Responding to Psychological trauma in refugees and post-conflict populations:
Is restoring safety enough?

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“It is sad that so many people are suffering the psychological wounds of conflict…but my job is not about curing suffering, nor about making people happy…it is about social and political stabilization, national reconstruction and development. Putting it bluntly, we don’t want this country to be a nuisance anymore – or to cost us economically and militarily. Mental Health is simply not high on the agenda”

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Grand Dilemmas in field:
Why to treat?
Who to treat?
How to treat?

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“So… this PTSD business: why should we care?”
Evidence from the World Mental Health Survey

Days out of role because of health problems are a major source of lost human capital.

Analysis of role of physical and mental disorders in accounting for days out of role in 24 countries that participated in the World Health Organization (WHO) World Mental Health (WMH) surveys.

The strongest individual-level effects (days out of role per year) were for bipolar disorder (17.3) and post-traumatic stress disorder (15.2). The strongest population-level effect was associated with pain conditions, which accounted for 21.5% of all days out of role.

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“Yeah, but the prevalence of PTSD is so high, it’s impossible to treat everyone... so best to focus on something else”

Major variation in prevalence across studies: Measures, sampling, type and quantum of trauma, time since trauma, post-conflict environment (Steel et al, JAMA, 2009): Strictly defined, about 16 percent

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“Won’t they just recover anyway?”

“If PTSD is a learned fear response, an evolutionarily adaptive reaction to life threat, then it should resolve spontaneously once danger has passed. Why do survivors need treatment?”

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General Trajectory of PTSD Symptoms: Disasters (Bonnano)

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Trajectory of PTSD/related disorders for Refugees


Improvement over extended periods of time but residual group with persisting symptoms

(Westermeyer, USA, Beiser, Canada)

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Self-reported psychological distress decreased significantly over time, but a substantial higher proportion of the refugee group still reached threshold scores after 23 years of resettlement compared with the Norwegian population.

The data suggest that refugees reaching threshold scores on measures such as the SCL–90–R soon after arrival warrant comprehensive clinical assessment.

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1.0
6.3*
3.0
0.8
30.0*
12.5*
4.7*
0%
10%
20%
30%
40%
50%
No trauma
0-5 years
5-10 years
10+ years

Number of years since main trauma

Prevalence

- 1-2 trauma categories
- 3 + trauma categories

* Significant increase in risk compared to respondents with no trauma

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Figure 1. Change in average mental health scores after asylum decision

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PTSD rates in Timor Leste

Post-emergency 34%
4 years of peace 2.3%
10 years later, following internal violence 16%

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Why PTSD?: Aren’t there other mental problems related to trauma?

Evidence accruing over last 20 years: *Multiple Comorbidity is the norm:*

1. Depression (comorbidity particularly disabling); prolonged grief
2. Other Anxiety Disorders including Separation Anxiety in Adulthood
3. D&A
4. Somatoform Disorders
5. Culture-specific Reactions
6. Anger attacks, Intermittent Explosive Disorder
7. Psychotic like Symptoms
8. Complex Traumatic Stress:

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What about cultural expressions of distress?

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Sakit Hati: An idiom of distress for anger-resentment in response to injustice
A Syndrome of Anger-resentment amongst West Papuan Refugees

“In traditional times, there were customs to deal with wrongdoing/transgressions – paying compensation or payback – and then feelings of anger were gone. Now when the whole society is suffering injustice there is no redress – so we feel Sakit Hati – sick from anger and resentment.”

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Chain of Anger and violence

Human Rights Trauma → subclinical anger

frustrations/ deprivation

Explosive ANGER

DV Community Wider Society

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“OK, you almost have me convinced”

“But I need a simple language account of the full scope of the problem so that I can convey the message to the funders...they need to understand the impact of the problem on reconstruction and development...otherwise, they won’t be interested...and it won’t help to use fancy diagnostic categories or make it sound like everyone is traumatized and incapacitated.”

