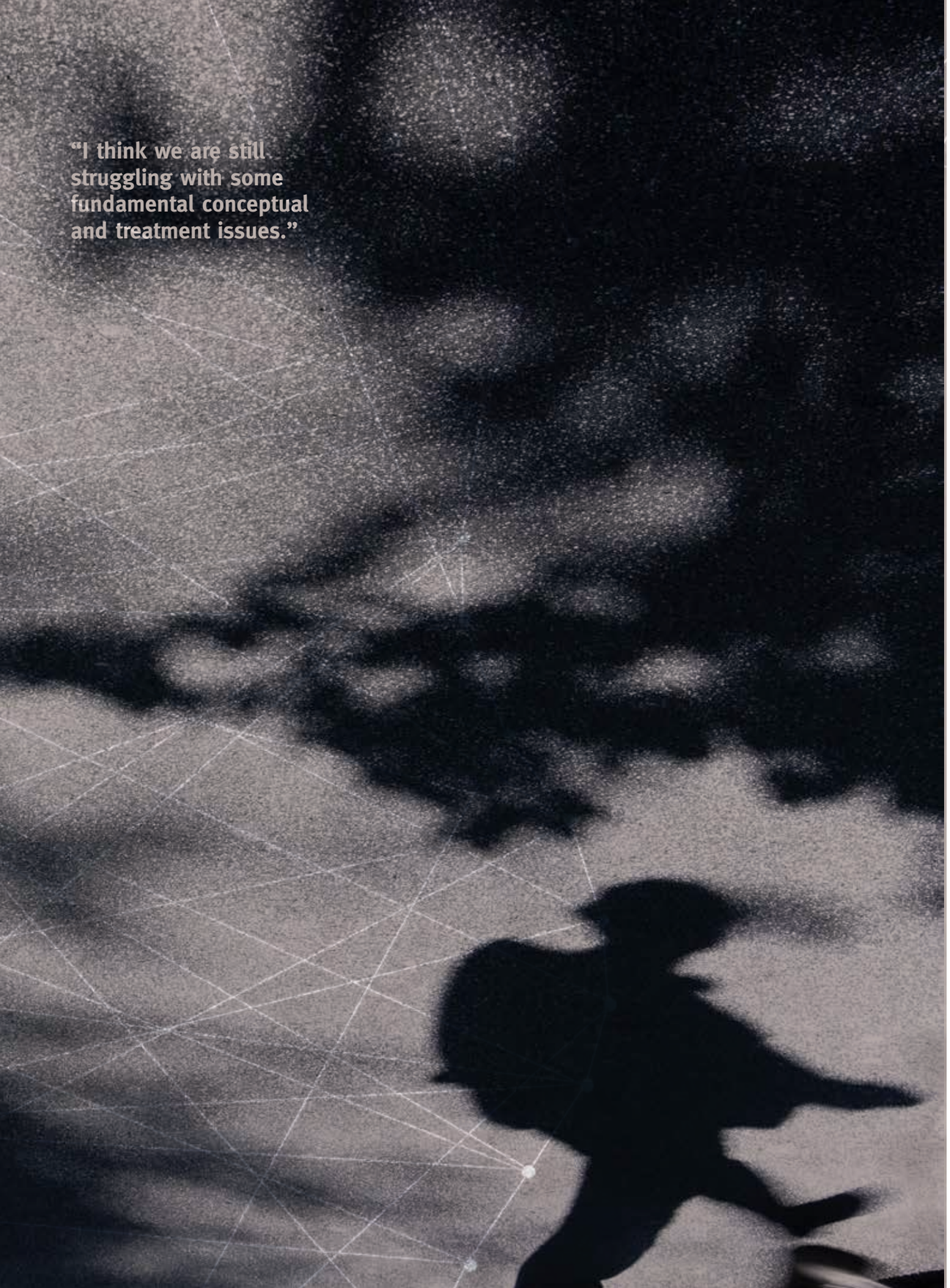

HEALTH

Professor DERRICK SILOVE is the director of Psychiatry Research and Teaching at the Mental Health Centre, Liverpool Hospital, he spoke at a research symposium at STARTTS about the latest research on refugee trauma.

Effective Interventions and Models for Refugee Trauma

It is great to be here and see so many interested people, which is encouraging. Healing goes back a long way, to the beginning of human history and I believe that as healers we have a major responsibility to be clear in our minds what exactly we are doing. Having been in this field for many years I must say that I am not sure I am that much clearer now than when I began. I think we are still struggling with some fundamental conceptual and treatment issues.

