Treatment of Posttraumatic Stress Disorder in Refugees: Latest Research Studies

Dr Angela Nickerson
Senior Lecturer
Director, Refugee Trauma and Recovery Program
School of Psychology, UNSW Australia
anickerson@psy.unsw.edu.au
Posttraumatic stress disorder in refugees
Guidelines for treatment of PTSD
Guidelines for treatment of PTSD

### Psychological interventions for adults with PTSD

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<tr>
<th>R3</th>
<th>Adults with PTSD should be offered trauma-focused cognitive behavioural interventions or eye movement desensitisation and reprocessing. (p.91)</th>
<th>Grade</th>
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*Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder, Phoenix Australia, 2013*
What is unique about refugee trauma?
What do we already know?

- Relatively small body of research on efficacious treatments for PTSD in refugees
- Studies have tended to focus on
  - Trauma-focused interventions
  - Multi-modal approaches
- Emerging evidence for trauma-focused interventions
- BUT – methodological limitations prevent strong conclusions
Research Evidence: An Update

- A number of new studies have been conducted in past four years
- Emphasis has been on trauma-focused therapy
  - Narrative Exposure Therapy
  - Eye Movement Desensitization and Reprocessing
  - Imagery Rescripting
- Several qualitative and theoretical papers detailing challenges associated with treating PTSD in refugees
Narrative Exposure Therapy

- Developed by Schauer, Neuner & Elbert (2013)

- Derived from Testimony Psychotherapy
  - Lira and Weinstein (Cienfuegos and Minelli, 1983)
  - Tested with Bosnian refugees in Boston (Weine et al., 1998)

- NET has demonstrated efficacy in
  - Multiple settings (Sudanese, Somali and Rwandan refugees in Uganda; asylum-seekers, former political prisoners)
  - Across delivery modes (doctoral-level therapists from Europe, lay clinicians in refugee camps)
Narrative Exposure Therapy

**Elements**
- Psychoeducation
- Derive timeline
- Imaginal exposure therapy
- Develop narrative
- Plan for use of narrative (if client wishes)

**Mechanisms by which NET may work**
- Emotional processing
- Integration of memories into autobiographical memory base
- Redress?
Brief NET for PTSD in Iraqi Refugees

- Participants were 63 Iraqi refugees resettled in Michigan, USA
- Participants were randomly assigned to brief NET (3 sessions) or waitlist control condition (2:1 ratio)
  - 60 to 90 minute sessions
  - Arabic-speaking therapists
- Assessment at baseline, 2-month and 4-month follow up
- High participation (95%) and retention (98%) rates

Refugees may experience traumatic events across the various phases of their journey. Before their flight, violence, political upheaval, loss of property, death of loved ones, and torture may occur, during their flight, there may be separation from family, and a perilous journey to the host country. During their reception in a new country, often involves stress related to adjustment. The cumulative nature of refugees’ stressors increases their risk for psychological problems, especially depression and posttraumatic stress disorder (PTSD). Fear, Wheeler, & Fenske, 2005; Keyes, 2006.

Many Iraq refugees suffer from posttraumatic stress. Efficient, culturally sensitive interventions are needed, and we adopted narrative exposure therapy in a brief version (brief NET) and tested its effects in a sample of traumatized Iraqi refugees. Iraqi refugees in the United States reporting elevated posttraumatic stress (PTSD) were randomized to brief NET or waitlist control conditions in a 2:1 ratio; brief NET was 3 sessions, conducted individually, in Arabic. Positive indicators (posttraumatic growth and well-being) and symptoms (posttraumatic stress, depressive, and somatic) were assessed at baseline and 2- and 4-month follow-up. Treatment retention (95.1% complete) and study retention (98.4% provided follow-up data) were very high. Significant condition by time interactions showed that those receiving brief NET had greater posttraumatic growth (d = 0.83) and well-being (d = 0.54) through 4 months than controls. Brief NET reduced symptoms of posttraumatic stress (d = 0.40) and depression (d = 0.46) more, but only at 2 months; symptoms of controls also decreased from 2 to 4 months, eliminating condition differences at 4 months. These outcomes of brief NET increased growth and well-being and led to symptom reduction in highly traumatized Iraq refugees. This preliminary study suggests that brief NET is both acceptable and potentially efficacious in traumatized refugees.
Brief NET for PTSD in Iraqi Refugees

PTSD Symptoms

- Baseline
- 2 months
- 4 months

NET vs. WLC (WLC: White Label Control)
Brief NET for PTSD in Iraqi Refugees

Posttraumatic Growth

- Baseline
- 2 months
- 4 months

NET vs WLC

* indicates significant difference
Brief NET for PTSD in Iraqi Refugees

- **Key findings**
  - PTSD symptoms - Medium between-groups effect size (d = 0.32)
  - NET results in significantly greater improvement in PTG

