

THE UNIVERSITY OF
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South Western Sydney
ACADEMIC UNIT

Contemporary Issues in treating Refugee Survivors of Trauma

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Healing
as an
ancient
art and
science



Treating refugee survivors of torture and trauma:
Where have we been, where are we now, where are
we going?



30 years since
early
beginnings of
STARTTS:
Challenge to
bring
conceptual
coherence to
chaos in order
to assist
survivors

The Team

Susan Rees

Alvin Tay

Mohsin Mohammed

Jess Baker

Natalino Tam

Ana Ladesic

Gordana Sobacic

and field teams...

STARTTS

Australian Program Consortium

Hopkins

Harvard

U. Copenhagen

Karolinska

Oxford

WHO

UNHCR

...and others...

Dysjunction between epidemiological and treatment research over the past 30 years

Treatments tested tend to be CBT derived. Observational research becoming more sophisticated in models being tested to correspond with real-life realities:

- Trauma → PTSD
- Trauma → stress → PTSD
- Trauma → stress → PTSD and other outcomes
- Trauma → stress → PTSD and other outcomes in context of changing ecosocial environment, endeavour to ascribe personal/communal “meaning”, and strive to regain capacity for adaptation.
- Extending model beyond index survivor to family, the community and the next generation.

Lag in testing treatments scientifically in the field

- Ideological resistance; empiricism is instrument of oppressive systems; objectification of suffering and human rights abuses
- Theoretical and conceptual controversies – biomedical vs anthropological vs psychosocial vs human rights
- Measures, tools, methodologies
- Representative populations (needles in haystacks)
- Randomization
- Analytic techniques (quant, qual, etc)

Carlsson, J., Sonne, C., & Silove, D. (2014). From pioneers to scientists: challenges in establishing evidence-gathering models in torture and trauma mental health services for refugees. *The Journal of Nervous and Mental Disease*, 202(9), 630-637.

Evidence emerging in past decade

- Supporting brief, structured, (expanded) CBT-informed therapies: Narrative Exposure Therapy.
- Flexible transdiagnostic approach (but atheoretical): CETA
- But surprisingly less evidence for an eclectic, integrated, rehabilitation approach corresponding to use in most T&T services: see findings of Danish studies.

A comparison of narrative exposure therapy, supportive counselling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. 2004, 72 (4):579-87notJ Consult Clin Psychol. Neuner et al.

Contextualized prolonged exposure

The participant constructs a detailed chronological account

The autobiography is recorded by the therapist and corrected with each subsequent reading.

During the discussion of traumatic experiences, the therapist asks for current emotional, physiological, cognitive, and behavioral reactions and probes for respective observations.

The participant is encouraged to relive these emotions while reporting the events.

The discussion of a traumatic event is not terminated until a habituation of the emotional reactions presented and reported by the patient takes place.

In the last session, the participant receives a written report of his biography.

(but note reservations about exposure in ALL survivors)

Mørkved, N., et al. "A comparison of narrative exposure therapy and prolonged exposure therapy for PTSD." *Clinical Psychology Review* 34.6 (2014): 453-467.

Review of Prolonged Exposure (PE) and Narrative Exposure Therapy (NET).

Examined treatment manuals, theoretical foundation, treatment components, and procedures, including the type, manner, and focus of exposure techniques and recording methods used. Examined extant clinical trials to investigate the range of treatment formats reported, populations studied, and clinical outcome data.

32 studies on PE and 15 studies on NET. PE has a solid evidence base and its current status as a first line treatment for the populations studied to this date is warranted. NET may have advantages in treating complex traumatization seen in asylum seekers and refugees.

NET and PE have several commonalities.

A transdiagnostic approach

Murray, Laura K., Shannon Dorsey, Emily Haroz, Catherine Lee, Maytham M. Alsiary, Amir Haydary, William M. Weiss, and Paul Bolton. "A common elements treatment approach for adult mental health problems in low-and middle-income countries." *Cognitive and Behavioral Practice* 21, no. 2 (2014): 111-123.

