Adapting service and treatment models to work with refugees

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Plan for the talk

- Psychological recovery after trauma
- Early intervention frameworks
- Treatment for Post-Traumatic Stress Disorder
- Adapting treatment with refugees
Early intervention after trauma
Maslow’s hierarchy of needs (1943)

- **Physiological needs**: breathing, food, water, shelter, clothing, sleep
- **Safety and security**: health, employment, property, family and social stability
- **Love and belonging**: friendship, family, intimacy, sense of connection
- **Self-esteem**: confidence, achievement, respect of others
- **Self-actualization**: morality, creativity, spontaneity, acceptance
Normal recovery

- Most people with recover psychologically from trauma without requiring intervention
- Distress is normal, and not the same as PTSD
- But follow-up and watchful waiting is advisable
- Initial symptoms fade for most people:

  PTS symptoms after rape (Rothbaum et al., 1992)
  - 94% at 1 week
  - 65% at 1 month
  - 47% at 3 months
Longitudinal Course of PTSD Symptoms

6% recovered

53% recovered

58% recovered

15-25%

UNRECOVERED

Weeks

3 months

9 months

YEARS

Shalev & Yehuda, 1999
Debriefing

- Critical incident stress debriefing used to be recommended but...
- Rose, S., Bisson, J., & Weseley, S. (2001) – 6 studies found no benefit, 2 RCTs show adverse effects

- Contrary to our instincts...
  “there appears to be a strong case for not intervening...in the first few weeks” (Brewin, 2001)

- Many crisis response teams still use some form of debriefing, there may yet be a useful model found
Early psychological interventions

Goal is to provide containment, safety and information

Interventions include:

- Provide information about normal range of psychological responses and validate theirs
- Encourage to seek support from family and friends
- Reassure acute reaction is likely to pass in time
- Encourage to allow self time to confront, not avoid memories
- Advise not to cope with drugs, sleeping tablets, cigarettes, caffeine
- Advise gentle relaxation/exercise to reduce arousal
- Provide information about community services e.g. Victim Support
- Ensure some follow-up in place
Early intervention for refugees

- Assessment of needs
- Practical support for immediate needs
- Establishing safety
- Activation/reinforcement of social support
- Basic psychological support
- ‘Watchful waiting’ for psychological problems
- Specific, evidence-based treatment for any psychological problems which emerge
Psychological problems after trauma
Psychological problems

- Victims may develop a variety of mental health problems following traumatic experiences

- These can include:
  - Depression
  - Panic Disorder
  - Generalised Anxiety Disorder
  - Substance Misuse
  - Somatisation and physical symptoms
  - Post-Traumatic Stress Disorder

- Pre-existing mental health problems, e.g. psychosis, may also be triggered or exacerbated
Psychological problems in refugee populations

- **Worldwide prevalence (Fazel, Wheeler & Danesh, 2005):**
  - PTSD – 9%
  - Depression – 5%
- **UK clinic sample (McColl & Johnson, 2006):**
  - PTSD – 41%
  - Depression – 50%
  - Psychosis – 53%
Traumatic Stress

- Freud - "a breach in the protective barrier against stimulation leading to overwhelming feelings of helplessness"

- Horowitz – “trauma occurs when an individual is faced with an overwhelming and negative experience that is incongruent within existing mental models of the world”

- DSM-5 Criterion A:
  Exposure to actual or threatened a) death, b) serious injury, or c) sexual violation
Prevalence of PTSD across trauma type (Breslau et al., 1998)

<table>
<thead>
<tr>
<th>Trauma type</th>
<th>% PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Held captive/tortured/kidnapped</td>
<td>53.8</td>
</tr>
<tr>
<td>Rape</td>
<td>49.0</td>
</tr>
<tr>
<td>Badly beaten up</td>
<td>31.9</td>
</tr>
<tr>
<td>Sexual assault (other than rape)</td>
<td>23.7</td>
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<tr>
<td>Other serious accident</td>
<td>16.8</td>
</tr>
<tr>
<td>Shot/stabbed</td>
<td>15.4</td>
</tr>
<tr>
<td>Sudden unexpected death of associate</td>
<td>14.3</td>
</tr>
<tr>
<td>Child’s life-threatening illness</td>
<td>10.4</td>
</tr>
<tr>
<td>Mugged/threatened with weapon</td>
<td>8.0</td>
</tr>
<tr>
<td>Witness killing/serious injury</td>
<td>7.3</td>
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<tr>
<td>Natural disaster</td>
<td>3.8</td>
</tr>
<tr>
<td>Car accident</td>
<td>2.3</td>
</tr>
<tr>
<td>Learning about trauma to others</td>
<td>2.2</td>
</tr>
<tr>
<td>Life-threatening illness</td>
<td>1.1</td>
</tr>
<tr>
<td>Discovering dead body</td>
<td>0.2</td>
</tr>
</tbody>
</table>
DSM-5 – Criterion A

