty.

Remuneration: There is no remuneration for participating in this study.

Costs of the Study: You will not be expected to cover any costs towards the study.

Confidentiality: Please do not write your personal information like name, contact details on the scales. All data collected will be pooled to ensure anonymity. Pooled data will be communicated scientifically. Data will be stored in a locked cupboard for 5 years

Research-related Injury: There are no injuries that you may be exposed to during the course of the study.

Persons to Contact in the Event of Any Problems or Queries:

Ms. A. Gumede (Student) Telephone no: 072 4724447

Dr. J.C. Ngobese-Ngubane (Supervisor) Telephone no: 031 373 2484

Dr. A. Essack (Co-supervisor) Telephone no: 031 536 2112

The Institutional Research Ethics administrator: - 031-373 2900. Complaints can be reported to the DVC: TIP F. Otieno on 031-3732382 or dvctip@dut.ac.za.

Participant consent form



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant

Date

Time

Signature / Right

Thumbprint

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Date

Signature

Full Name of Witness (If applicable)

Date

Signature

Full Name of Legal Guardian (If applicable)

Date

Signature

Appendix G: DSM-5 inclusion criteria

DSM V Inclusion Criteria:

Participants must meet the inclusion criteria for PTSD as stated by the DSM V, (2013) which is:

A. The person has been exposed to a traumatic event in which both of the following have been present:

- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
- (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.
- (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix H: CAP-5 (Weathers)

CAPS-5 Page 1

National Center for PTSD
CLINICIAN-ADMINISTERED PTSD SCALE FOR DSM-5
PAST WEEK VERSION

Name: _____ ID#: _____
Interviewer: _____ Date: _____
Study: _____

Frank W. Weathers, Dudley D. Blake, Paula P. Schnurr,
Danny G. Kaloupek, Brian P. Marx, & Terence M. Keane

National Center for Posttraumatic Stress Disorder
May 1, 2015

NOTE: This is the PAST WEEK version of the CAPS-5, which should be used only to evaluate PTSD symptom severity over the past week. PTSD diagnostic status should be evaluated with the PAST MONTH version of the CAPS-5.

Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

NOTE: Criterion A should already have been evaluated in a prior administration of the PAST MONTH version of the CAPS-5. Thus, for most applications of the PAST WEEK version, Criterion A does not need to be re-evaluated.

[Administer Life Events Checklist or other structured trauma screen]

I'm going to ask you about the stressful experiences questionnaire you filled out. First I'll ask you to tell me a little bit about the event you said was the worst for you. Then I'll ask how that event may have affected you over the past week. In general I don't need a lot of information – just enough so I can understand any problems you may have had. Please let me know if you find yourself becoming upset as we go through the questions so we can slow down and talk about it. Also, let me know if you have any questions or don't understand something. Do you have any questions before we start?

The event you said was the worst was (EVENT). What I'd like for you to do is briefly describe what happened.

Index event (specify):

<p>What happened? (How old were you? How were you involved? Who else was involved? Was anyone seriously injured or killed? Was anyone's life in danger? How many times did this happen?)</p>	<p>Exposure type:</p> <p>Experienced ____</p> <p>Witnessed ____</p> <p>Learned about ____</p> <p>Exposed to aversive details ____</p> <p>Life threat? NO YES [self ____ other ____]</p> <p>Serious injury? NO YES [self ____ other ____]</p> <p>Sexual violence? NO YES [self ____ other ____]</p> <p>Criterion A met? NO PROBABLE YES</p>
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For the rest of the interview, I want you to keep (EVENT) in mind as I ask you about different problems it may have caused you. You may have had some of these problems before, but for this interview we're going to focus just on the past week. For each problem I'll ask if you've had it in the past week, and if so, how often and how much it bothered you.

Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. (B1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

<p>In the past week, have you had any <u>unwanted memories</u> of (EVENT) while you were awake, so not counting dreams? [Rate 0=Absent if only during dreams]</p> <p>How does it happen that you start remembering (EVENT)?</p> <p>[If not clear:] (Are these <u>unwanted memories</u>, or are you thinking about [EVENT] on purpose?) [Rate 0=Absent unless perceived as involuntary and intrusive]</p> <p>How much do these memories bother you?</p> <p>Are you able to put them out of your mind and think about something else?</p> <p>[If not clear:] (Overall, how much of a problem is this for you? How so?)</p> <p>Circle: Distress = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How often have you had these memories in the past week? # of times _____</p> <hr/> <p>Key rating dimensions = frequency / intensity of distress Moderate = at least 1 X week / distress clearly present, some difficulty dismissing memories Severe = at least 2 X week / pronounced distress, considerable difficulty dismissing memories</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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2. (B2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.

<p>In the past week, have you had any <u>unpleasant dreams</u> about (EVENT)?</p> <p>Describe a typical dream. (What happens?)</p> <p>[If not clear:] (Do they wake you up?)</p> <p>[If yes:] (What do you experience when you wake up? How long does it take you to get back to sleep?)</p> <p>[If reports not returning to sleep:] (How much sleep do you lose?)</p> <p>How much do these dreams bother you?</p> <p>Circle: Distress = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How often have you had these dreams in the past week? # of times _____</p> <hr/> <p>Key rating dimensions = frequency / intensity of distress Moderate = at least 1 X week / distress clearly present, less than 1 hour sleep loss Severe = at least 2 X week / pronounced distress, more than 1 hour sleep loss</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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3. (B3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

<p>In the past week, have there been times when you <u>suddenly acted</u> or <u>felt</u> as if (EVENT) were <u>actually happening</u> again?</p> <p><i>[If not clear:] (This is different than thinking about it or dreaming about it – now I'm asking about flashbacks, when you feel like you're actually back at the time of [EVENT], actually reliving it.)</i></p> <p>How much does it seem as if (EVENT) were happening again? <i>(Are you confused about where you actually are?)</i></p> <p>What do you do while this is happening? <i>(Do other people notice your behavior? What do they say?)</i></p> <p>How long does it last?</p> <p><u>Circle:</u> Dissociation = Minimal Clearly Present Pronounced Extreme</p> <p>How often has this happened in the past week? # of times _____</p> <hr/> <p>Key rating dimensions = frequency / intensity of dissociation Moderate = at least 1 X week / dissociative quality clearly present, may retain some awareness of surroundings but relives event in a manner clearly distinct from thoughts and memories Severe = at least 2 X week / pronounced dissociative quality, reports vivid reliving, e.g., with images, sounds, smells</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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4. (B4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