Table 1. Table of Elements in CETA

Component	Simplified Name	Description	Rationale for Inclusion
Engagement	Encouraging Participation	<ul style="list-style-type: none"> • Specific attention to perceptual and concrete obstacles to engagement • Linking program to assisting with client's problems • Includes family when appropriate or necessary for client participation 	<ul style="list-style-type: none"> • Attention to engagement, particularly perceptual barriers (stigma, concerns of inefficacy), linked to better retention in treatment • In these sites, family engagement/permission was a potentially important addition per local counselors and supervisors
Psychoeducation	Introduction	<ul style="list-style-type: none"> • Program information (duration, content, expectations); often using analogies • Normalization/validation of current symptoms/ problems 	<ul style="list-style-type: none"> • Initial component in most EBT
Anxiety management strategies	Relaxation	<ul style="list-style-type: none"> • Learn strategies to improve physiological tension/stress • Employment of existing strategies for tension/ stress • Offered deep breathing, meditation, progressive muscle relaxation, and imagery. Others added by local cultures. 	<ul style="list-style-type: none"> • Included in EBT for trauma exposure and anxiety as a specified or an optional component • Included as optional in CETA for these sites
Behavioral Activation	Getting Active	<ul style="list-style-type: none"> • Identifying and engaging in pleasurable, mood- boosting, or efficacy- increasing activities 	<ul style="list-style-type: none"> • One of the most effective CBT components/foci for treating depression • Included as optional in CETA
Cognitive Coping/Restructuring	Thinking in a Different Way – separated to Part I and Part II	<ul style="list-style-type: none"> • Understand the association between thoughts, feelings, and behavior • Learn to evaluate and restructure thinking to be more accurate and/or 	<ul style="list-style-type: none"> • Common and effective element of EBT CBT for depression, anxiety, and trauma exposure

Component	Simplified Name	Description	Rationale for Inclusion
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Imaginal Gradual Exposure	Talking about Difficult Memories	<ul style="list-style-type: none"> Facing feared and avoided memories (details and associated thoughts and feelings) Gradual desensitization/exposure 	<ul style="list-style-type: none"> Aspects of imaginal exposure included in all EBT for symptoms related to trauma exposure (variation across EBT in method) Included in all cases at these sites due to trauma history
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In Vivo Exposure	Live Exposure	<ul style="list-style-type: none"> Facing innocuous triggers/reminders in the client's environment Gradual desensitization/exposure 	<ul style="list-style-type: none"> Included in many EBT for symptoms related to trauma exposure and for all EBT for anxiety disorders Included as optional
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Suicide/Homicide /Danger Assessment and Planning	Safety	<ul style="list-style-type: none"> Assessing client risk for suicide, homicide, and domestic violence Developing a focused plan with the client and client's family (when appropriate) Additional referral/ reporting when needed 	<ul style="list-style-type: none"> Particularly important area of training for lay counselors, without prior former mental health training and experience Used in varying degrees in each case
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Screening and Brief Intervention for Alcohol	Alcohol Intervention	<ul style="list-style-type: none"> Utilizes concepts of Motivational Interviewing to get client buy-in to change substance use/abuse behavior. 	<ul style="list-style-type: none"> Added as optional in CETA only to Thailand site based on qualitative data that alcohol abuse was a significant problem
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Bolton, P et al. A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Med*, 11(11), e1001757.

Single-blinded, wait-list randomized controlled trial of transdiagnostic psychotherapy, Common Elements Treatment Approach (CETA), for low-resource settings, compared with wait-list control (WLC).

Delivered by lay workers to Burmese survivors of imprisonment, torture, and related traumas who met severity criteria for depression and/or posttraumatic stress (PTS).

CETA participants experienced significantly greater reductions of baseline symptoms across all outcomes with the exception of alcohol use

Effect sizes (Cohen's *d*) were moderate to large.

Multicomponent Behavioral Intervention in a Conflict-Affected Area of Pakistan

A Randomized Clinical Trial

Atif Rahman, PhD et al, JAMA, 2016

Randomized clinical trial in 3 primary care centers in Peshawar, Pakistan, amongst 346 adult primary care attendees with high levels of both psychological distress and functional impairment

Lay health workers administered 5 weekly 90-minute individual sessions of problem solving, behavioral activation, strengthening social support, and stress management.

After 3 months of treatment, the intervention group had lower anxiety, depression, PTSD, functional impairment and problems for which the person sought help.

Testing a flexible cognitive–behavioural therapy and medical treatment, including antidepressants

To estimate treatment effects of flexible cognitive–behavioural therapy (CBT) and antidepressants (sertraline and mianserin) in traumatised refugees.

