

Working with Survivors of Torture and Trauma: Research Evidence and Clinical Implications

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What is a Refugee?

- ▶ A person who, owing to a well-founded fear of being **persecuted** for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is **outside the country** of his nationality, and is **unable** to or, owing to such fear, is unwilling to **avail himself of the protection** of that country...

(UNHCR, 1951)

- Over 50 million people forcibly displaced
(UNHCR, 2014)



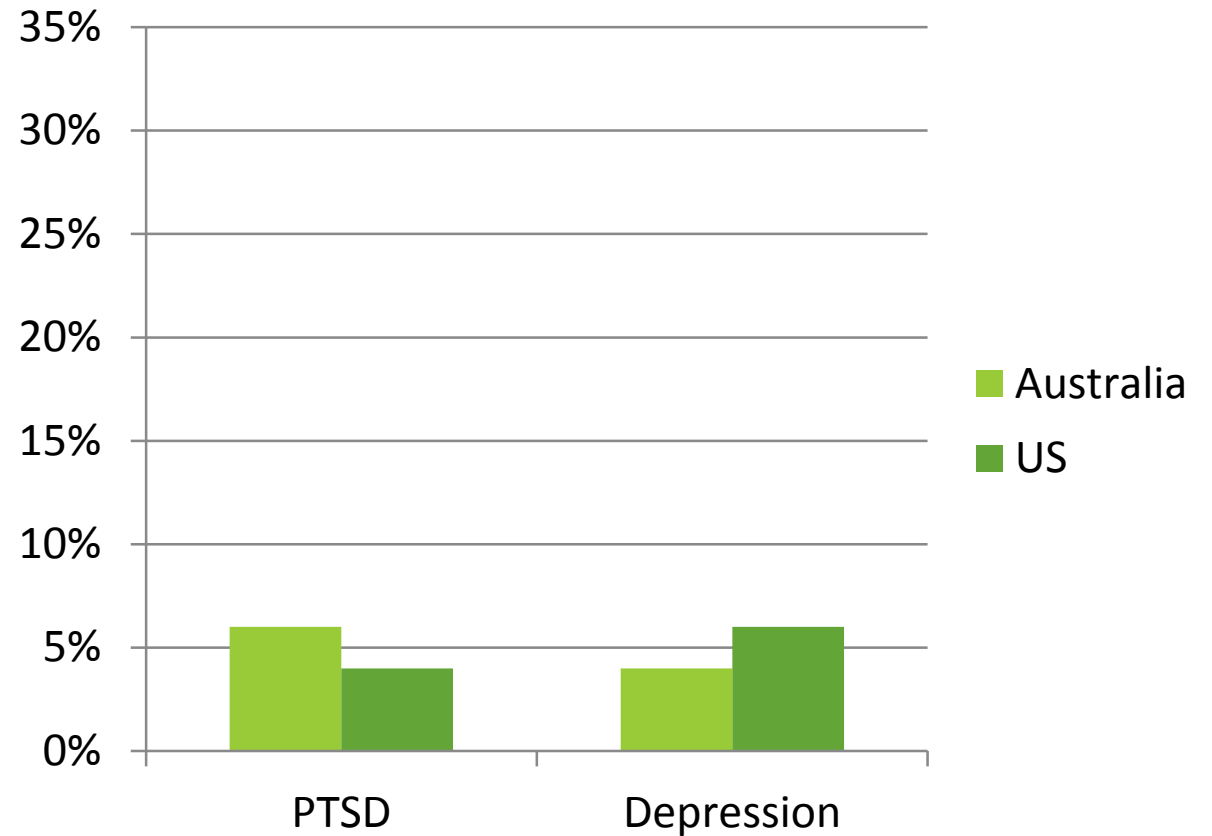
Mental Health of Refugees

➤ PTSD

- General population
 - 4% (US) to 6% (Aus)
(Kessler., 2006; ABS, 2007)

➤ Depression

- General population
 - 4% (Aus) to 6.% (US)