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Isolation/marginalization

Loss/Displacement

Legislation/migration policy

Culture, cultural change, spirituality

Trauma

Human Rights

Family disruption and roles

Social and Emotional Well-being

Adaptation vs Psychosocial dysfunction

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ADAPT Psychosocial Model
(Silove, 1999;2004)

Adaptation & Development After Persecution
&
Trauma

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Interacting Social and psychological “pillars” of stability undermined by mass conflict and gross human rights violations

Interrelated threats to:

Safety-security → → PTSD/anxiety

Attachment-bonding → → Grief.

Injustice → → anger

Identity-role → → isolation, liminality

Coherence and meaning → → alienation

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Principles underlying the ADAPT model

1. Mass conflict and displacement undermine the key psychosocial pillars that provide the foundation for stable societies.

2. The social world mirrors and interacts with the personal/psychic world and vice versa.

3. Most psychological and psychosocial reactions are normative not pathological. Interplay of bio-psycho-social-cultural-spiritual factors.

4. Several steps from point of objective threat to psychopathology depending on the interplay of vulnerability and resiliency factors.

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5. Most people and groups are capable of recovering if their psychosocial world is repaired.

6. Recovery is an active process – individuals and their collectives mobilize their own resources (resourcefulness), striving to survive and adapt, rebuilding the damaged pillars (in the social and personal worlds).

7. Posttraumatic “growth” and positive change are possible

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Principles underlying the ADAPT model

8. Ecosocial recovery environment is pivotal to trajectory of symptoms and disability

9. Population level symptoms may be a barometer of how successful the social recovery process is proceeding

10. There is a small but significant number of persons in which maladaptive responses become relatively fixed and unresponsive to improvements in eco-social conditions. In addition, there is a significant number of people with pre-existing disorders that are exacerbated by conflict.
Community Recovery and development

Safety Bonds Justice Identity/roles Meaning

Clinical Traumatology

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Positive outcomes:

• Posttraumatic Growth
• Deepening of experience
• Sensitization to injustice
• Pursuit of just causes
• Compassion and tolerance
• Drive to educate/prevent/reconcile (Levi; Ghandi; Frankl; Bettelheim)
• Transcendent perspective that rises above pursuit of personal ambition, power, possessions

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The PTSD response is a normative evolutionary survival reaction, a barometer of ongoing insecurity/security in societies exposed to mass violence and displacement. Existential issues and the sense of injustice, can add to maintenance of symptoms.

The reaction can become dysregulated in a variable minority so that it is hyper-responsive to environmental cues, generating an inappropriate and persistent learned fear response.

Challenge: Defining the Complex interaction between individual vulnerability and the eco-social environment (ADAPT psychosocial pillars)

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<table>
<thead>
<tr>
<th>PTSD</th>
<th>Severe Distress</th>
<th>Range of Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Rights trauma Indonesian period</td>
<td>+++</td>
<td>Torture, imprisonment, forced separation etc</td>
</tr>
<tr>
<td>Human Rights Trauma Internal conflict</td>
<td>+++</td>
<td>Torture, imprisonment, forced separation etc</td>
</tr>
<tr>
<td>Murder</td>
<td>+</td>
<td>Family, friends</td>
</tr>
<tr>
<td>Ongoing Family/Community Conflict</td>
<td>++</td>
<td>Tensions between spouses, family, neighbours, youth</td>
</tr>
<tr>
<td>Poverty</td>
<td>++</td>
<td>Extreme deprivation and hardship: not enough to feed, clothe children, pay for school, etc</td>
</tr>
<tr>
<td>Injustice over extended periods</td>
<td>+++</td>
<td>Identifying key events and level of distress: occupation, internal conflict, now</td>
</tr>
</tbody>
</table>

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HOW DO WE TURN ALL OF THIS INTO A SCIENCE OF INTERVENTION?