<p>In the past week, have you gotten <u>emotionally upset</u> when <u>something reminded you</u> of (EVENT)?</p> <p>What kinds of reminders make you upset?</p> <p>How much do these reminders bother you?</p> <p>Are you able to calm yourself down when this happens? <i>(How long does it take?)</i></p> <p><i>[If not clear:] (Overall, how much of a problem is this for you? How so?)</i></p> <p><u>Circle:</u> Distress = Minimal Clearly Present Pronounced Extreme</p> <p>How often has this happened in the past week? # of times _____</p> <hr/> <p>Key rating dimensions = frequency / intensity of distress Moderate = at least 1 X week / distress clearly present, some difficulty recovering Severe = at least 2 X week / pronounced distress, considerable difficulty recovering</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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5. (B5) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

<p>In the past week, have you had any <u>physical reactions</u> when <u>something reminded you</u> of (EVENT)?</p> <p>Can you give me some examples? <i>(Does your heart race or your breathing change? What about sweating or feeling really tense or shaky?)</i></p> <p>What kinds of reminders trigger these reactions?</p> <p>How long does it take you to recover?</p> <p><u>Circle:</u> Physiological reactivity = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How often has this happened in the past week? # of times _____</p> <hr/> <p><small>Key rating dimensions = frequency / intensity of physiological arousal Moderate = at least 1 X week / reactivity clearly present, some difficulty recovering Severe = at least 2 X week / pronounced reactivity, sustained arousal, considerable difficulty recovering</small></p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

6. (C1) Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

<p>In the past week, have you tried to <u>avoid thoughts</u> or <u>feelings</u> about (EVENT)?</p> <p>What kinds of thoughts or feelings do you avoid?</p> <p>How hard do you try to avoid these thoughts or feelings? <i>(What kinds of things do you do?)</i></p> <p><small>[If not clear:]</small> <i>(Overall, how much of a problem is this for you? How would things be different if you didn't have to avoid these thoughts or feelings?)</i></p> <p><u>Circle:</u> Avoidance = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How often in the past week? # of times _____</p> <hr/> <p><small>Key rating dimensions = frequency / intensity of avoidance Moderate = at least 1 X week / avoidance clearly present Severe = at least 2 X week / pronounced avoidance</small></p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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7. (C2) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

<p>In the past week, have you tried to <u>avoid things</u> that <u>remind you</u> of (EVENT), like certain people, places, or situations?</p> <p>What kinds of things do you avoid?</p> <p>How much effort do you make to avoid these reminders? <i>(Do you have to make a plan or change your activities to avoid them?)</i></p> <p><small>[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn't have to avoid these reminders?)</small></p> <p><small>Circle: Avoidance = Minimal Clearly Present Pronounced Extreme</small></p> <p>How often in the past week? # of times _____</p> <hr/> <p><small>Key rating dimensions = frequency / intensity of avoidance Moderate = at least 1 X week / avoidance clearly present Severe = at least 2 X week / pronounced avoidance</small></p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

8. (D1) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

<p>In the past week, have you had <u>difficulty remembering</u> some <u>important parts</u> of (EVENT)? <i>(Do you feel there are gaps in your memory of [EVENT]?)</i></p> <p>What parts have you had difficulty remembering?</p> <p>Do you feel you should be able to remember these things?</p> <p><small>[If not clear:] (Why do you think you can't? Did you have a head injury during [EVENT]? Were you knocked unconscious? Were you intoxicated from alcohol or drugs?) [Rate 0=Absent if due to head injury or loss of consciousness or intoxication during event]</small></p> <p><small>[If still not clear:] (Is this just normal forgetting? Or do you think you may have blocked it out because it would be too painful to remember?) [Rate 0=Absent if due only to normal forgetting]</small></p> <p><small>Circle: Difficulty remembering = Minimal Clearly Present Pronounced Extreme</small></p> <p>In the past week, how many of the important parts of (EVENT) have you had difficulty remembering? <i>(What parts do you still remember?)</i> # of important aspects _____</p> <p>Would you be able to recall these things if you tried?</p> <hr/> <p><small>Key rating dimensions = amount of event not recalled / intensity of inability to recall Moderate = at least one important aspect / difficulty remembering clearly present, some recall possible with effort Severe = several important aspects / pronounced difficulty remembering, little recall even with effort</small></p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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9. (D2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

<p>In the past week, have you had <u>strong negative beliefs</u> about yourself, other people, or the world?</p> <p>Can you give me some examples? (<i>What about believing things like "I am bad," "there is something seriously wrong with me," "no one can be trusted," "the world is completely dangerous"?</i>)</p> <p>How strong are these beliefs? (<i>How convinced are you that these beliefs are actually true? Can you see other ways of thinking about it?</i>)</p> <p><u>Circle:</u> Conviction = Minimal Clearly Present Pronounced Extreme</p> <p>How much of the time in the past week have you felt that way, as a percentage?</p> <p>% of time _____</p> <p>Did these beliefs start or get worse after (EVENT)? (<i>Do you think they're related to [EVENT]? How so?</i>) <u>Circle:</u> Trauma-relatedness = Definite Probable Unlikely</p> <hr/> <p>Key rating dimensions = frequency / intensity of beliefs Moderate = some of the time (20-30%) / exaggerated negative expectations clearly present, some difficulty considering more realistic beliefs Severe = much of the time (50-80%) / pronounced exaggerated negative expectations, considerable difficulty considering more realistic beliefs</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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10. (D3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