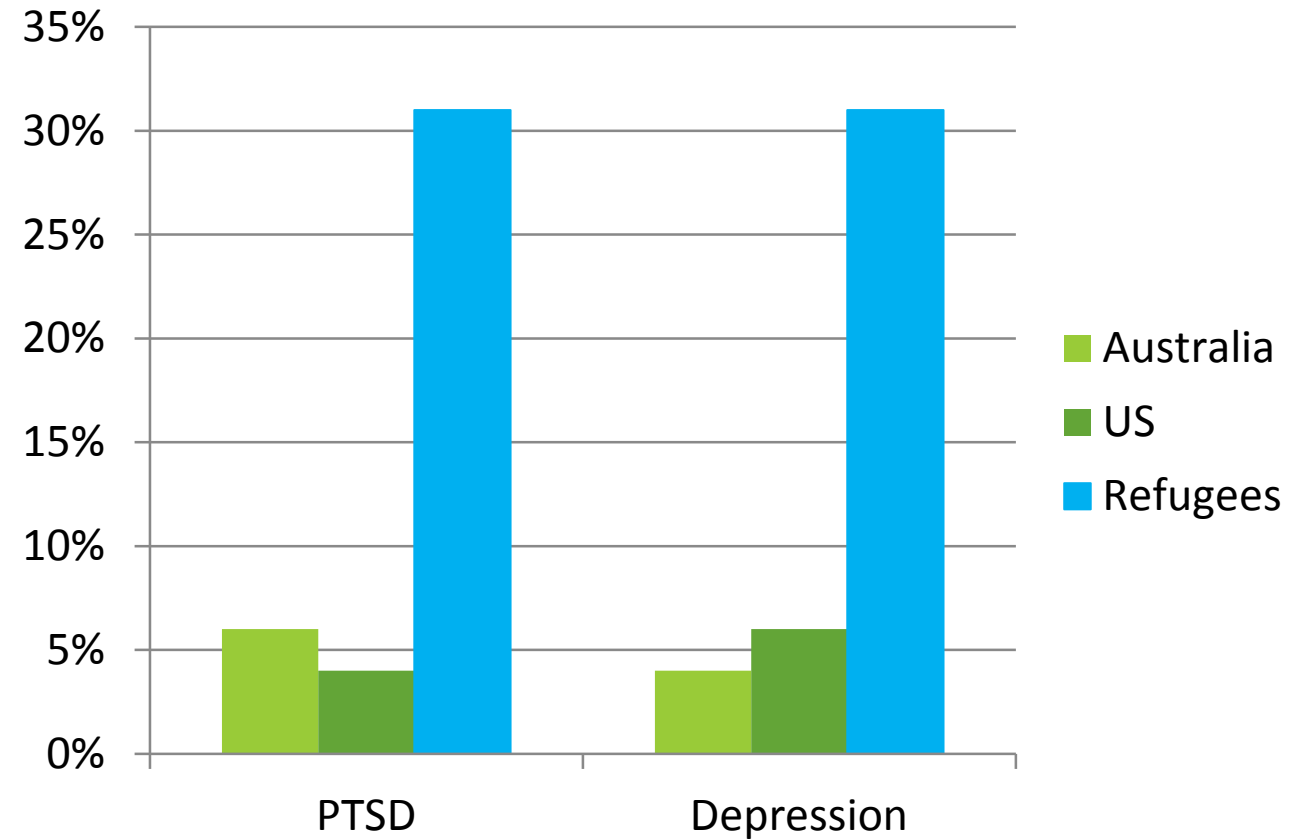
Mental Health of Refugees

➤ PTSD

- Refugee groups
 - 4% to 79-86% (Steel., 2002; Mollica., 1998)
- Refugee/post-conflict meta-analysis 30.6% (Steel et al., 2009)

➤ Depression

- Refugee groups
 - 11.5% and 55% (Hinton, 1993; Mollica, 1993)
- Meta-analysis 30.8% (Steel et al., 2009)



Mental Health of Refugees

PTSD & Depression

- Extremely high levels of comorbidity
- 26% -Bosnian refugees in camp (Mollica et al., 1999)
- 19% -Bhutanese refugees in Nepal (Van Ommeren et al., 2001)
- Combination of PTSD and depression is associated with much greater functional disability (Mollica et al., 1999; Momartin et al., 2004)



Mental Health of Refugees

- Anxiety

- Panic Disorder (Hinton et al., 2003)
- Generalized Anxiety Disorder
(Van Ommeren et al., 2001)

- Anger

- Explosive anger (Nickerson & Hinton, 2012;
Silove et al., 2009)

- Grief

- Prolonged Grief Disorder (Morina et al.,
2010; Nickerson et al., 2011)



Trauma Experiences



Trauma Experiences & Refugee Mental Health

- Nature of refugee trauma
 - Human-instigated
 - Repeated
 - Multiple types of traumatic events
 - Loss
- Dose-response association
(Mollica et al., 1998)



Trauma Experiences & Refugee Mental Health

- Torture and gross HRVs
 - Context & purpose
 - Use of relationship
 - Protective factors
 - Impact on mental health
- “Enacting” trauma
 - Forced perpetration
 - Inability to intervene
 - Forced choices



Trauma Experiences & Refugee Mental Health

- Psychological effects
 - PTSD responses
 - Anger
 - Low levels of trust
 - Difficulties regulating emotions
 - “Permanent change”
 - Challenging of fundamental beliefs
 - High levels of avoidance
 - Guilt



Displacement

Displacement & Refugee Mental Health

- Refugee camps
 - Scarce food, water, shelter
 - Disease, medical resources
 - Trauma exposure
 - Interpersonal violence
- Average length of time in refugee camp is 17 years



Displacement & Refugee Mental Health

- Neighbouring countries
 - Persecution may extend across borders
 - Exposure to ongoing conflict
- Journeys to countries of asylum
 - By sea (drownings, lack of food/water etc.)
 - By land (dangerous border crossings, exposure to elements, lack of food/water etc.)



Displacement & Refugee Mental Health

- Psychological impact of displacement
 - Fear for the future
 - Hypervigilance
 - Separation from loved ones
 - Helplessness/ depression symptoms



Ongoing Stressors

Ongoing Stressors & Refugee Mental Health

- Post-migration environment
 - Unemployment
 - Communication difficulties
 - Financial difficulties
 - Lack of social support
- Immigration process/policy
 - Immigration detention
 - Visa status
 - Extended processing times



Ongoing Stressors & Refugee Mental Health

- Psychological impact
 - Hopelessness
 - Changes in status/ identity
 - Loss of social support
 - Boredom/ loneliness
 - Often psychological difficulties emerge at this stage
- Contribution to refugee mental health well-documented (Laban et al., 2005; Nickerson et al., 2011; Steel et al., 2006; Steel et al., 1997).