Method

Randomised controlled clinical trial with 2×2 factorial design. Participants were refugees with war-related traumatic experiences, post-traumatic stress disorder (PTSD). Treatment was weekly sessions with a physician and/or psychologist over 6 months including SSRIs and hypnotics.

Results

217 of 280 patients completed treatment (78%). There was no effect on PTSD symptoms, no effect of psychotherapy and no interaction between psychotherapy and medicine. A small but significant effect of treatment with antidepressants was found on depression.

Conclusions

In a pragmatic clinical setting, there was no effect of flexible CBT and antidepressants on PTSD, and there was a small-to-moderate effect of antidepressants and psychoeducation on depression in traumatised refugees.

Major challenges in concepts of intervention

1. Should the focus be on individuals, families, the community or the “system”?
2. Preventive, empowering, resilience building, advocacy, therapy?
3. Is therapy about relieving symptoms, rehabilitation/functioning, resettlement/integration, restoring sense of humanity and meaning, encouraging adaptation?

4 **Diagnostically, should we maintain overweening focus on PTSD; give equal status to other diagnoses; or adopt a transdiagnostic/comorbid perspective?**

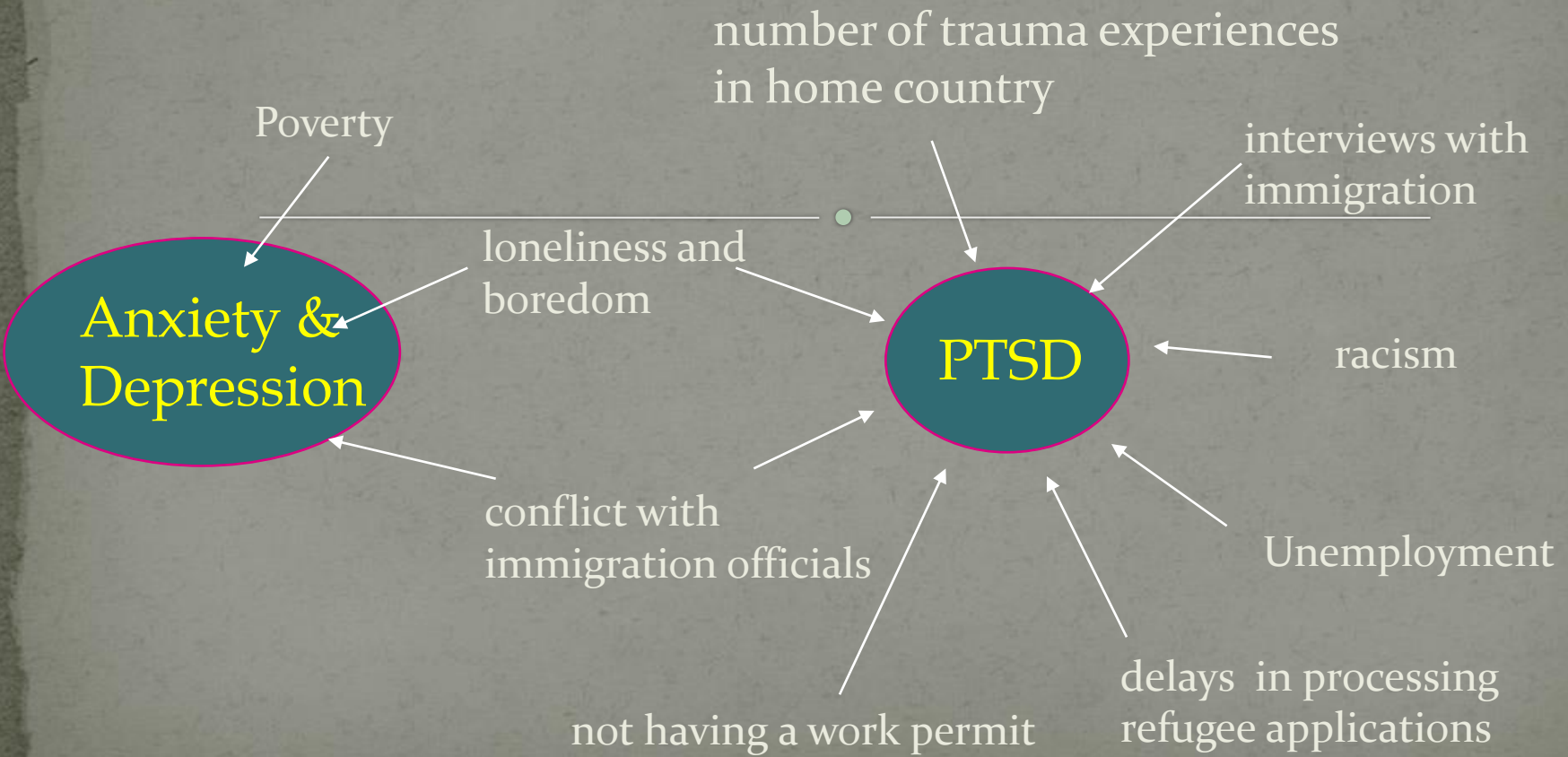
Multicausality and multifinality? Are pathways to specific categories much the same, greatly overlapping; or are they distinct enough to warrant specific attention? For example, complicated grief and PTSD?