- **Limitations**
  - Self-report measures as follow-up assessment
  - No treatment control group

- **Implications**
  - Dosage of intervention likely to be important
  - Impact of post-migration environment
  - Utility of measuring positive outcomes as well as symptom reductions
Imagery rescripting

- Imagine traumatic experience and an intervention that changes course of events
- Evidence that decreases non-fear emotions such as shame, guilt and anger
- Has been previously added to imaginal exposure (Arntz et al., 2007; Kindt et al., 2007)
- Authors propose will increase tolerability of intervention and reduce drop-outs
- Adaptation in current study so intervention was before trauma took place (but after anticipation of trauma)
Imagery rescripting for PTSD in refugees

- Participants were 10 refugees from a variety of backgrounds (e.g., Iraq, Turkey, Kosovo, Afghanistan)
- Concurrent multiple baseline design was employed
  - Participants randomly assigned to 5 different baseline lengths (6 to 10 weeks),
  - Next, 5 weeks of supportive treatment given to control for nonspecific effects
- Treatment
  - 10 sessions of imagery rescripting
Imagery rescripting for PTSD in refugees

- **Results**
  - No significant change during baseline, exploratory or follow-up periods in PTSD symptoms
  - Significant reduction in PTSD symptoms during treatment period (within-subjects effect size = 1.6)
  - Significant reduction in depression symptoms during treatment period (within-subjects effect size = 0.9)
Imagery rescripting for PTSD in refugees

Findings suggest imagery rescripting may be promising in reducing trauma-related symptoms in refugees.

However, limitations associated with study make it difficult to draw strong conclusions.

- All participants already in treatment
- Measures taken by treating therapist (with 1 day training)
- Discussion of trauma during exploratory phase
Eye Movement Desensitization and Reprocessing

- Developed by Shapiro (2001)
- Client recalls traumatic memories while engaging in eye movements or bilateral stimulation (e.g., tapping)
- Has been previously piloted with refugees seeking asylum in Netherlands (Ter Heide et al., 2011)
- No systematic study in refugees
EMDR for PTSD in Syrian refugees

- Participants were randomly selected Syrian refugees with PTSD living in camp in Turkey (N = 29)
- Randomly assigned to EMDR or waitlist control group
- Blind outcome assessments
- EMDR intervention components
  - Formulation; rationale; cognitive therapy; desensitization; body scan; closure (imagine holy light coming from heaven)
  - Maximum of 7 90 minute sessions
  - Delivered by Turkish psychologist with Syrian interpreters
EMDR for PTSD in Syrian refugees

PTSD symptoms

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<tr>
<th></th>
<th>BL</th>
<th>Posttreatment</th>
<th>1 month FU</th>
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<tr>
<td>EMDR</td>
<td>*</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>WLC</td>
<td>20</td>
<td>50</td>
<td>30</td>
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* Significant difference
EMDR for PTSD in Syrian refugees

![Chart showing depression symptoms with BL and Posttreatment data for EMDR and WLC groups.]
EMDR for PTSD in Syrian refugees

- **Findings**
  - EMDR resulted in significant decreases in PTSD and depression in Syrian refugees.

- **Limitations**
  - No treatment control group.
  - Absence of long-term follow-up.
  - Not treatment-seeking sample.

- **Cultural considerations**
  - Stigma - treatment carried out in kindergarten building – research team provided childcare.
  - Treatment fidelity – no participant agreed to audiotaping of session (supervisor observed at least 1 session with each therapist).
Methodological Challenges

- Quality of studies
  - Control group important, but better to have active control condition
  - Small sample sizes
  - Absence of long-term follow-up assessments
  - Non-blind assessments
  - Therapists
  - PTSD measurement

- However......
  - Challenges of conducting this research must be acknowledged
  - Studies are improving overall
Theoretical challenges

- We still don’t have a good understanding of the unique psychological impact of the refugee experience
  - Prolonged, repeated trauma
  - Displacement
  - Post-migration stressors

- More research needed on core mechanisms underlying refugee mental health

- Lead to development of tailored interventions for refugees and asylum-seekers in a variety of contexts
Emotion Regulation in Refugees

- Studies investigating how refugees regulate their emotions following different types of traumatic experiences
- In collaboration with STARTTS, SSI and other refugee service providers in Sydney
- Evidence that
  - Torture profoundly affects the strategies that are used, and how effective they are
  - Cognitive reappraisal reduces intrusive memories and trauma-related distress in refugees with PTSD
- Mechanistic studies form building-blocks for interventions
Where to from here?

- High-quality randomized controlled trials
  - Active control groups
  - Blind assessments
  - Randomization
  - Manualized interventions
  - Follow-up assessments

- Research into specific mechanisms underpinning refugee mental health
  - Translation of these findings to treatment interventions that are tailored to the refugee experience
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