Models of Post-Trauma Mental Health

Models of Post-Trauma Mental Health

- Models of understanding post-trauma mental health
 - Developed with western survivors of single incident civilian trauma or military active duty or veterans
- Focus on fear conditioning
 - Pairing of traumatic stimuli with fear reaction
 - Elicits fear response when exposed to reminders of traumatic event



Psychological Treatments for PTSD

- Treatments focus on processing the trauma to reduce fear and avoidance
 - Validated with civilian trauma survivors
- Key treatment components
 - Imaginal & *in vivo* exposure therapy
 - Cognitive therapy
- Models (and therefore treatments) don't consider unique aspects of refugee experience



Civilian Trauma vs. Refugee Trauma

“Classic” civilian trauma	Persecution & human rights violations
Single-incident	Prolonged, repeated
Unlikely to be repeated	May be likely to be repeated
Opportunities for disconfirming evidence	Limited opportunities for disconfirming evidence
Non-interpersonal or instigated by one or small group of individual/s	Human-instigated and societal
Recovery environment intact	Dislocated from important sources of support
Future may be predictable	Uncertainty about the future
Institutional assistance available	Institutions may be unfamiliar, ineffectual or implicated in persecution

Challenges for Existing Treatment Approaches

- Nature of trauma
 - Multiple traumatic events
 - Loss may co-occur and result in different symptom profiles (Nickerson et al., 2013)
 - Implications for therapeutic relationship & context
 - Avoidance
- Evidence-based interventions for PTSD assume that the individual is in conditions of safety
 - Allows the client to focus on the treatment
 - Provides disconfirming evidence for maladaptive beliefs about traumatic events
 - May not be possible....



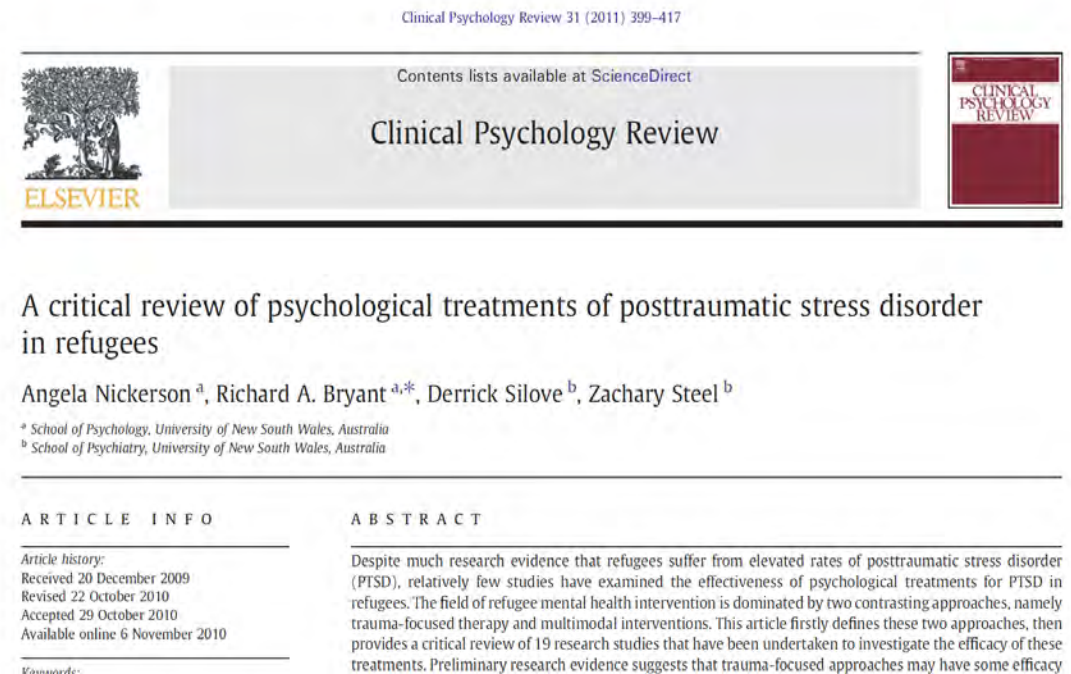
Challenges for Existing Treatment Approaches

- Ongoing stressors
 - Traditional view – focus on managing ongoing stressors before embarking on PTSD-focused intervention
- Mental health literacy
- Lack of familiarity with available and effective intervention options
- Stigma
- Mismatch between worldview of client and clinician



Psychological Treatment for PTSD in Refugees: the Evidence

- Multimodal approaches commonly implemented, but have not demonstrated robust effects
- Evidence supports the use of trauma-focused approaches
- Limited research investigating applicability of gold-standard PTSD interventions for refugees
 - Cognitive Processing Therapy
 - Refugees– Schultz et al (2006), *Cognitive Behavioural Practice*
 - Iraq - Bolton et al (2014), *BMC Psychiatry*
 - Congo – Bass et al (2013), *New Eng J Medicine*
 - Strongest evidence base for Narrative Exposure Therapy



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)
 - See Robjant & Fazel, 2010 and Morkved et al 2014 *Clin Psych Rev*



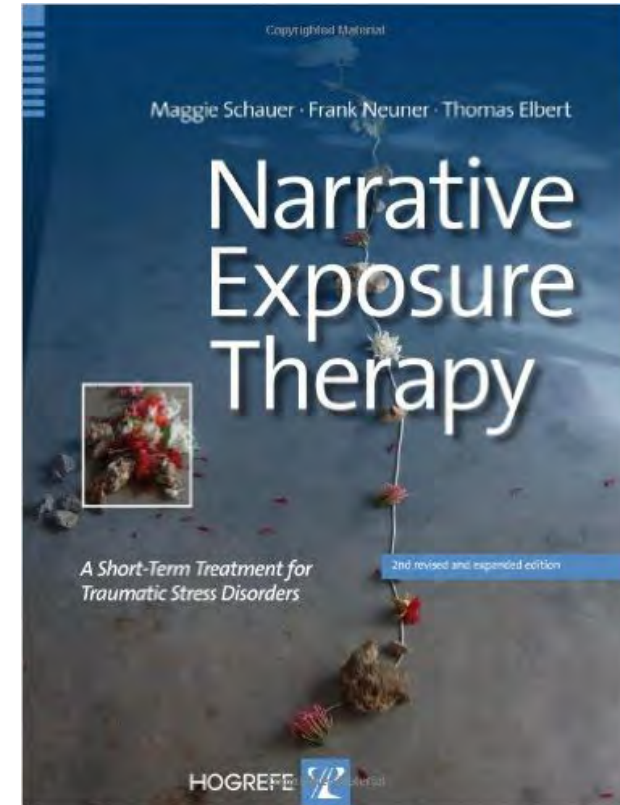
Narrative Exposure Therapy

○ Elements

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

○ Mechanisms by which NET works

- Emotional processing
- Integration of memories into autobiographical memory base
- Redress?