My talk today is about where we have been, where we are and where we are going, in terms of treatment research mainly. I will make reference to epidemiology and other research as I go along. Even though I have been involved with STARTTS from its beginnings, the exciting part is that we are constantly evolving in our efforts to bring order to the chaos, to achieve a conceptual overview and framework that covers the extraordinary phenomena we deal with – suffering, trauma and displacement.

There is what I call a disjunction between the treatment research and its development, and the more conceptually based epidemiological observational research. What I mean is that treatment research was slow to take off – I will come to the reasons for that soon – while the epidemiology and conceptually based observational research has been going longer.

We started with a very simple "trauma goes to PTSD" model, essentially borrowed from general traumatology. It really started in the late 1970s and 1980s, when Post-traumatic Stress Disorder (PTSD) was first adopted as a diagnosis. Even though there was a lot of controversy in our field, the major focus of research was to explore and describe the mental health effects of trauma among refugee populations. So we were very PTSD-fixated – then we rediscovered stress. Why didn't we do that at the beginning? I think the asylum-seeker research team and others brought to the fore how important ongoing stressors are in determining the mental health of refugees.

Then models have developed further to include other disorders as well as issues of functioning and adaptation. Then we tried to broaden it to family and community, which is not easy in research because of limitations in the methodology. So I think the researchers tried to follow the clinical cause, which is

learning from clinicians and service providers where the focus really is, and expanding and making more complex the models we test.

There has been a lag in treatment research primarily because there was opposition to conducting research on treatment among refugee groups: there were also simple technical difficulties.

It started with ideological opposition – that we should not be studying refugees and their treatment in an objective way, ignoring their subjective existential experiences. We span a huge range of disciplines, among them human rights, psychosocial issues, culture and anthropology. We did not really have the metrics, the tools or the methodologies well worked out at the beginning.

It was difficult to get representative samples of people in the community, rather than those selected because they volunteered or we chose them. Randomisation has always been an issue with services. Understandably, we are going to allocate some people to what we think is the most active treatment as opposed to treatments that might be inferior. To achieve that is a difficult thing for a service, but there are ways around it.

For example, the Danish Rehabilitation and Research Centre for Torture Victims has overcome these issues in clever ways. Then we also lacked the statistical and analytic techniques. So there were many reasons why treatment research lagged behind in the field.

But if we look at the past 10 years there is now sufficient evidence to say some positive things.

The first is that there is support for what I call expanded Cognitive Behavioural Therapy that is being adapted to the needs of refugees, taking into consideration cultural issues and so on. Narrative Exposure Therapy (NET) is the obvious example and I am sure many people are familiar with Frank Neuner's work and the others who followed his path.

Another approach has been a more flexible transdiagnostic approach and the Common Elements Treatment Approach (CETA) created by the team at Johns Hopkins University, who I work with. There is remarkably little data available to support what we have all believed in, the Comprehensive Multidimensional Approach characterised by STARTTS and many other agencies.

NET is basically a simple exposure technique done by lay people using a Narrative and Autobiographical Approach, where you trace the history of the person from early days through their trauma in a systematic way using timelines.

When compared, at least conceptually, with the Standard Prolonged Exposure Therapy used in PTSD in general (not refugee) populations (when the person is repeatedly put through the traumatic experience over and over until he or she appears to habituate to the stress of it), probably there is not a lot of difference between the two. Perhaps NET is better adapted to refugees, but conceptually it is doing roughly the same thing.

The Transdiagnostic Approach, developed by Laura Murray from the Paul Bolton group and others at Johns Hopkins, starts to recognise that in refugees who have suffered a lot of trauma and stress comorbidity is far more common than single diagnoses. Anyone who has PTSD very likely has depression, panic attacks, grief symptoms and a whole range of other things. Should we be treating one disorder or group of symptoms, ignoring any others?

At least the Transdiagnostic Approach allows you to be flexible in a limited way, so you can focus more on PTSD symptoms such as depression, anxiety. They also have a module for drug and alcohol abuse. They were not trying to invent something new, but took the best approaches that have been shown to work "off-the-shelf" as therapy components, put them all together, adapted them to the refugee population and packaged them in a way allowing for flexibility, depending on the main problem. If it is depression, you may go down the behavioural activation path more; if it is PTSD, you may do more imaginal exposure, and so on. So in a way that makes sense.

The Bolton group has tested this therapy rigorously using randomised, controlled trials in countries around the world – post-conflict countries, not necessarily only among refugees but conflict-affected populations – and, by and large, have shown good results. Interestingly they have not tested it for alcohol problems, but we all know how difficult it is to treat that, but for PTSD, depression and anxiety it is showing promising results. A new treatment supported by the World Health Organisation is somewhat similar, perhaps even briefer.

