

EFFECTIVE TREATMENT FOR REFUGEE ADULTS WITH POST-TRAUMATIC STRESS DISORDER (PTSD): A SUMMARY OF PRACTICE RECOMMENDATIONS FOR CLINICIANS

WHAT IS PTSD?

PTSD involves a group of symptoms experienced by some people after exposure to a potentially traumatic event such as an assault, intimate partner violence or life-threatening illness.

PTSD SYMPTOMS:

- Re-experiencing the event
- Negative emotions and beliefs
- Physiological and emotional reactivity to reminders of the traumatic event
- Avoiding reminders of the traumatic event



More than 28% of adults exposed to trauma will exhibit symptoms of PTSD one month after a traumatic event and 17% will continue to meet criteria one year later.¹ About 9% of refugee adults in high- and middle-income countries have PTSD, although it is significantly more common in certain communities (e.g., one-third or more of adults who have recently fled armed conflict).^{2,3} PTSD can cause difficulty with social roles, including parenting. Given the impact that a parent's health can have on that of their children, when PTSD affects refugee parents it can also negatively impact their children's psychosocial adjustment and development.^{4,5}

PTSD IS TREATABLE

The good news is that effective treatment improves functioning and reduces the duration and intensity of symptoms.¹ Many treatments also reduce co-occurring psychological symptoms, such as somatic symptoms and depression.⁶ **The bad news** is that almost half of adults with PTSD never get treatment, and of those who do, well over half do not get adequate treatment.¹ Without treatment, PTSD can take as long as 14 years or more to remit.¹

PTSD TREATMENT IS EFFECTIVE

In 2018, the Patient-Centered Outcomes Research Institute (PCORI) published a detailed review of PTSD treatments.¹ They examined 207 English-language studies of psychological and pharmacological treatments and found that many are effective. The review included research with refugees and showed that evidence-based interventions are helpful for adults with different trauma histories and cultural backgrounds.

PTSD TREATMENT IS EVIDENCE-BASED

In the PCORI review, they graded the overall strength of evidence for each treatment as high, moderate, low, or insufficient by examining “five key domains: risk of bias (includes study design and aggregate quality), consistency, directness, precision of the evidence, and reporting bias.”ⁱ **We recommend that clinicians and patients consider treatments for which there is high or moderate overall strength of evidence.**¹

PSYCHOLOGICAL TREATMENTS WITH HIGH STRENGTH OF EVIDENCE

Cognitive Behavioral Therapy (CBT) with Exposure

CBTⁱⁱ with exposure is generally delivered in 12–16 weekly sessions. It focuses on the interaction between a person’s thoughts, feelings and behaviors and changing those that interfere with functioning. Techniques include challenging maladaptive thoughts, encouraging the patient to test assumptions, encouraging engagement in productive activities, and confronting feared stimuli (e.g., talking about a traumatic event) while in a safe environment (exposure). Treatment extinguishes conditioned emotional responses and reduces emotional reactivity to the trauma.

CBT with “Mixed Interventions”

In its review, PCORI used CBTⁱⁱ with “mixed interventions” to denote CBT that includes various components such as coping skills training and exposures.

PSYCHOLOGICAL TREATMENTS WITH MODERATE STRENGTH OF EVIDENCE

Narrative Exposure Therapy (NET)

NETⁱⁱ is generally delivered over 12 or more weekly sessions and was designed to treat complex and repeated trauma (e.g., armed conflict or torture). The therapist helps the patient create a narrative of their life, concentrating on traumatic events, which helps the patient form a cohesive story out of their often-fragmented traumatic memories. It reframes the patient’s role from victim to survivor.