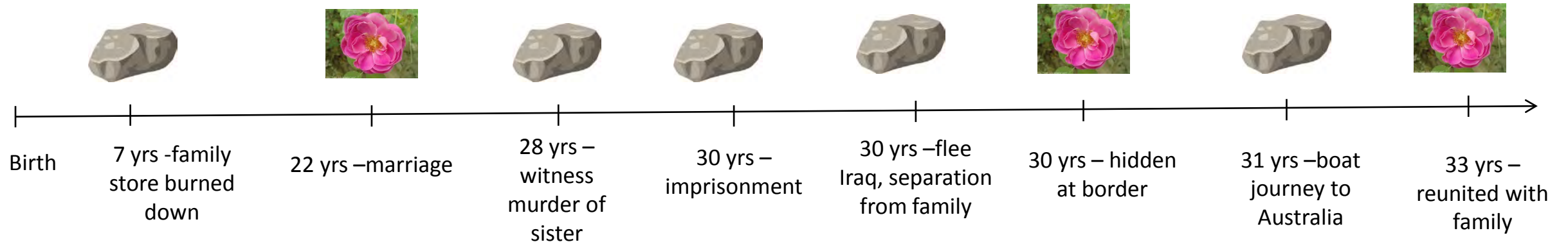


Psychoeducation & Lifeline

- Psychoeducation

- Normalization
- Legitimization
- Description of trauma reactions
- Explanation of therapeutic procedure

- Lifeline



Narrative

- Narrative at each session
 - At beginning of each session, re-read story to date
 - Move forward
- “Hot” memories
 - Slow down
 - Sensory details
 - Thoughts, feelings, physical sensations
 - “Like a movie”
- Integration into narrative
- Bringing narrative to a close
 - Finish at a point of (relative) safety
 - Move to present
 - Emotional and physiological reactions decrease
- Cognitive restructuring/ meaning-making



Treatment with MH Lifeline & Testimony

○ Lifeline

- Lay out lifeline in chronological order
- Focus on seeing full biography
- Recognize courage of client

○ Testimony

- Story serves as testimony document
- Signed by therapist, client and interpreter who “bear witness”
- Client can choose what he/she wishes to do with the testimony
- Powerful component of therapy