So there is a pretty good compendium of these treatments. They vary in detail and emphasis, but we probably have a reasonable package of these treatments if you want to do a structured, short-term intervention. Our University of Copenhagen colleagues tested what we would see as being the more "bread and butter" standard approach to treatment, which has many components and includes medication, Cognitive Behaviour Therapy (CBT), exposure techniques and, where necessary, stress management, problem solving and so on. They tested it within an agency setting, like a real-life setting perhaps like STARTTS, where people are put through a long and comprehensive intervention.

Being an honest group, in the *British Journal of Psychiatry* they published quite a spectacular result – virtually no change, particularly in PTSD symptoms. The symptoms were exactly the same at the end of the treatment as at the beginning. Depression showed a slightly better outcome, but still pretty modest given the extent of the treatments involved. Now I guess you have to ask yourselves then why is that the case? Why are we getting such discrepant results when a short-term CBT treatment is working so well in Neuner's studies, for example, and this comprehensive, flexible treatment conducted in an agency that specialises in treating refugees appears not to be working?

It raises several key issues we have been struggling with in the field for some time and I thought I would just detail some of them because I do not think we have fully resolved them. Should the focus of treatment be primarily on individuals or families? Or, at the wider level, the community, or the system? Should we change conditions in the public health system rather than treat individuals?

Diagnostically we have been focused on PTSD, but the more we look for other disorders, the more we find them.

Obviously there is no simple answer. We have not systematised our thoughts very much about how well and for whom this works. Should it be preventative, empowering, resilience - building, advocacy or therapy? Again, there is some blurring. Good services such as STARTTS do all those things, but there is some blurring of where lie the boundaries between these areas.

If it is therapy, is it really about relieving symptoms? Is it about rehabilitation or the functioning of people in spite of their symptoms? Is it about restoring a sense of humanity and meaning to the person and not worrying too much about symptoms? or are we just trying to encourage a broad notion of adaptation to their new eco-social system?

Diagnostically we have been focused on PTSD, but the more we look for other disorders, the more we find them. People with grief, adult separation anxiety, panic disorder – we have listed at least 13 categories in our new measure where people commonly score very high according to the *Diagnostic and Statistical Manual of Mental Disorders* or *The International Classification of Disease*. Does PTSD drive all these other disorders, or is it just one of many [factors]? If you treat one, do you treat them all?

It sounds like a kind of Buddhist axiom or something, but if you treat PTSD, is it good enough and everything else will fall into place? I mean panic symptoms, depression and so on, do they get better? Or is it more likely some of those symptoms are not going to improve unless you focus on them?

Then, trying to answer the question about why treatments work in some places and not others, does the population matter? I think we have not really paid enough attention to this because the obvious answer is yes. We all know that working with asylum-seekers it is a lot harder than working with settled refugees because of the stressors and fears for the future they suffer and the administrative and legal issues they go through. Many services in resettlement countries have much more specialised groups of people coming to them. There are many filters in the care of those people before they get to the refugee service. They have often seen GPs or others and been prescribed medication. They have been in the country a long time. They may have chronic symptoms.

If you look at the profile of the treatment group our Copenhagen colleagues did not do so well with, they are that hard-core group that has been severely tortured or isolated, unemployed, they might have head injuries and other organic disorders, chronic pain … it's a group we all know to be treatment-resistant. I have learnt that there is no option but long-term therapy for those who are so disabled. Providing an environment where you build up trust and deal with existential issues current and past while gradually unfolding the trauma story seems the only way you can do it.

There is no possible way of doing that quickly and if you go too fast you will do more damage than good. Now, that runs completely counter to the kind of treatment studies I've mentioned and, as I say, I think it is fundamentally about different populations, different subgroups needing quite different forms of care. Again, the research community has not really focused on the diversity of needs and the fact that treatments have to differ.

Some people may be familiar with the comprehensive ADAPT model – a conceptual framework for mental health and psychosocial support I have put up that tries to give a framework to explore all these issues in a coherent way without oversimplifying our notions about treatment.

It is founded on the notion that adaptation is a fundamental tendency among humans, that is why we are so successful and why we survive, and what is fundamental to the refugee experience is the sequential changes in the eco-social environment they live in.

Refugees go through all the phases of conflict: flight, transition and resettlement, and many others in-between. Every time they go through these phases their institutional foundations are shaken, which is more than just suffering discrete trauma, or discrete stressors: it is about the whole ecology of life.