Does treating one, treat all? For example, does specific treatment of PTSD attend to complicated grief?

Does treating all, treat each one?: Does a generic/transdiagnostic approach cover all components of the post-traumatic stress response?

5. Does the population profile matter? Asylum seekers under extreme duress; selection filters for specialized services in high income, resettlement countries; general populations with elevated symptoms in humanitarian settings, and later, in post-conflict environments.

Predictors of depression, anxiety and PTSD



Between heaven

Drugs of land... the
crushed wooden hull of
a boat. Photo: Frank
before the 'Tampa' came
alongside.
THEIR STORY
WILL BE TOLD IN A
MAY 2001 ISSUE



and hell



In assessing needs, history, culture and context really matter:

Harvard Team using HTQ: Cambodians: Compared survivors of Khmer Rouge (Siem Reap) with ethnic Cambodians in Thailand (Surin)

Study in California using CIDI: random sample of 490 Cambodian survivors resettled for >2 decades

Steel et al. Used CIDI to compare >1000 randomly sampled Vietnamese in Sydney with Vietnamese in Mekong Delta and Australian-born (ABS 1997)

Comparison of Cambodians and Vietnamese living in country in conflict during same epoch

Cambodians in Siem Reap, directly affected by Khmer Rouge, decades later

PTSD: 20%

Depression: 49%

Cambodians in Surin, Thailand, spared KR:

PTSD: 2.2%

Khmer Rouge survivors in California, 2 decades later, using CIDI:

PTSD: 62%

Vietnamese

Vietnamese refugees in Australia based on CIDI:	PTSD 3.5%.
Vietnamese in MK Delta:	PTSD: <2.5%
Australian born, ABS, 1997:	PTSD: 3.5%

An attempt at a comprehensive model

Based on evolutionary models of adaptation, social ecology, human rights, development theory and mental health

Reciprocal interactions involving the individual, the small group (family, kinships), and larger influences (institutions, national, geopolitical forces).

Synthesis of existing knowledge.

Bronfenbrenner's ecological systems theory: The ecology of human development is the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded.

Habermas: Distinction between the public/objective world and the subjective and inter-subjective world. In our field, a challenge to bridge the gap (a public health approach, a behavioural/functional approach, and the existential approach, the subjective meaning of experiences (culturally influenced) which changes constantly as ecosocial environment changes.



The Gestalt influences the meaning, significance and impact of trauma, stress and deprivation

ADAPT Psychosocial Model

(Silove, 1999;2004)

Adaptation &

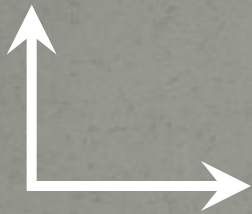
Development

After

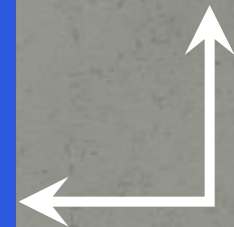
Persecution &

Trauma

*Community
Recovery
and
development*



*Human
Rights*



*Clinical
Traumatology*

Interacting psychosocial “pillars” of stability undermined by mass conflict, human rights violations and displacement

Threats to:

- Safety-securityPTSD, anxiety, paranoia



- Attachment-bonding.....Grief, separation anxiety



- Justiceanger, resentment, bitterness



- Identity-role.....anomie, liminality...identity diffusion...isolation



- Coherence and meaning...alienation, existential crisis.