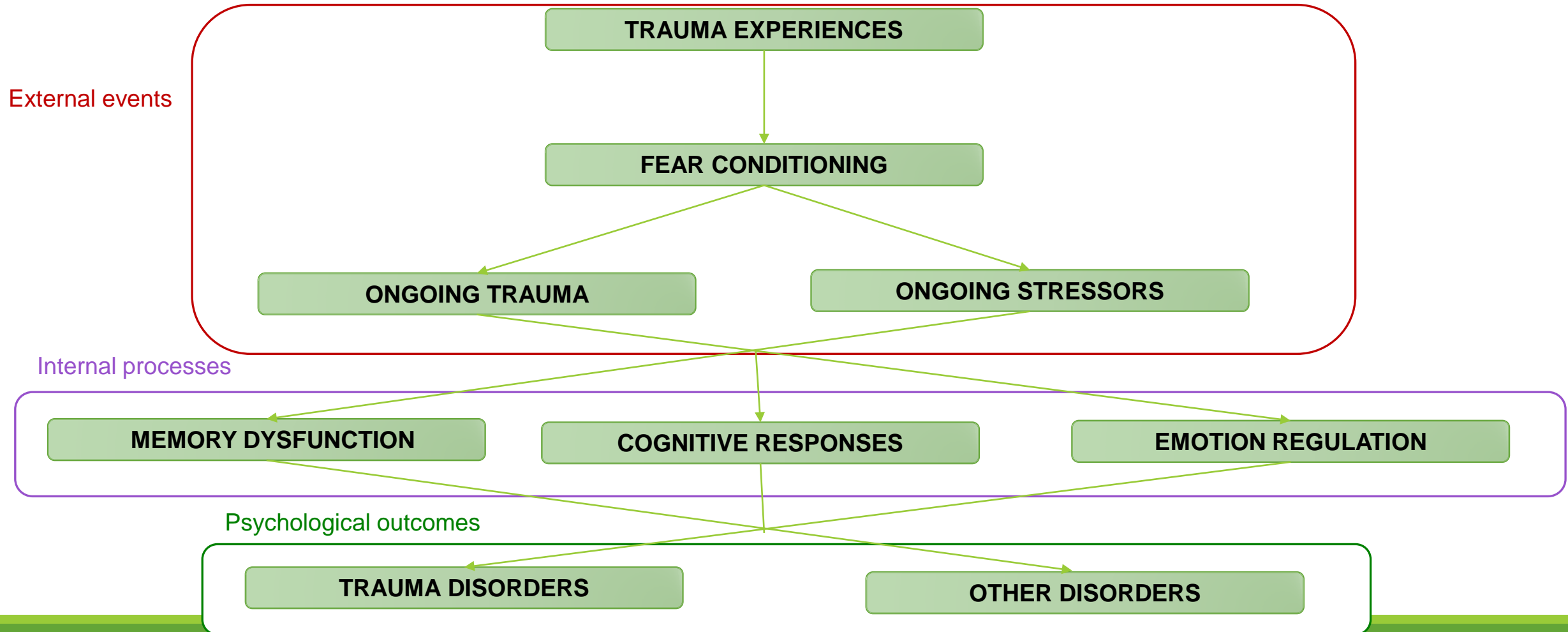
Pathways to Refugee Mental Health

The State of the Evidence

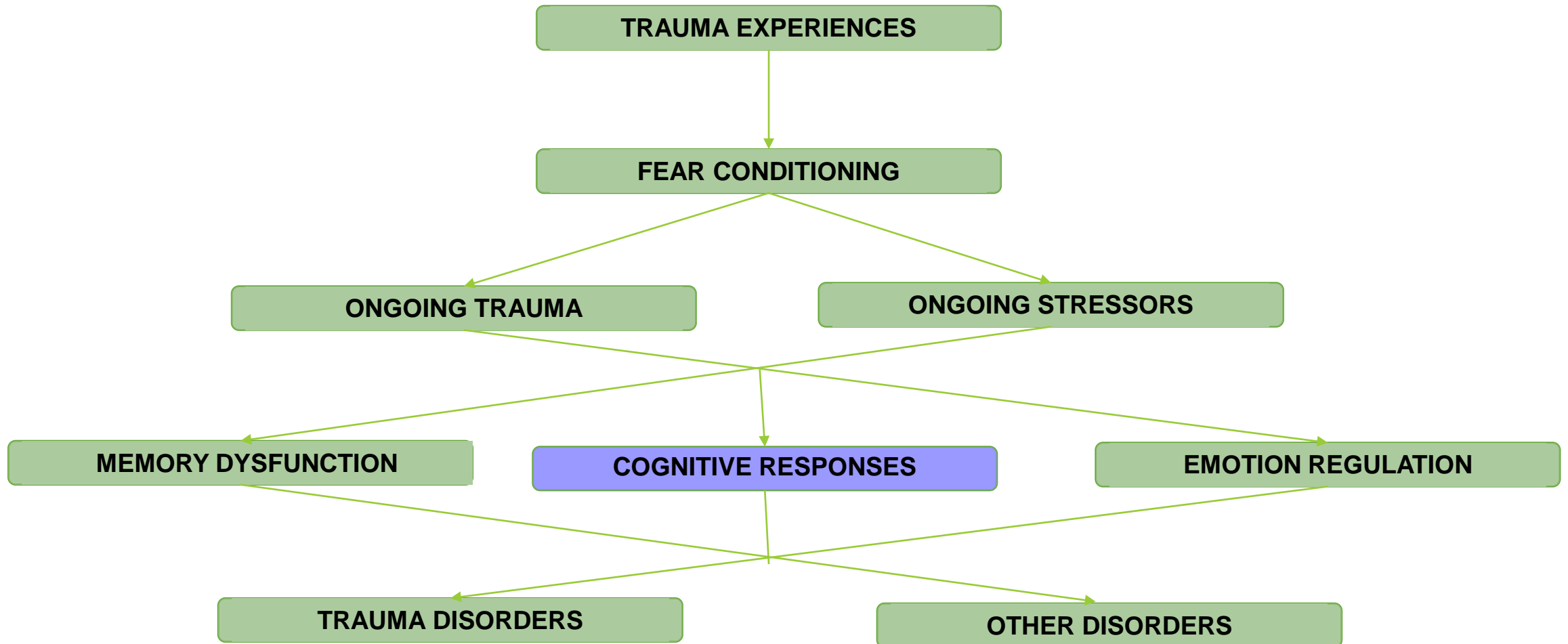
- Evidence that psychological effects of persecution can be treated effectively
- BUT – many people don't respond
- We don't yet know much about mechanisms underlying refugee mental health
 - Specific ways in which the refugee experience uniquely impacts on mental health are poorly understood
 - Necessary to understand why existing treatments work – and how we can make them better



Pathways to Refugee Mental Health



Pathways to Refugee Mental Health



Cognitive Responses & Refugee Trauma

- Research evidence - cognitive responses to trauma are critical
 - Cognitive models of PTSD (e.g., Ehlers & Clark, 2000)
 - Cognitive therapy efficacious for PTSD
- The nature of the refugee experience is likely to give rise to specific types of cognitions
 - Interpersonal violations
 - Lack of control
 - Changes in identity
- Very limited specific research on cognitive responses in refugees



Moral injury

“The lasting psychological impact of ...bearing witness to acts that transgress deeply held moral beliefs and expectations”

- Litz et al. 2009

- Developed in context of military to describe effects of moral and ethical challenges in war
- Refugees are exposed to persecution
 - Events that contravene deeply-held moral frameworks such as murder, sexual assault and torture
- Displacement to new environment
 - Dislocation from support structures & cultural frameworks



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**Does moral injury predict
mental health over and
above refugee experiences?**

Cognitive Responses in Refugees

- Participants
 - 134 refugees from variety of backgrounds, seeking treatment at outpatient clinic in Zurich
 - 83% of the sample were tortured
- Methodology
 - Survey measures administered on an electronic tablet, using the MULTICASI program
 - Study investigated psychological mechanisms underlying refugee mental health
- Assessed MI using 6-item measure developed for this study
 - *“I am troubled by morally wrong things done by other people”*
 - *“I am distressed by how people have broken important moral rules”*



Results

	PTSD		Depression		Anger		MH-QOL	
	R ² = 0.39		R ² = 0.36		R ² = 0.25		R ² = 0.19	
	Beta	R ² ch	Beta	R ² ch	Beta	R ² ch	Beta	R ² ch
Age	-0.10		-0.06		0.12		0.18	
Gender	<.001	0.01	0.08	0.01	0.10	0.03	0.01	0.03
Trauma	3.66***	0.10	0.22*	0.05	0.21*	0.04	-0.12	0.01
LDC	4.36***	0.12	0.39***	0.14	0.29***	0.08	-0.22*	0.05
Moral injury	5.69***	0.16	0.42***	0.16	0.34***	0.10	-0.33***	0.10