<p>In the past week, have you <u>blamed yourself</u> for (EVENT) or what happened as a result of it? Tell me more about that. (<i>In what sense do you see yourself as having caused [EVENT]? Is it because of something you did? Or something you think you should have done but didn't? Is it because of something about you in general?</i>)</p> <p>What about <u>blaming someone else</u> for (EVENT) or what happened as a result of it? Tell me more about that. (<i>In what sense do you see [OTHERS] as having caused [EVENT]? Is it because of something they did? Or something you think they should have done but didn't?</i>)</p> <p>How much do you blame (YOURSELF OR OTHERS)?</p> <p>How convinced are you that [YOU OR OTHERS] are truly to blame for what happened? (<i>Do other people agree with you? Can you see other ways of thinking about it?</i>)</p> <p>[Rate 0=Absent if only blames perpetrator, i.e., someone who deliberately caused the event and intended harm]</p> <p><u>Circle:</u> Conviction = Minimal Clearly Present Pronounced Extreme</p> <p>How much of the time in the past week have you felt that way, as a percentage?</p> <p>% of time _____</p> <hr/> <p>Key rating dimensions = frequency / intensity of blame Moderate = some of the time (20-30%) / distorted blame clearly present, some difficulty considering more realistic beliefs Severe = much of the time (50-80%) / pronounced distorted blame, considerable difficulty considering more realistic beliefs</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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11. (D4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

<p>In the past week, have you had any strong negative feelings such as fear, horror, anger, guilt, or shame?</p> <p>Can you give me some examples? <i>(What negative feelings do you experience?)</i></p> <p>How strong are these negative feelings?</p> <p>How well are you able to manage them?</p> <p>[If not clear:] <i>(Overall, how much of a problem is this for you? How so?)</i></p> <p>Circle: Negative emotions = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How much of the time in the past week have you felt that way, as a percentage?</p> <p>% of time _____</p> <p>Did these negative feelings start or get worse after (EVENT)? <i>(Do you think they're related to [EVENT]? How so?)</i> Circle: Trauma-relatedness = <i>Definite</i> <i>Probable</i> <i>Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of negative emotions Moderate = some of the time (20-30%) / negative emotions clearly present, some difficulty managing Severe = much of the time (50-80%) / pronounced negative emotions, considerable difficulty managing</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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12. (D5) Markedly diminished interest or participation in significant activities.

<p>In the past week, have you been less interested in activities that you used to enjoy?</p> <p>What kinds of things have you lost interest in or don't do as much as you used to? <i>(Anything else?)</i></p> <p>Why is that? [Rate 0=Absent if diminished participation is due to lack of opportunity, physical inability, or developmentally appropriate change in preferred activities]</p> <p>How strong is your loss of interest? <i>(Would you still enjoy [ACTIVITIES] once you got started?)</i></p> <p>Circle: Loss of interest= <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>Overall, in the past week, how many of your usual activities have you been less interested in, as a percentage? % of activities _____</p> <p>What kinds of things do you still enjoy doing?</p> <p>Did this loss of interest start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> Circle: Trauma-relatedness = <i>Definite</i> <i>Probable</i> <i>Unlikely</i></p> <hr/> <p>Key rating dimensions = percent of activities affected / intensity of loss of interest Moderate = some activities (20-30%) / loss of interest clearly present but still has some enjoyment of activities Severe = many activities (50-80%) / pronounced loss of interest, little interest or participation in activities</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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13. (D6) Feelings of detachment or estrangement from others.

<p>In the past week, have you felt <u>distant</u> or <u>cut off</u> from other people?</p> <p>Tell me more about that.</p> <p>How strong are your feelings of being distant or cut off from others? <i>(Who do you feel closest to? How many people do you feel comfortable talking with about personal things?)</i></p> <p><u>Circle:</u> Detachment or estrangement = <i>Minimal Clearly Present Pronounced Extreme</i></p> <p>How much of the time in the past week have you felt that way, as a percentage?</p> <p>% of time _____</p> <p>Did this feeling of being distant or cut off start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite Probable Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of detachment or estrangement Moderate = some of the time (20-30%) / feelings of detachment clearly present but still feels some interpersonal connection Severe = much of the time (50-80%) / pronounced feelings of detachment or estrangement from most people, may feel close to only one or two people</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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14. (D7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

<p>In the past week, have there been times when you had <u>difficulty experiencing positive feelings</u> like love or happiness?</p> <p>Tell me more about that. <i>(What feelings are difficult to experience?)</i></p> <p>How much difficulty do you have experiencing positive feelings? <i>(Are you still able to experience any positive feelings?)</i></p> <p><u>Circle:</u> Reduction of positive emotions = <i>Minimal Clearly Present Pronounced Extreme</i></p> <p>How much of the time in the past week have you felt that way, as a percentage?</p> <p>% of time _____</p> <p>Did this trouble experiencing positive feelings start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite Probable Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of reduction in positive emotions Moderate = some of the time (20-30%) / reduction of positive emotional experience clearly present but still able to experience some positive emotions Severe = much of the time (50-80%) / pronounced reduction of experience across range of positive emotions</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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Criterion E: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

15. (E1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

<p>In the past week, have there been times when you felt especially irritable or angry and showed it in your behavior?</p> <p>Can you give me some examples? <i>(How do you show it? Do you raise your voice or yell? Throw or hit things? Push or hit other people?)</i></p> <p><u>Circle:</u> Aggression = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How often in the past week? # of times _____</p> <p>Did this behavior start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite</i> <i>Probable</i> <i>Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of aggressive behavior Moderate = at least 1 X week / aggression clearly present, primarily verbal Severe = at least 2 X week / pronounced aggression, at least some physical aggression</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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16. (E2) Reckless or self-destructive behavior.

<p>In the past week, have there been times when you were taking more risks or doing things that might have caused you harm?</p> <p>Can you give me some examples?</p> <p>How much of a risk do you take? <i>(How dangerous are these behaviors? Were you injured or harmed in some way?)</i></p> <p><u>Circle:</u> Risk = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>How often have you taken these kinds of risks in the past week? # of times _____</p> <p>Did this behavior start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite</i> <i>Probable</i> <i>Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / degree of risk Moderate = at least 1 X week / risk clearly present, may have been harmed Severe = at least 2 X week / pronounced risk, actual harm or high probability of harm</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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17. (E3) Hypervigilance.