Principles underlying the ADAPT model

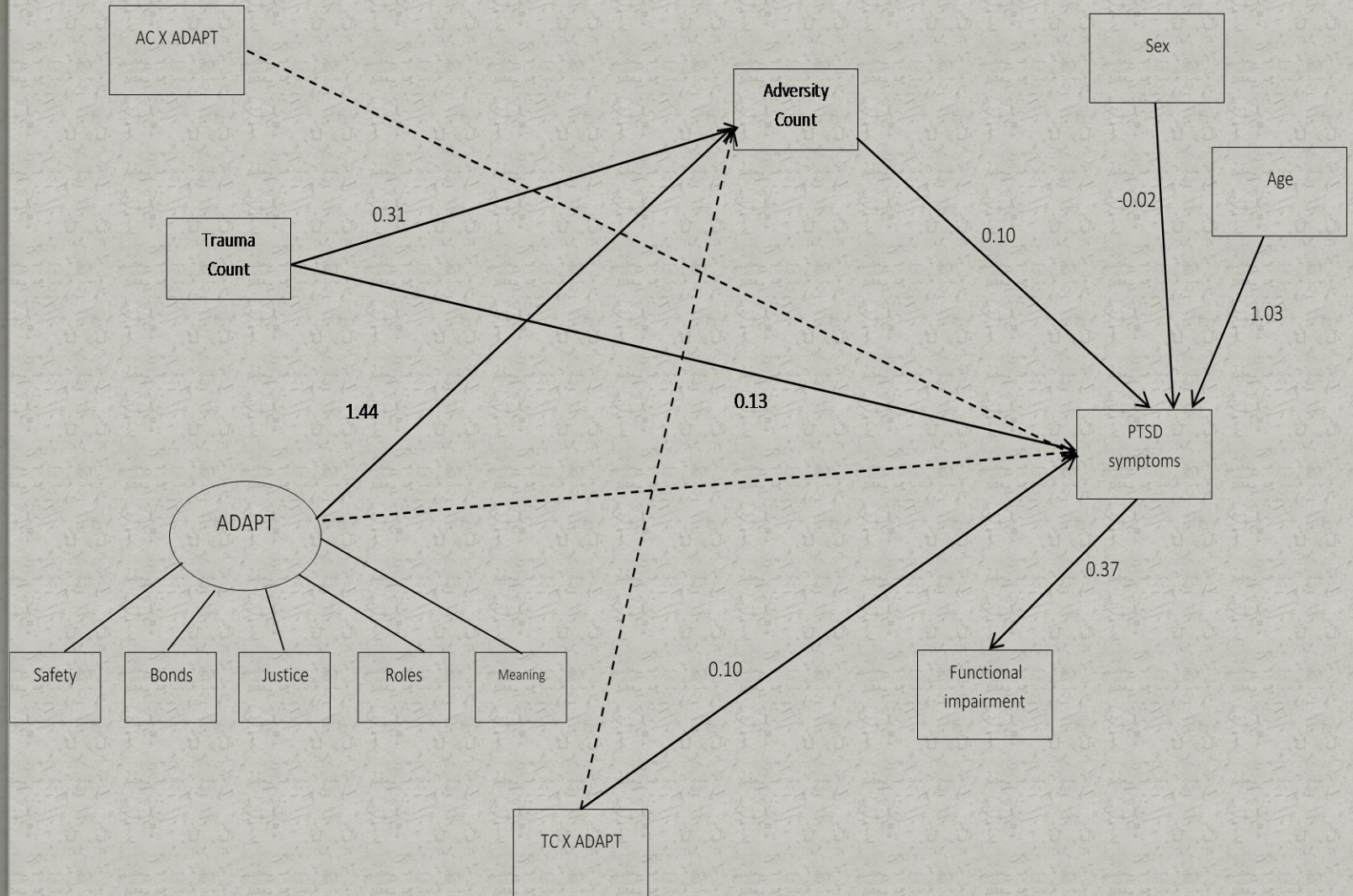
- Most psychological and psychosocial reactions to extreme stress are normative not pathological. Determined by an interplay of bio-psycho-social-cultural-spiritual factors (how do you adapt to “mad” places)
- Reciprocal, continuous and ever-changing feedback loops between different levels (micro, meso, macro, etc) impacting on mental health of individual and collectives (Bronfenbrenner):
- Constant mirroring and interaction of intra-psycho and ecological
- Recovery is an active process – individuals and their collectives mobilize their own resources (resourcefulness), striving to survive and adapt
- (Healthy) social structures promote a natural return to homeostasis and stability