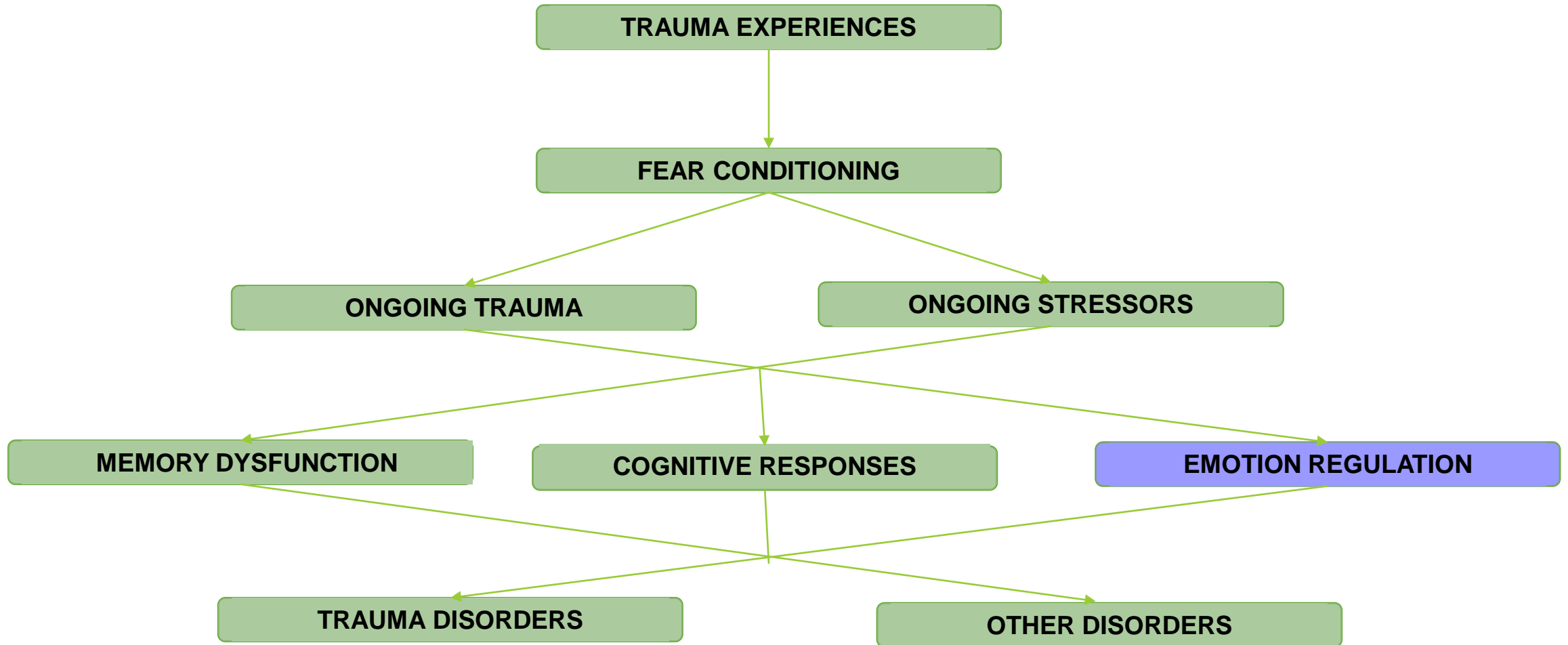
* $p < .05$, ** $p < .01$, *** $p < .001$

Cognitive Responses: Treatment Implications

- Cognitive appraisals may be different
 - May be deeply ingrained after repeated trauma exposure
 - May not be unrealistic
- Contextual challenges in cognitive therapy
 - i.e. Availability of disconfirming evidence
- Emerging evidence for efficacy of CPT with refugees (Schulz et al., 2006)



Pathways to Refugee Mental Health



Refugees and Emotion Regulation

- *“Capacity to monitor, evaluate, and modify emotional reactions in a manner that facilitates adaptive functioning”* (Gratz & Roemer, 2004)
- Emotion regulation may be disrupted by repeated interpersonal trauma (Stevens et al., 2013; Walsh et al., 2011)
- Emotion dysregulation associated with psychopathology, including PTSD, depression, anxiety disorders, anger and aggression (Goldsmith et al., 2013; Besharat et al., 2013)
- Emotion regulation mediates relationship between trauma exposure, living difficulties and mental health outcomes in tortured refugees (Nickerson et al., 2013)



Which Emotion Regulation Strategies are Effective for Refugees?

- PTSD strongly associated with emotional suppression (Seligowski et al., 2015)
- Negative relationship between PTSD symptoms and cognitive reappraisal
 - Observational and experimental studies (Boden et al., 2013; Shepherd & Wild, 2014)
- Cognitive reappraisal underpins CBT interventions



Which Emotion Regulation Strategies are Effective for Refugees?

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Is cognitive reappraisal effective in reducing distress in refugees?

How does this relate to trait emotion regulation?

Which Emotion Regulation Strategies are Effective for Traumatized Refugees?

