Adapting trauma-focused CBT for refugees and asylum-seekers

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Recovery after trauma
Longitudinal Course of PTSD Symptoms

6% recovered

53% recovered

58% recovered

15-25% unrecovered

Shalev & Yehuda, 1999
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
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
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
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%
### 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>
</tr>
<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>
</tr>
<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>
Review

THE CROSS-CULTURAL VALIDITY OF POSTTRAUMATIC STRESS DISORDER: IMPLICATIONS FOR DSM-5

Devon E. Horner, M.D. Ph.D. and Roberto Lewis-Fernández, M.D.

Background: There is considerable debate about the cross-cultural applicability of the posttraumatic stress disorder (PTSD) category as currently specified. Concerns include the possible status of PTSD as a Western culture-bound disorder and the validity of individual item and criteria thresholds. This review examines various types of cross-cultural validity of the PTSD criteria as defined in DSM-IV-TR, and presents options and preliminary recommendations to be considered for DSM-5. Methods: Searchers conducted the mental health literature, particularly since 1994, regarding culture-, race-, or ethnicity-related factors that might limit the applicability of the diagnostic criteria of PTSD in DSM-IV-TR and the possible criteria for DSM-5. Results: Substantial evidence of the cross-cultural validity of PTSD was found. Therefore, evidence of cross-cultural validity in certain areas suggests the need for further research: the relative salience of different PTSD symptoms, the role of the interpretation of symptomatology, and the prevalence of symptom clusters. This review also indicates that the need to modify certain criteria, such as the items on distressing dreams and on posttraumatic stress disorder symptoms, to increase their cross-cultural applicability. Text additions are suggested to increase the applicability of the manual across cultural contexts, specifying that cultural syndromes—such as those included in the DSM-IV-TR Culture—may be a prominent part of the trauma response in certain cultures, and that these syndromes may influence PTSD symptom salience and severity. Conclusion: The DSM-IV-TR PTSD category demonstrates various types of validity. Cross-cultural modification and textual clarifications are suggested to further improve its cross-cultural applicability.


Key words: DSM-5; culture; classification diagnostic criteria; PTSD; trauma

INTRODUCTION: STATEMENT OF THE ISSUES AND THEIR SIGNIFICANCE FOR DSM-5

In this article, we review evidence on the validity of the DSM-IV-TR posttraumatic stress disorder (PTSD) criteria for traumatized members of diverse cultural groups. The diagnostic revision updating DSM-5 has paid special attention to the cross-cultural validity of diagnostic criteria. The cross-cultural applicability of the PTSD category as currently specified has generated considerable debate, both in terms of its cultural, race-, and ethnicity-related factors that might limit the applicability of the diagnostic criteria of PTSD in DSM-IV-TR and the possible criteria for DSM-5.

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“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.

Drug treatments for PTSD should not be used as a routine first-line treatment for adults in preference to a trauma-focused psychological therapy.

Non-trauma-focused interventions such as relaxation or non-directive therapy, which do not address traumatic memories, should not routinely be offered”
Trauma-focused Cognitive Behavioural Therapy (TF-CBT)

Prolonged Exposure Therapy (Edna Foa)

Cognitive Therapy (Anke Ehlers & David Clark)


Eye Movement Desensitisation and Reprocessing (EMDR)

(Francine Shapiro)

Narrative Exposure Therapy

(Schauer, M., Neuner, F., & Elbert, T., 2005)
Do these treatments work with refugees?

- 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
COMMON ISSUES

SOCIAL PROBLEMS
- LEGAL
- HOUSING

PHYSICAL PROBLEMS
- PAIN
- MEDICAL

LOSSES
- STATUS
- COMMUNITY

BARRIERS
- MONEY
- CULTURE & LANGUAGE
- STIGMA

PSYCHOLOGICAL PROBLEMS
- DEPRESSION
- PTSD
- PSYCHOSIS

FAMILY
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
TF-CBT: Phased approach

- Stabilisation & symptom management
- Trauma-focused therapy
- Reintegration

Judith Herman: Complex PTSD
References

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