<p>In the past week, have you been especially <u>alert</u> or <u>watchful</u>, even when there was no specific threat or danger? <i>(Have you felt as if you had to be on guard?)</i></p> <p>Can you give me some examples? <i>(What kinds of things do you do when you're alert or watchful?)</i></p> <p><i>[If not clear:] (What causes you to react this way? Do you feel like you're in danger or threatened in some way? Do you feel that way more than most people would in the same situation?)</i></p> <p><u>Circle:</u> Hypervigilance = <i>Minimal Clearly Present Pronounced Extreme</i></p> <p>How much of the time in the past week have you felt that way, as a percentage?</p> <p>% of time _____</p> <p>Did being especially alert or watchful start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite Probable Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of hypervigilance Moderate = some of the time (20-30%) / hypervigilance clearly present, e.g., watchful in public, heightened awareness of threat Severe = much of the time (50-80%) / pronounced hypervigilance, e.g., scans environment for danger, may have safety rituals, exaggerated concern for safety of self/family/home</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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18. (E4) Exaggerated startle response.

<p>In the past week, have you had any <u>strong startle</u> reactions?</p> <p>What kinds of things made you startle?</p> <p>How strong are these startle reactions? <i>(How strong are they compared to how most people would respond? Do you do anything other people would notice?)</i></p> <p>How long does it take you to recover?</p> <p><u>Circle:</u> Startle = <i>Minimal Clearly Present Pronounced Extreme</i></p> <p>How often has this happened in the past week? # of times _____</p> <p>Did these startle reactions start or get worse after (EVENT)? <i>(Do you think they're related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite Probable Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of startle Moderate = at least 1 X week / startle clearly present, some difficulty recovering Severe = at least 2 X week / pronounced startle, sustained arousal, considerable difficulty recovering</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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19. (E5) Problems with concentration.

<p>In the past week, have you had any <u>problems with concentration</u>?</p> <p>Can you give me some examples?</p> <p>Are you able to concentrate if you really try?</p> <p><i>[If not clear:] (Overall, how much of a problem is this for you? How would things be different if you didn't have problems with concentration?)</i></p> <p><i>Circle: Problem concentrating = Minimal Clearly Present Pronounced Extreme</i></p> <p>How much of the time in the past week have you had problems with concentration, as a percentage?</p> <p>% of time _____</p> <p>Did these problems with concentration start or get worse after (EVENT)? <i>(Do you think they're related to [EVENT]? How so?)</i> <i>Circle: Trauma-relatedness = Definite Probable Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of concentration problems Moderate = some of the time (20-30%) / problem concentrating clearly present, some difficulty but can concentrate with effort Severe = much of the time (50-80%) / pronounced problem concentrating, considerable difficulty even with effort</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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20. (E6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

<p>In the past week, have you had any problems <u>falling</u> or <u>staying</u> asleep?</p> <p>What kinds of problems? <i>(How long does it take you to fall asleep? How often do you wake up in the night? Do you wake up earlier than you want to?)</i></p> <p>How many total hours do you sleep each night?</p> <p>How many hours do you think you should be sleeping?</p> <p><i>Circle: Problem sleeping = Minimal Clearly Present Pronounced Extreme</i></p> <p>How often in the past week have you had these sleep problems? # of times _____</p> <p>Did these sleep problems start or get worse after (EVENT)? <i>(Do you think they're related to [EVENT]? How so?)</i> <i>Circle: Trauma-relatedness = Definite Probable Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of sleep problems Moderate = at least 1 X week / sleep disturbance clearly present, clearly longer latency or clear difficulty staying asleep, 30-90 minutes loss of sleep Severe = at least 2 X week / pronounced sleep disturbance, considerably longer latency or marked difficulty staying asleep, 90 min to 3 hrs loss of sleep</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
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Criterion F: Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

NOTE: Items 21 and 22 are not applicable for the PAST WEEK version. They are listed here without prompts only to maintain correspondence with item numbering on the PAST MONTH version. Onset and duration of symptoms should be assessed with

- 21. Onset of symptoms
- 22. Duration of symptoms

Criterion G: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- 23. Subjective distress

Overall, in the past week, how much have you been bothered by these (PTSD SYMPTOMS) you've told me about? [Consider distress reported on earlier items]	<ul style="list-style-type: none"> 0 <i>None</i> 1 <i>Mild, minimal distress</i> 2 <i>Moderate, distress clearly present but still manageable</i> 3 <i>Severe, considerable distress</i> 4 <i>Extreme, incapacitating distress</i>
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- 24. Impairment in social functioning

In the past week, have these (PTSD SYMPTOMS) affected your relationships with other people? How so? [Consider impairment in social functioning reported on earlier items]	<ul style="list-style-type: none"> 0 <i>No adverse impact</i> 1 <i>Mild impact, minimal impairment in social functioning</i> 2 <i>Moderate impact, definite impairment but many aspects of social functioning still intact</i> 3 <i>Severe impact, marked impairment, few aspects of social functioning still intact</i> 4 <i>Extreme impact, little or no social functioning</i>
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- 25. Impairment in occupational or other important area of functioning

<p>[If not clear:] Are you working now?</p> <p>[If yes:] In the past week, have these (PTSD SYMPTOMS) affected your work or your ability to work? How so?</p> <p>[If no:] Why is that? (Do you feel that your [PTSD SYMPTOMS] are related to you not working now? How so?)</p> <p>[If unable to work because of PTSD symptoms, rate at least 3=Severe. If unemployment is not due to PTSD symptoms, or if the link is not clear, base rating only on impairment in other important areas of functioning]</p> <p>Have these (PTSD SYMPTOMS) affected any other important part of your life? [As appropriate, suggest examples such as parenting, housework, schoolwork, volunteer work, etc.] How so?</p>	<ul style="list-style-type: none"> 0 <i>No adverse impact</i> 1 <i>Mild impact, minimal impairment in occupational/other important functioning</i> 2 <i>Moderate impact, definite impairment but many aspects of occupational/other important functioning still intact</i> 3 <i>Severe impact, marked impairment, few aspects of occupational/other important functioning still intact</i> 4 <i>Extreme impact, little or no occupational/other important functioning</i>
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Global Ratings

26. Global validity

Estimate the overall validity of responses. Consider factors such as compliance with the interview, mental status (e.g., problems with concentration, comprehension of items, dissociation), and evidence of efforts to exaggerate or minimize symptoms.	0	<i>Excellent, no reason to suspect invalid responses</i>
	1	<i>Good, factors present that may adversely affect validity</i>
	2	<i>Fair, factors present that definitely reduce validity</i>
	3	<i>Poor, substantially reduced validity</i>
	4	<i>Invalid responses, severely impaired mental status or possible deliberate "faking bad" or "faking good"</i>