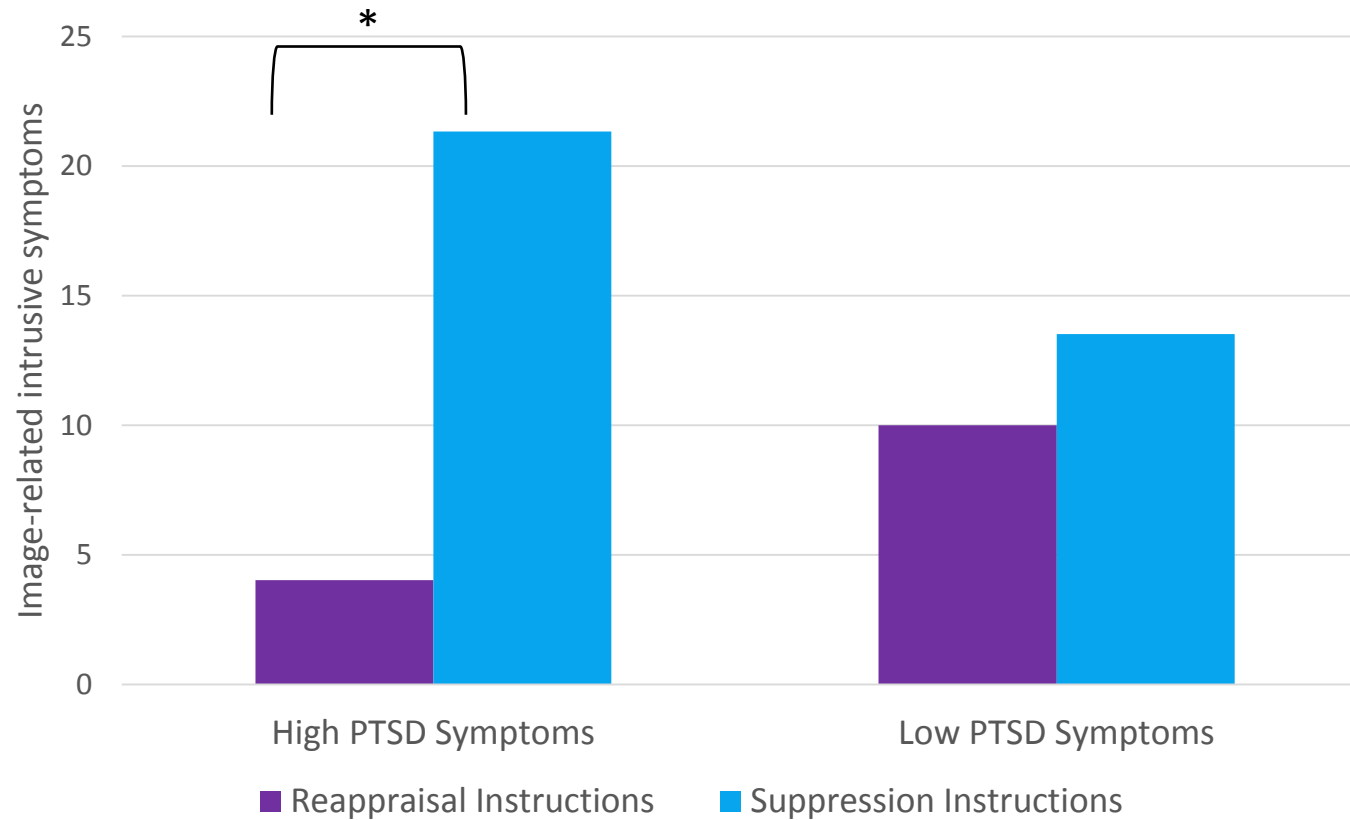
- Experimental study
 - Participants – 70 refugees and asylum-seekers from variety of backgrounds
- Methodology
 - Session One
 - Clinical Interview
 - Session Two
 - Emotion regulation instructions
 - View trauma-related images



Does Reappraisal Reduce Negative Affect?

- No significant differences between reappraisal and suppression in impact on self-reported affect for participants high and low in PTSD

Does Reappraisal Reduce Intrusions?



Refugees and Emotion Regulation: Treatment Implications

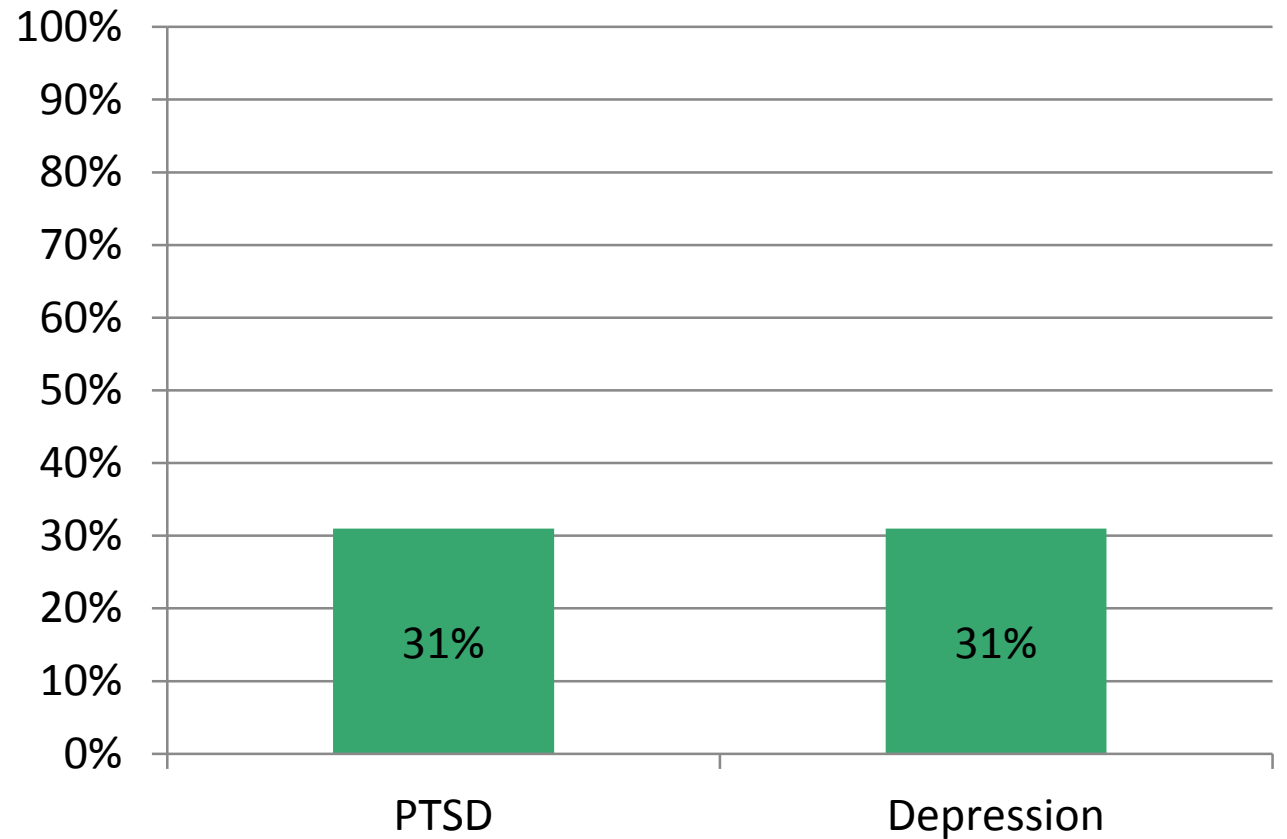
- Suggests that reappraisal may be a useful strategy for reducing distress
 - Enhance existing interventions with cognitive component?
- Emotion regulation difficulties can be contraindications for first-line treatments for PTSD and interfere with treatment response (Forbes et al., 2003; 2008; Foa et al., 1995)
- Phase-based interventions
 - Skills Training in Affective and Interpersonal Regulation (STAIR; Cloitre et al., 2002)
- Promising direction, but needs to be tested with refugees