Exposure to actual or threatened a) death, b) serious injury, or c) sexual violation, in one or more of the following ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the traumatic event(s) as they occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or close friend; cases of actual or threatened death 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); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.
DSM-5 – 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. Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
2. Recurrent distressing dreams in which the content or affect of the dream is related to the event(s)
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) are recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to reminders of the traumatic event(s)
Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by avoidance or efforts to avoid one or more of the following:

1. Distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
2. External reminders (i.e., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about, or that are closely associated with, the traumatic event(s)
DSM-5 – 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:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia that is not due to head injury, alcohol, or drugs)

2. 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”). (Alternatively, this might be expressed as, e.g., “I’ve lost my soul forever,” or “My whole nervous system is permanently ruined”).

3. Persistent, distorted blame of self or others about the cause or consequences of the traumatic event(s)

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)

5. Markedly diminished interest or participation in significant activities

6. Feelings of detachment or estrangement from others

7. Persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing)
DSM-5 – 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:

1. Irritable or aggressive behaviour
2. Reckless or self-destructive behaviour
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)
Criterion F: duration
- Persistence of symptoms for more than one month

Criterion G: functional significance
- Significant symptom-related distress or functional impairment (e.g., social, occupational)

Criterion H: exclusion
- Disturbance is not due to medication, substance use, or other illness.

**Specify if: With dissociative symptoms.**
In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
**Depersonalization:** experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream)
**Derealization:** experience of unreality, distance, or distortion (e.g., "things are not real")

**Specify if: With delayed expression**
Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately
Treatment

- **NICE guidelines recommend:**
  - All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing). These treatments should be provided on an individual outpatient basis.
  - Trauma-focused psychological treatment should be offered regardless of the time that has elapsed since the trauma.
  - Non-trauma-focused interventions such as relaxation or non-directive therapy, which do not address traumatic memories, should not routinely be offered to people who present with chronic PTSD.
  - Drug treatments for PTSD should not be used as a routine first-line treatment for adults in preference to a trauma-focused psychological therapy.
Eye movement desensitisation and reprocessing (EMDR)

- Developed by Francine Shapiro (1989)
- Involves activating a trauma memory and then using bilateral stimulation (eye movements or taps)
- Aim is to process the trauma memory, and associated emotions and cognitions, as contextualised memories rather than implicit memories
- Evidence base is good, and comparable to CBT
Trauma-focused CBT

- **Prolonged exposure** (Foa et al., 1992, 2007)
  - Repeated recounting of traumatic experiences
  - Hierarchy of feared experiences
  - Focus on habituation to feared stimuli (including trauma memory)

- **Cognitive Therapy** (Ehlers & Clark, 2000)
  - Traumatic events processed in a way that leads to a sense of current threat due to:
    - Excessively negative appraisals of the event and/or its sequelae
    - A disturbance of autobiographical memory characterised by poor elaboration and contextualisation, strong associative memory and strong perceptual priming
  - Focus on addressing appraisals of trauma, elaborating trauma memory (e.g. imaginal reliving), addressing maintenance cycles
Does treatment still work?

- Many treatment studies under-represent or exclude minority groups
- Trauma-focused treatment with refugee populations:
  - Paunovic & Ost (2001); Otto et al. (2003); Hinton et al. (2004, 2009); d’Ardenne et al. (2007) – Cognitive Behavioural Therapy
  - Shulz et al. (2006) – Cognitive Processing Therapy
  - Neuner et al. (2004, 2008, 2010); Bischesu et al. (2007); Halvorsen & Stenmak (2010) – Narrative Exposure Therapy
Adapting treatment for refugees
TF-CBT: Phased approach

Stabilisation & symptom management ↔ Trauma-focused therapy ↔ Reintegration

Judith Herman: Complex PTSD
**Memory work**

- Often multiple trauma, so start with overall narrative
  - NET - lifeline
  - CBT – timeline
  - EMDR – ‘10 worst’
- Then process individual traumas
  - NET - lifeline
  - CBT – reliving/rescripting
  - EMDR – eye movements
Reintegration

- Focus on establishing new connections
- Adapting to new culture, without losing own
- Setting goals for future e.g. work, study
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