27. Global severity

Estimate the overall severity of PTSD symptoms. Consider degree of subjective distress, degree of functional impairment, observations of behaviors in interview, and judgment regarding reporting style.	0	<i>No clinically significant symptoms, no distress and no functional impairment</i>
	1	<i>Mild, minimal distress or functional impairment</i>
	2	<i>Moderate, definite distress or functional impairment but functions satisfactorily with effort</i>
	3	<i>Severe, considerable distress or functional impairment, limited functioning even with effort</i>
	4	<i>Extreme, marked distress or marked impairment in two or more major areas of functioning</i>

28. Global improvement

Rate total overall improvement since the previous rating. Rate the degree of change, whether or not, in your judgment, it is due to treatment.	0	<i>Asymptomatic</i>
	1	<i>Considerable improvement</i>
	2	<i>Moderate improvement</i>
	3	<i>Slight improvement</i>
	4	<i>No improvement</i>
	5	<i>Insufficient information</i>

Specify whether with dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

29. (1) Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

<p>In the past week, have there been times when you felt as if you were separated from yourself, like you were watching yourself from the outside or observing your thoughts and feelings as if you were another person?</p> <p>[If no:] <i>(What about feeling as if you were in a dream, even though you were awake? Feeling as if something about you wasn't real? Feeling as if time was moving more slowly?)</i></p> <p>Tell me more about that.</p> <p>How strong is this feeling? <i>(Do you lose track of where you actually are or what's actually going on?)</i></p> <p>What do you do while this is happening? <i>(Do other people notice your behavior? What do they say?)</i></p> <p>How long does it last?</p> <p><u>Circle:</u> Dissociation = Minimal Clearly Present Pronounced Extreme</p> <p>[If not clear:] <i>(Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?)</i> [Rate 0=Absent if due to the effects of a substance or another medical condition]</p> <p>How often has this happened in the past week? # of times _____</p> <p>Did this feeling start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = Definite Probable Unlikely</p>	<p>0 Absent</p> <p>1 Mild / subthreshold</p> <p>2 Moderate / threshold</p> <p>3 Severe / markedly elevated</p> <p>4 Extreme / incapacitating</p>
<p>Key rating dimensions = frequency / intensity of dissociation</p> <p>Moderate = at least 1 X week / dissociative quality clearly present but transient, retains some realistic sense of self and awareness of environment</p> <p>Severe = at least 2 X week / pronounced dissociative quality, marked sense of detachment and unreality</p>	

30. (2) Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

<p>In the past week, have there been times when things going on around you seemed unreal or very strange and unfamiliar?</p> <p>[If no:] <i>(Do things going on around you seem like a dream or like a scene from a movie? Do they seem distant or distorted?)</i></p> <p>Tell me more about that.</p> <p>How strong is this feeling? <i>(Do you lose track of where you actually are or what's actually going on?)</i></p> <p>What do you do while this is happening? <i>(Do other people notice your behavior? What do they say?)</i></p> <p>How long does it last?</p> <p><u>Circle:</u> Dissociation = <i>Minimal</i> <i>Clearly Present</i> <i>Pronounced</i> <i>Extreme</i></p> <p>[If not clear:] <i>(Was this due to the effects of alcohol or drugs? What about a medical condition like seizures?)</i> [Rate 0=Absent if due to the effects of a substance or another medical condition]</p> <p>How often has this happened in the past week? # of times _____</p> <p>Did this feeling start or get worse after (EVENT)? <i>(Do you think it's related to [EVENT]? How so?)</i> <u>Circle:</u> Trauma-relatedness = <i>Definite</i> <i>Probable</i> <i>Unlikely</i></p> <hr/> <p>Key rating dimensions = frequency / intensity of dissociation Moderate = at least 1 X week / dissociative quality clearly present but transient, retains some realistic sense of environment Severe = at least 2 X week / pronounced dissociative quality, marked sense of unreality</p>	<p>0 <i>Absent</i></p> <p>1 <i>Mild / subthreshold</i></p> <p>2 <i>Moderate / threshold</i></p> <p>3 <i>Severe / markedly elevated</i></p> <p>4 <i>Extreme / incapacitating</i></p>
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CAPS-5 SUMMARY SHEET

Name: _____ ID#: _____ Interviewer: _____ Study: _____ Date: _____

A. Exposure to actual or threatened death, serious injury, or sexual violence		
Criterion A met?	0 = NO 1 = YES	

B. Intrusion symptoms (need 1 for diagnosis)		Past Week	
	Sev	Sx (Sev ≥ 2)?	
(1) B1 – Intrusive memories		0 = NO	1 = YES
(2) B2 – Distressing dreams		0 = NO	1 = YES
(3) B3 – Dissociative reactions		0 = NO	1 = YES
(4) B4 – Cued psychological distress		0 = NO	1 = YES
(5) B5 – Cued physiological reactions		0 = NO	1 = YES
B subtotals	B Sev =	# B Sx =	

C. Avoidance symptoms (need 1 for diagnosis)		Past Week	
	Sev	Sx (Sev ≥ 2)?	
(6) C1 – Avoidance of memories, thoughts, feelings		0 = NO	1 = YES
(7) C2 – Avoidance of external reminders		0 = NO	1 = YES
C subtotals	C Sev =	# C Sx =	

D. Cognitions and mood symptoms (need 2 for diagnosis)		Past Week	
	Sev	Sx (Sev ≥ 2)?	
(8) D1 – Inability to recall important aspect of event		0 = NO	1 = YES
(9) D2 – Exaggerated negative beliefs or expectations		0 = NO	1 = YES
(10) D3 – Distorted cognitions leading to blame		0 = NO	1 = YES
(11) D4 – Persistent negative emotional state		0 = NO	1 = YES
(12) D5 – Diminished interest or participation in activities		0 = NO	1 = YES
(13) D6 – Detachment or estrangement from others		0 = NO	1 = YES
(14) D7 – Persistent inability to experience positive emotions		0 = NO	1 = YES
D subtotals	D Sev =	# D Sx =	