Iranian Historical Photographs Gallery : www.fourman.com

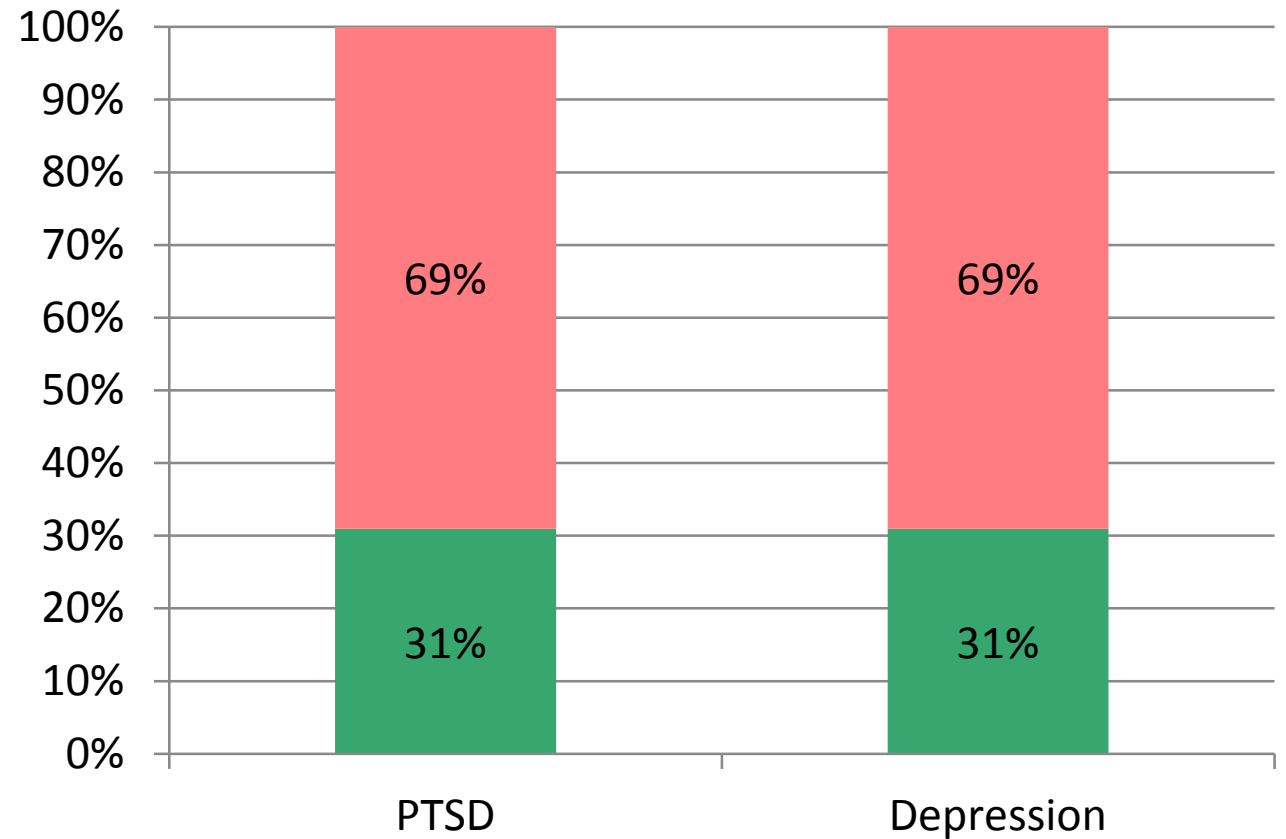
Mental Health of Refugees

○ But, remember.....



Mental Health of Refugees

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Summary & Future Directions

- Refugee context leads to distinctive mental health features
- Important to consider these when planning and implementing treatment interventions with refugees
- Need for more research to understand unique psychological processes underpinning refugee mental health, and to develop and adapt treatments to facilitate recovery in refugees
- Resilience is the modal outcome – need to understand how refugees adapt well following exposure to trauma and displacement if we are to help those who develop psychological difficulties



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