Principles underlying the ADAPT model cont'd

- Model restores meaning to symptoms: PTSD is an exaggerated evolutionary survival response to overwhelming threat, etc.
- Degree of specificity of symptom patterns although substantial overlap and comorbidity.
- Posttraumatic “growth” and positive change are possible
- Ecosocial recovery environment is pivotal to trajectory of symptoms and disability, a public health perspective
- Population level symptoms are a *barometer* of how successful the social recovery process is proceeding.

In Timor Leste, six year follow-up study found massive shift in symptoms over time (PTSD > 3% at baseline in 2004; 15% in 2010)

Figure 1. Structural equation model examining the moderated mediation effects of ADAPT on the paths leading from indices of conflict-related Trauma Count (TC), Adversity Count (AC) to PTSD symptoms with covariates (unstandardized path coefficients are presented).



Tay, A.K., Rees, S., Chan, J., Kareth, M., Silove, D., 2015. Examining the broader psychosocial effects of mass conflict on PTSD symptoms and functional impairment amongst West Papuan refugees resettled in Papua New Guinea (PNG). *Social Science & Medicine* 132, 70-78.

Tay, A.K., Rees, S., Chen, J., Silove, D. (2015). Examining the broader psychosocial effects of mass conflict on PTSD symptoms and functional impairment amongst West Papuan refugees resettled in PNG. *Social Science and Medicine*, 6, 20-25.

Preliminary evidence...

Amongst Timorese....

Insecurity (and role/identity difficulties)...PTSD

Injustice....explosive anger and depression.

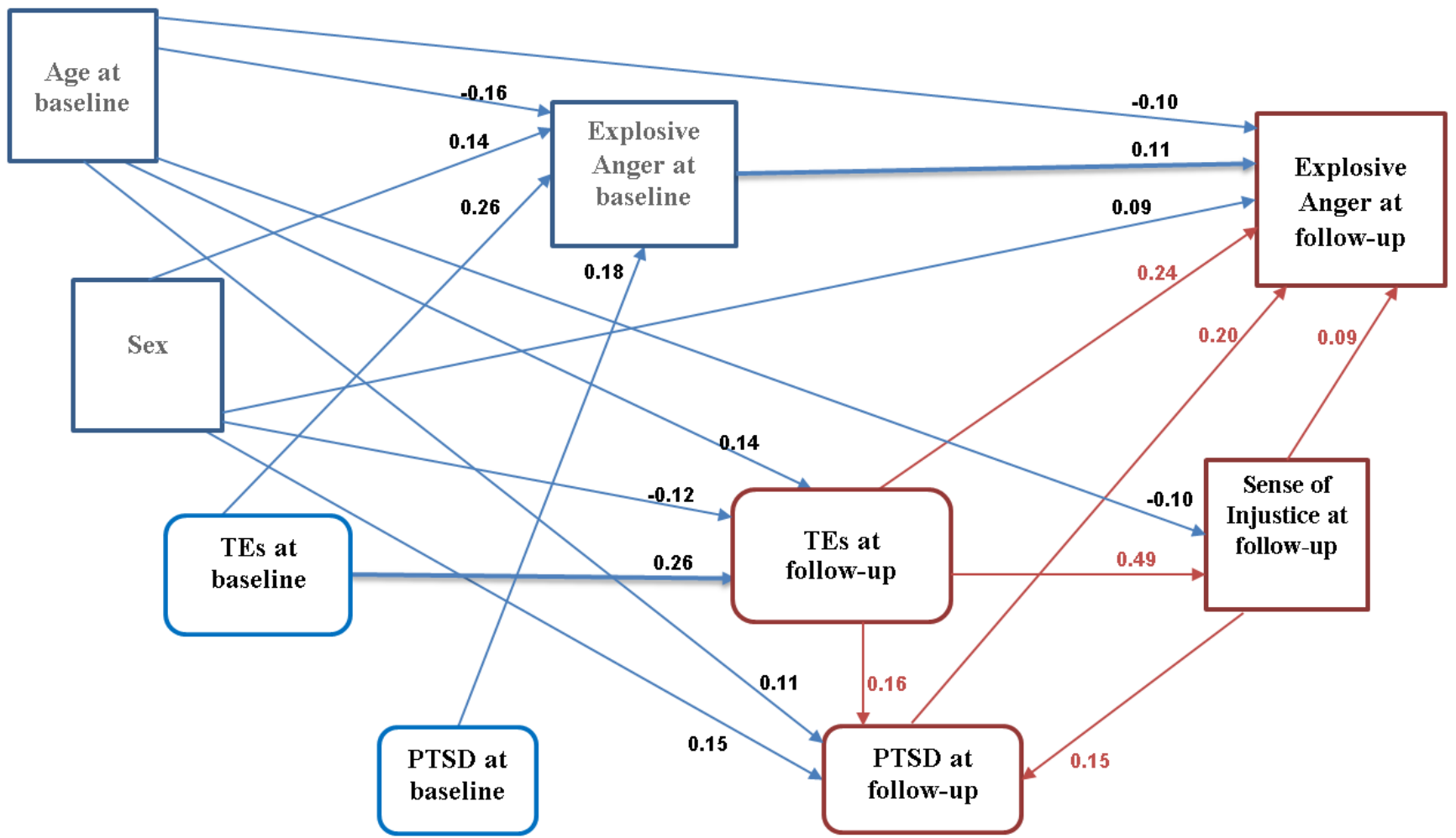
Trauma (human rights) plus post-traumatic frustrations/deprivations and disappointments → sense of injustice/frustration → explosive anger. Anger triggered by “minor” interpersonal events, often in family, resulting in inappropriate aggression (IPV, against children). Potential ripple effect of trauma → family (partner, transgenerational effects).