E. Arousal and reactivity symptoms (need 2 for diagnosis)		Past Week	
	Sev	Sx (Sev ≥ 2)?	
(15) E1 – Irritable behavior and angry outbursts		0 = NO	1 = YES
(16) E2 – Reckless or self-destructive behavior		0 = NO	1 = YES
(17) E3 – Hypervigilance		0 = NO	1 = YES
(18) E4 – Exaggerated startle response		0 = NO	1 = YES
(19) E5 – Problems with concentration		0 = NO	1 = YES
(20) E6 – Sleep disturbance		0 = NO	1 = YES
E subtotals	E Sev =	# E Sx =	

PTSD totals	Past Week	
	Total Sev	Total # Sx
Sum of subtotals (B+C+D+E)		

F. Duration of disturbance	Current
(22)	NOT APPLICABLE

G. Distress or impairment (need 1 for diagnosis)	Past Week	
	Sev	Cx (Sev ≥ 2)?
(23) Subjective distress		0 = NO 1 = YES
(24) Impairment in social functioning		0 = NO 1 = YES
(25) Impairment in occupational functioning		0 = NO 1 = YES
G subtotals	G Sev =	# G Cx =

Global ratings	Past Week
(26) Global validity	
(27) Global severity	
(28) Global improvement	

Dissociative symptoms (need 1 for subtype)	Past Week	
	Sev	Sx (Sev ≥ 2)?
(29) 1 -- Depersonalization		0 = NO 1 = YES
(30) 2 -- Derealization		0 = NO 1 = YES
Dissociative subtotals	Diss Sev =	# Diss Sx =

Appendix I: Post-Traumatic Stress Diagnostic Scale (PDS) (McCarthy)

Post-Traumatic Stress Diagnostic Scale (PDS) (McCarthy)

Appendix M: Scale 2



Subject ID _____

PTSD Diagnostic Scale for DSM-5

Date _____

TRAUMA SCREEN

(PDS-5)

Have you ever experienced, witnessed, or been repeatedly confronted with any of the following:
(Check all that apply)

- ____ Serious, life threatening illness (heart attack, etc.)
- ____ Physical Assault (**attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.**)
- ____ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)
- ____ Military combat or lived in a war zone
- ____ Child abuse (severe beatings, sexual acts with someone **5 years older than you, etc.**)
- ____ Accident (serious injury or death from a car, at work, a house fire, etc.)
- ____ Natural disaster (severe hurricane, flood, earthquake, etc.)
- ____ Other trauma (Please describe briefly):

None

***** If NONE, please STOP and return this questionnaire *****

.....
If you marked any of the above items, which single traumatic experience is on your mind and currently bothers you the most:

(Check only one)

- ____ Serious, life threatening illness (heart attack, etc.)
- ____ Physical Assault (**attacked with a weapon, severe injuries from a fight, held at gunpoint, etc.**)
- ____ Sexual assault (rape, attempted rape, forced sexual act with a weapon, etc.)
- ____ Military combat or lived in a war zone
- ____ Child abuse (severe beatings, sexual acts with someone **5 years older than you, etc.**)
- ____ Accident (serious injury or death from a car, at work, a house fire, etc.)
- ____ Natural disaster (severe hurricane, flood, earthquake, etc.)

____ Other trauma (Please describe briefly):

Instructions: Below is a list of problems that people sometimes have after experiencing a traumatic event. Write down the most distressing traumatic event that you checked on the last page:

Page 1

Appendix J: Screen for Posttraumatic Stress Symptoms (SPTSS) (Carlson)

SPTSS for DSM-5

IN THE BLANK SPACE BEFORE EACH QUESTION, PUT A NUMBER TO TELL HOW OFTEN THAT THING HAS HAPPENED TO YOU IN THE PAST WEEK.

0= not at all

1= 1 or 2 times

2= almost every day

3= at least once every day

4= more than once every day

1. I found myself remembering bad things that happened to me over and over, even when I didn't want to think about them.	
2. I had bad dreams about terrible things that happened to me.	
3. I felt or acted as if I was back in the past at the time of a terrible event.	
4. When something reminded me of something bad that happened to me, I got upset and had a hard time calming down.	
5. When something reminded me of something bad that happened to me, I felt shaky, sweaty, and nervous and my heart beat really fast.	
6. I tried not to think, feel, or remember things that remind me of something bad that happened to me.	
7. I avoided people, places, or situations that remind me of something awful that happened to me in the past.	
8. I couldn't remember key parts of bad events that happened to me.	
9. I felt really pessimistic about myself, other people, or the way the world is.	
10. I felt sure that I or someone else was to blame for what happened to me.	
11. I could not shake feelings of fear, horror, anger, guilt, or shame.	
12. I didn't feel like doing things that I used to like doing.	
13. I felt cut off and isolated from other people.	
14. In situations when I used to have good feelings like happiness or love, I didn't.	
15. I felt very irritable and lost my temper without a good reason.	
16. I got into situations that were dangerous for me or other people.	
17. I was very aware and nervous about what was going on around me.	
18. I got startled very easily and "jumped" when I hear a sudden sound or was surprised.	
19. I had trouble focusing my attention.	
20. I had trouble getting to sleep or staying asleep.	

**HAVE YOU BEEN THROUGH A
TRAUMATIC EVENT RECENTLY?**

**You may be suffering from POST-TRAUMATIC
STRESS DISORDER**

**If you are between the ages of 18 & 65 years you
could qualify for free treatment in a research
study conducted at DUT: Homoeopathic Day
Clinic.**

For more information please contact:

Ms. Aphelele Gumede (072 472 4447)

Or

Clinic reception: 031 373 2041

Appendix L: Randomisation List

Randomisation List



PATIENT NUMBER	SIMILLIMUM GROUP	COMPLEX GROUP
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		

22		
23		
24		
25		
26		
27		
28		
29		
30		

Appendix M: Case history form

Case History Form



Date: _____/_____/20____

Title:

Surname.....First Name.....

Address (area where patient lives).....

Contact Details:.....

Age.....Gender.....

Marital status S/M/W/D (Please circle one)

Occupation (if unemployed, previous).....

Children: Yes / No

(if yes –include gender & ages))1.....2.....3.....

4.....5.....6.....7.....8.....