FIELD TRANSITIONING FROM PIONEERING PHASE OF DISCOVERY AND MODEL BUILDING TO AGE OF EMPIRICISM: TESTING OUR TREATMENT MODELS TO ASSESS WHAT WORKS

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55 persons admitted to the Rehabilitation and Research Centre for Torture Victims in 2001 and 2002. No change in mental symptoms or health-related quality of life was observed after 9 months. The minor decrease in some symptoms observed between the 9 and 23 months may reflect regression toward the mean or the natural course of symptoms in this cohort.

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METHODS: An observational study in four specialized treatment centres (in Serbia, Croatia, and Bosnia-Herzegovina). 463 met inclusion criteria, including a diagnosis of PTSD. Treatments were multimodal and not standardized.

CONCLUSIONS: The recovery rate among patients treated in specialized centres for war-related PTSD several years after the war was poor (14%), and symptom improvements were small. Improving recovery rates might require different treatment methods or different service models.

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Possible explanations....?

Multimodal treatments don’t work (!)

No standardization of multimodal treatments – individual therapists doing their own “thing”.

Outcome indices are too restricted: focused excessively on symptoms - what about existential issues, acculturation, feelings of belonging, etc.

The clinic paradox: specialized refugee trauma clinics tend to attract and concentrate the most severe and chronic cases that may not be responsive to multimodal approaches

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Emerging evidence suggests that NET is an effective treatment for PTSD in individuals who have been traumatised by organised violence.

NET has been used to treat asylum seekers and refugees in low and middle-income as well as high-income settings and lay counsellors have been trained to deliver the therapy.

Treatment trials of KIDNET have shown its effectiveness in reducing PTSD amongst children.

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A critical review of psychological treatments of posttraumatic stress disorder in refugees

► Posttraumatic sequelae of refugee experiences suggest distinct PTSD responses in refugees.

► There is a marked lack of controlled trials of posttraumatic stress disorder in refugee populations.

► Current practice of multimodal therapy for refugees lacks empirical support.

► Trauma-focused therapy has the best support, although many aspects need to be better addressed through theory-driven trials.

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Review of reports of mental health and psychosocial support activities (2007–10) and interventions.

In 160 reports, the five most commonly reported activities were basic counselling for individuals (39%); facilitation of community support of vulnerable individuals (23%); provision of child-friendly spaces (21%); support of community-initiated social support (21%); and basic counselling for groups and families (20%). Most evidence in favour of individual trauma-focused therapy which was least often used and little support for psychosocial programs that are most commonly used.

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Sixty-six publications (12 treatment outcome studies and 54 intervention descriptions, covering a range of treatment modalities). Most interventions are evaluated positively, while some studies lack evidence for efficacy and effectiveness.

• Conclusion: Scarcity of rigorous studies, diversity of interventions, and mixed results of evaluations demonstrate a need to identify evidence-based interventions. The literature presents consensus on a number of treatment-related issues, yet the application remains limited across interventions.
Challenges to undertaking intervention research in service setting

- Service pressures and priorities
- Anti-scientism/skepticism
- Challenges in random allocation
- Lack of funding
- Lack of expertise in methodologies
- Ethical constraints
- Organizational structure

But these are not insurmountable obstacles

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Challenges for future

• Ethically and scientifically acceptable: Randomized cluster, waitlist control, RCT comparing two credible interventions, adding a component into one arm of a trial within standard multimodal interventions.
• Embed in assessment of ADAPT framework, assessing non-therapeutic ecosocial factors, fixed and changing aspects.
• Local partnerships and ownership; build research culture and capacity; Multilateral/multidisc teams (aid, university, NGOs); may slow process but investment is worth it
• Research focus on commonly used interventions: Widen scope beyond PTSD and depression. Much greater research focus on psychosocial approaches; complex responses to stress; existential issues; cultural (idioms of distress), psychosis, context-specific functional changes

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Challenges for future

• Integrate etic and emic approaches; develop rapid qualitative assessments of idioms of distress for “new” humanitarian settings

• Research in Real Life Settings; closing the gap between practice, monitoring and evaluation and high quality research

• Utility and timeliness in dissemination of findings; strategies for rapid feedback and implementation vital (funding and resources)