Cognitive Processing Therapy (CPT)

CPTⁱⁱ is generally delivered over 12 one-hour sessions. The patient and therapist write an impact statement and detailed account of the trauma while the therapist helps correct maladaptive thoughts and beliefs. The patient reads this statement in subsequent sessions as a form of exposure to reduce the emotional impact of these thoughts. Therapists can adapt this process for patients who have difficulty reading or writing.⁷

Cognitive Therapy (CT)

CTⁱⁱ is generally delivered over 12–16 weekly sessions. The therapist helps the patient identify thoughts, beliefs and triggers that maintain the PTSD symptoms. The therapist may use questioning to restructure maladaptive thoughts, create contrasts between “then” vs. “now” to reduce the feeling of immediate threat, and help create an autobiographic narrative that provides context to often disjointed traumatic memories.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDRⁱⁱ is generally delivered 1–2 times per week for 6–12 weeks. After working on coping and social resources and assessing the patient’s reaction to the trauma, the therapist asks the patient to imagine the traumatic experience while focusing attention on an external bilateral stimuli (e.g., alternating hand tapping). EMDR reduces the intensity of the memory and increases positive adaptive beliefs, (e.g., “It was not my fault.”)

PHARMACOLOGICAL TREATMENTS WITH MODERATE STRENGTH OF EVIDENCE

Selective Serotonin Reuptake Inhibitors (SSRI)

fluoxetine, paroxetine

Selective Norepinephrine Reuptake Inhibitor (SNRI)

venlafaxine

In placebo-controlled trials, fluoxetine, paroxetine and venlafaxine successfully reduced symptoms of PTSD, sometimes to the point of full remission (paroxetine and venlafaxine). For patients with both PTSD and depression, paroxetine and venlafaxine have moderate evidence for treating both disorders and reducing overall disability. Venlafaxine also has moderate evidence for improving quality of life but may cause nausea.

A Closer Look at Research with Refugee Adults

- PTSD treatment is effective for a wide variety of refugee populations, including resettled refugees with different trauma histories and cultural backgrounds.¹
- Psychological treatment is effective whether delivered via interpreter or bilingual clinician.⁸
- Research specific to refugee populations includes evidence that:
 - » CBT with exposures/mixed treatments and NET were effective with resettled refugees from Africa, Central Asia, the Middle East, Southeast Europe, and Southeast Asia living in the U.S. and Europe.^{9,10}
 - » NET was more effective than supportive counseling and psychoeducation for refugees from the Sudanese civil war living in a settlement in northern Uganda.¹¹
 - » EMDR reduced symptoms of PTSD and depression among adult refugees in Kilis Refugee Camp at the Turkish–Syrian border.¹²
 - » NET was effective among Rwandan and Somali refugees in unsafe settlements.¹³
 - » Taking either sertraline or venlafaxine led to a small, but significant reduction in PTSD symptoms among a group of predominantly Middle Eastern, Central Asian or Southeast European refugees resettled in Denmark.¹⁴

RECOMMENDATIONS FOR CLINICIANS CARING FOR REFUGEE ADULTS WITH PTSD



→ **Ensure that patients are offered effective treatment options.** Offer reassurance that treatment has been helpful to others from similar backgrounds. If appropriate, describe the ways in which treatment can improve family well-being (e.g., child behavior and development), in addition to helping the adult with PTSD.



→ **Set realistic expectations regarding treatment length and experience (e.g., treatment takes time to work).**



→ **When patients are English-language learners, work with qualified interpreters to offer treatment recommendations and deliver care.**



→ **When planning treatment, take into account the needs of adults with limited literacy and post-migration stressors.** Stressors may include ongoing trauma, PTSD triggers, barriers to care and financial difficulties. **Additionally, consider post-migration strengths.** Strengths may include community support, as well as role models who have themselves received successful treatment for PTSD.

ⁱ High: High confidence the evidence reflects the true effect. Further research is very unlikely to change the confidence in the estimate of effect. Moderate: Moderate confidence the evidence reflects the true effect. Further research may change the confidence in the estimate of the effect and may change the estimate.

ⁱⁱ Links to further description and treatment manuals available at: <https://www.apa.org/ptsd-guideline/treatments/index>

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