Note:

- For any symptom: description now, **location, sensation, aetiology, modalities, concomitants, history, treatment/ management** so far.
- If no symptoms for any section of the case, write **NAD (No Appreciable Disease)** in the space provided.

1. MAIN COMPLAINT/S:

[illegible]

- If a patient is a child below 10 years of age, ask about history of mother's pregnancy and the childbirth. If appropriate, ask about the circumstances of the birth – wanted child? Father present and supportive? Family supportive? Etc.

[illegible]

If the patient does not understand the question, **do not pursue** it because you will not get useful information.

A pack year is a measure of exposure/ risk. Equivalent to smoking a 20-cigarette pack a day for one year. Work this out after taking the case if need be.

: bottles spirits_____

- | | |
|-------|------|
| Name: | For: |
| | |
| | |

Name:	For:

--	--

4. **FAMILY MEDICAL HISTORY:**

MOTHER <div></div> <div></div> <div></div>	FATHER <div></div> <div></div> <div></div>
MOTHER'S MOTHER <div></div> <div></div> <div></div>	FATHER'S MOTHER <div></div> <div></div> <div></div>
MOTHER'S FATHER <div></div> <div></div> <div></div>	FATHER'S FATHER <div></div> <div></div> <div></div>
SIBLINGS <div></div> <div></div> <div></div>	

5. **GASTROINTESTINAL:** Indigestion, heartburn, cramps, flatulence, appetite, cravings and aversions. Aggravations. Thirst.

TYPE OF DRINK:	QUANTITY PER DAY:
How many teaspoons of sugar in tea/ coffee?	How many cups a day?

6. **BOWEL FUNCTION:** Constipation, diarrhea, haemorrhoids (**detail is necessary only if problem is present**).

7. **URINATION:** Frequency, urgency, pain. (**detail is necessary only if UTI is present**). Males over 40 years of age: strength of stream, stop-start, pain on ejaculation = Prostate.

--

8. **MENSTRUATION:** Duration of overall cycle and regularity, duration of menses, volume, colour, consistency, pain, concomitants (e.g. headaches, constipation, diarrhea etc). **Menarche.** **Pre-menstrual symptoms.** Date of start of last menstrual period. **Pregnancies** – how many [reason for termination], complications, including post-natal depression. **Peri-menopause:** all of the above, as well as symptoms of hot flushes, dry skin, dyspareunia, mood swings. **Menopause:** age of onset. Brief history of menstruation i.e. any problems with menstruation?

9. **GENITALS:** Eruptions, discharge, infections. Females: history of thrush.

10. **SEXUALLY ACTIVITY:** Any problems? Desire/libido? History of **STD's.** **HIV STATUS?** **Cd4Count** if positive. When? **How many partners?** **Emotions regarding a positive status?** **Education regarding safe sex.**

11. **CHEST:** Problems with breast, breathing, cardiac.

12. **HEAD:** Ears, eyes, nose, throat/ voice. Headache: **painkillers?** Name, how many, how often? **Issue of medication overuse headache** (= **rebound headache** due to **addiction/dependency**. **Combination ingredient medicines worse than single ingredient medicines**. **Medication overuse** is defined in terms of **treatment days per month**, such that **treatment occurs at least three months**. The headache is present **on more than 15 days per month**.

13. **SLEEP:** Pattern, quality, position. Dreams (only worth pursuing if outstanding/ recurrent dreams)

14. **SKIN:** Current and history, rashes, warts, boils, pimples, easy bruising, rate of healing.

15. **MUSCULOSKELETAL:** Location, modalities, concomitants (e.g. weather changes).

16. **GENERAL:** Energy, weather preferences.

17. **MENTAL:** Ask things that have not already come up in the consultation. **Do not go over that material again unless it seems appropriate to do so**. If you had to **describe yourself**, what **type of person** would you say you are? / What are you **characteristics?** / What is your **personality?** Anxiety / worries, anger, sadness/ depression. **Relationships. What makes you happy?**

Appendix N: Follow up consultation form

Follow up consultation form

DATE: / /2015

MAIN COMPLAINT(S):

NEW SYMPTOMS THAT HAVE APPEARED SINCE THE REMEDY

Is this an old symptom that has reappeared or is it a new symptom altogether?

If it is an old symptom, when did it start, is it as bad as before, or not, and is it affecting the patient adversely?

If it is a new symptom, when did it start, how did it start, and was there any reason?

ENERGY:
Any change, and if there is how, when and how much?

SLEEP:

Quality: _____

Quantity: _____

Dreams: _____

Other: _____

APPETITE:

Change: _____

New cravings or aversions: _____

Thirst: _____

OTHER CHANGES:
Has anything else changed since the remedy?

MENTALS:

How have you been feeling emotionally since the remedy?

Physical Examination Form/ SOAPE Note-Case Summary



PATIENT DETAILS

DATE: / / 2015	Patient's name & surname:
---------------------------------	---------------------------

S

MAIN COMPLAINT(S)

1.	3.
2.	4.

O

ON EXAMINATION

BP: / mmHg	OBSERVATION (Unusual)
PULSE: bpm	
RESP: bpm	
Temp:	
WEIGHT: kg	
URINE DIPSTICK:	PREGNANCY:

GENERAL EXAMINATION

Jaundice	
Anaemia	
Cyanosis	
Clubbing	
Oedema	
Dehydration	
Lymphadenopathy	

SYSTEM REVIEW

Respiratory Examination	
Cardiovascular Examination	
Abdominal Examination	
Musculoskeletal Examination	

A**DIAGNOSIS (MEDICAL)**

ICD-10 CODE:	Written Diagnosis:
---------------------	---------------------------

CENTRE OF THE CASE

1.	3.
2.	4.

CASE ANALYSIS

MENTALS	GENERALS	PARTICULARS

RUBRICS [3]

P**REMEDY DIFFERENTIALS**

1.	4.
2.	5.
3.	6.

PRESCRIPTION

1.	2.	3.	4.
Rx:	Rx:	Rx:	Rx:
Mitte:	Mitte:	Mitte:	Mitte:
Sig:	Sig:	Sig:	Sig:

E**PATIENT EDUCATION/ADVICE**

1.
2.
3.