What I have suggested – and this is derived from clinical experience, from talking to everybody about it and the existing literature – is the idea of organising the psychosocial pillars into five categories, framework we all rely on for a stable life. When they are disrupted and undermined, it is very hard to maintain mental health or a capacity to function and adapt effectively.

These pillars are:

- **Safety:** Without safety or a sense of safety we are always under stress and experience a sense of threat.
- **Interpersonal bonds:** We are herd creatures, living in groups and families and in smaller and larger collectives, and when that is disrupted or destroyed then we are in a difficult situation, as we know, we experience loss, grief and separation anxiety, among other things.
- **Justice:** A sense of justice is fundamental because, while also a legal and human-rights concept, it is a psychological, cognitive and very deeply seated existential notion. When we are abused or suffer gross injustices, the natural feelings of anger, frustration and resentment can become pathologies.
- **Identity:** Refugees often lose a sense of identity. They lose their roles, qualifications may not be recognised or they have to take on new and hybrid forms of cultural and national identity, so another fundamental system is disrupted.
- **Meaning:** The experiences refugees suffer challenge their notions of meaning, their religious and existential beliefs, their faith in humanity – just the sense of who they are. Re-establishing meaning is a big task and often a major focus of therapy. This is a conceptual model.

Researcher Alvin Tay tried to develop an ADAPT measure based on those five psychosocial pillars and we used it with West Papuan refugees living in shanty towns in Port Moresby. It showed that past trauma and ongoing stressors clearly predict PTSD and functional impairment.

If you apply ADAPT to it as a kind of background, then you can see it influences just about everything. It exerts an influence over stress and has a moderating influence over trauma: that is, the way you interpret the trauma depends on the background of these psychosocial pillars. If you think of a painting, it is about the background of that painting, not the immediate event [in the foreground], that influences people and the collective response.

We have been studying the link between the sense of injustice and anger in East Timor for some time. This is part of a cycle of violence model we are trying to test in stages because it is very complex. We are all familiar with and we often invoke it in our own work, which is the axiom "violence begets violence". What we see, and we are all familiar with this, is that unfortunately, in families where there has been extreme trauma, often the trauma is played out in the family in the form of domestic violence, abuse of kids and so on.

So the families are left with this residue of anger and violence and it can have serious consequences for the family and the wider community, as well as potential transgenerational effects on kids. Of course, that is not a linear model. That is not true of every family that has endured trauma: there are many positive resilience factors that can interrupt the cycle.

In our studies on explosive anger we have found that it is extremely common in the Timorese society where trauma is a major factor in causing explosive anger. The sense of injustice we measured plays a strong role in the pathways leading to that anger over time and the reasons why anger remains chronic and persistent and people explode over very small issues, leading to aggression.

What I found in places like Timor, Bougainville and others where we are trying to connect with policymakers and funders, we forget sometimes how difficult it is to seek money to treat mental health problems. It is hard in Australia, but it is far more difficult in post-conflict countries where funding priorities do not include mental health. Even within the health disciplines, other areas are given far greater priority and mental health is right down at the bottom of the barrel.

If you go to the policymakers and the funders and say the word "trauma" they say: "Yeah, trauma is terrible, we agree. We will give you a little bit of money for this little service for trauma." You say: "PTSD" and they say, "Well, yeah, I have heard of that, that is where you have people who have bad memories and that must also be awful, so we will give you $100 for that."

PHOTO: iSTOCK

...unfortunately, in families where there has been extreme trauma, often the trauma is played out in the family in the form of domestic violence, abuse of kids and so on.

But if you say "anger and aggression", then they say: "Oh, you mean you can deal with anger and aggression?" We say: "We aren't so sure, but we think it is a major problem" and they will say "well, that is the overwhelming problem here!" because it is affecting peace-building. People are exploding with anger at work and at home. There are reports of domestic violence, kids being abused and so on. If you talk to the community leaders they all say the same thing.

We have to be careful not to pretend we can solve all those problems, but it is interesting that anger, which in psychiatry has been buried away in PTSD as a subsidiary feature, is the thing that resonates with people outside our field. It's important that researchers speak the same language as the wider community and the wider aid community.

It is still a very new field and there are very few studies. The two I have spoken about are not even published. One is a brief intervention based on the ADAPT model that we have trialled in Timor, which seems very effective but is a very small study. The other is an ADAPT module for treatment that we are testing in several communities in South-East Asia. Again, early results look promising.

But it does suggest we have to broaden our conceptual foundation beyond PTSD and towards issues that really are seen and felt to be the most relevant in the communities we work with. R