Simple linear model but many interactions and potential to break the chain.

Persisting sense of injustice and anger (ADAPT Pillar 3) are central to model

An injustice-anger driven cycles of violence model for post-conflict countries

Six year follow-up of two communities in Timor extending through a period of internal violence at midpoint



Salience of Explosive Anger

- Potential to interact with larger forces (historical, political, economic, factional) to increase risk of group violence in early years following mass conflict (“violence begets violence”).
- Tragic pathway where activists struggling to defend human rights end up becoming “perpetrators”, a potentially profound impact on their sense of integrity.
- Readily recognized response by community leaders, politicians, AID agencies, policy/planners of peace-building and reconstruction programs.
- Anger and aggression, in family, in gangs, in different factions/tribes, in political groups the major threat to peace and biggest risk to recurrent violence.
- Cultural descriptions: Sakit Hati, laran moras, Odio.
- But, according to western nosologies, anger/irritability has ambiguous status: intermittent explosive disorder (IED) but also part of PTSD and hence subordinate to it.

Some evidence...

- Findings in Timor Leste
 - 40% of adults in two communities had broadly defined explosive anger.

 - 50% continued to have anger at 6 year follow-up.
 - Strong relationship between extensive traumatic losses/grief and explosive anger.
 - Only a small percent of those with explosive anger also had PTSD or threshold depression.
 - Qualitative research found that women with explosive anger reported harsh parenting.
 - Indirect evidence to suggest that families with high levels of explosive anger are affected by IPV.
- Dyadic analysis showed that families where one member of couple exposed to high levels of trauma increased risk of explosive anger in partner.

 - Two population groups with high levels of explosive anger: young adults in urban environments with low levels of employment/economic independence; and older men with high rates of trauma (veterans of resistance war): both groups disaffected and prominent in internal conflict of 2006-7.
 - Pregnant and postpartum women: Two-fifths (43.6%) had explosive anger. Levels of functional impairment were related to frequency of explosive anger episodes. Explosive anger was associated with age (>35 years), low levels of education, traumatic event count, ongoing adversity and intimate partner violence.

Two interventions based on ADAPT

Evidence of ADAPT-informed therapy being effective for extreme anger in Timor-Leste: A waitlist controlled trial (Kalhari Hewage et al.)

Developed ADAPT therapy – being trialled in multiple settings in SE Asia: Alvin Tay et al.

Challenges ahead

Defining when to focus on symptom improvement and when to function on rehabilitation/gradual “recovery” approach: “allowing existential thawing”

When to use individual or family approaches.

How generic can treatments be; how much do they need to be adapted to local history, culture and context?

Dealing with a wide range of “disorders” – how to determine the focus?

Biological factors: TBI, pain, promising biological interventions.