SIGNATURES

Clinician's Name:	Student's Name: Aphelele Gumedde	Dispenser's name:
Clinician's Signature:	Student's Signature	Dispenser's Signature:
Date:	Date:	Date:

HOMOEOPATHIC COMPLEX REMEDIES

•***Aconitum napellus***: for recurring panic following a traumatic experience. This remedy is most appropriate for individuals who have heart palpitations and shortness of breath which produce a tremendous fear of death. Aconitum is often the first remedy given for trauma, even if the trauma occurred years ago. It is for a state of fear, anxiety, anguish of the mind and body. Physical and mental restlessness, fright is the most characteristic manifestation of this remedy. Attacks of panic or terror started after a frightful experience. Fear of fright remains (Vermeulen 1994)

•***Arnica montana***: - for chronic conditions (such as depression) that occur after a traumatic experience. This remedy is most appropriate for individuals who generally deny that anything is wrong. Traumatism of grief, remorse or sudden realisation of financial loss. Traumatic remedy par excellence; mechanical injuries. Morose, delirious, fear remains at night after fright. Sudden fear that rouses one from sleep at night especially after an accident. Ailments from fright or anger (Vermeulen, 1994).

•***Delphinium staphysagria***: -for individuals who feel fearful, powerless, or unable to speak up or defend themselves. The main idea characterizing this remedy is suppression of emotions, particularly those cantering around romantic relationship. This remedy is often given acutely for the physical effects of suppressed anger. *Delphinium staphysagria* anger is often so well suppressed that it is not only unexpressed; it is not even felt. She is a person who feels her problems belong to her alone. She would never presume to be a burden to others. Imagines insults. Great indignation about the things done by others or by himself, grieves about the consequences. Believes he will lose his fortune, (Vermeulen, 1994)

•***Datura stramonium***: -for anxiety disorders that occur after a shock or traumatic experience involving violence. The individual for whom this remedy is most appropriate tends to be generally fearful and have night terrors. Can't bear to be

alone, apprehension, starts up in a fright, all motions are hasty and forcible. Victims of mental violence, full of excitement and rage. Religious insanity, despair of salvation.(Vermeulen, 1994)

•***Ignatia amara***:-for changeable mood, silently brooding. Sad and tearful. Ailments from shock, grief, disappointment and hearing bad news. Oversensitive and nervous. Highly emotional. Full of suppressed grief and broods over imaginary troubles. Spasms and insanity after fright (Vermeulen, 1994).

Appendix Q: German Homoeopathic Pharmacopoeia-Preparation for Homoeopathic complex (Method 10)

German Homoeopathic Pharmacopoeia-Preparation for Homoeopathic complex (Method 10)

Preparations according to Method 10 are pillules. They are prepared by transferring a liquid preparation to sucrose pillules (size 3; 110 to 130 pillules weigh 1g), this being done by evenly moistening 100 parts of sucrose pillules with 1 part of liquid preparation. Differences in the mixture ratio are permitted; this difference must be stated on the label. The alcohol content of the liquid preparation should be not less than 60 per cent (m/m), otherwise the final potentisation step of the decimal or centesimal dilution used must be carried out with alcohol 62 per cent (m/m). Impregnate the pillules (globules, globuli) in a closed vessel, then air-dry. In specific cases granule size 1, 2, and 4 to 10 may be used:

SIZE NUMBER	AMOUNT OF PILLULES	MASS (g)
1	470-530	1
2	220 at 280	1
3	110 at 130	1
4	70 at 90	1
5	40 at 50	1
6	22 at 28	1
7	10	Approximately 1

8	5	Approximately 1
9	3	Approximately 1
10	2	Approximately 1

The Centesimal Scale for the Simillimum

This scale has a 1:100 dilution ratio and it is prepared in the following manner:

- Step 1: One part of the mother tincture is diluted in 99 parts of a water and alcohol mixture (96%ROH).
- Step 2: This liquid is then succussed 10 times in its bottle by firmly hitting the bottle's base against a firm but resistive surface such as the palm of a hand or a leather covered book. The resulting liquid is called a 1C potency, "1" referring to its first stage of dilution and the Roman numeral, "C", referring to its 1:100 dilution ratio.
- Step 3: One part of this 1C potency is again diluted and succussed in 99 parts of a water and alcohol mixture (96% ROH) to produce a 2C remedy.
- Step 4: This serial process of dilution and succussion, called potentisation, is further repeated to produce increasingly higher potencies of the remedy.
- Step 5: The desired potency for the Simillimum is 30CH therefore the serial process of dilution and succussion will be from 29CH to 30CH in the same manner as discussed above.

The Centesimal Scale for the homoeopathic complex

The homoeopathic complex containing (Aconitum napellus 30CH, Arnica montana 30CH, Ignatia Amara 30CH, Delphinium staphysagria 30CH and Datura stramonium 30CH) will be the same as above except that:

Step 5: The desired potency homoeopathic complex is 30CH therefore the serial process of dilution and succussion will be a combination of all the chosen complex remedies from 29CH to 30CH in the same manner as discussed above.

Participants are to take 10 drops of the 30 plussed medication, two times a day after succession.

Appendix R: How to take homoeopathic treatment

How to take Homoeopathic treatment

Hold the bottle tightly and vigorously shake the bottle 10 times before each dose as instructed on the label.

The dosage is 10 drops sublingually twice daily.

Take your treatment at least ½ hour before a meal OR ½ an hour after a meal.

Avoid eating mint, or using camphor (eg. Vicks) whilst on treatment.

Store your treatment away from heat, light and electromagnetic radiation (e.g. T.V., computers and cellphones)

If drinking coffee, try to wait ½ hour after taking your treatment, before having any.

Always take your treatment as instructed/ directed.

For any queries regarding your treatment, please Contact the researcher/supervisor(s) of the study:

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OR

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Appendix S: Editing certificate

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EDITING CERTIFICATE

Re: Aphelele Sibahle Zodumo Gumede

**Master's dissertation: The Efficacy of a Homoeopathic Simillimum as
Compared to a Homoeopathic Complex in the Management of Post-
Traumatic Stress Disorder**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. I returned the document to the student with track changes so correct implementation of the changes in the text and references is the responsibility of the student. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology I supervised numerous Master's degree dissertations.

Dr Richard Steele

14 March 2018

per email