An eye for complexity: EMDR versus stabilisation in traumatised refugees

Oog voor complexiteit: EMDR versus stabilisatie bij getraumatiseerde vluchtelingen

(met een samenvatting in het Nederlands)

Proefschrift

ter verkrijging van de graad van doctor aan de Universiteit Utrecht op gezag van de rector magnificus prof. dr. G.J. van der Zwaan, ingevolge het besluit van het college voor promoties in het openbaar te verdedigen op vrijdag 30 oktober 2015 des middags te 4.15 uur

door
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te Meppel

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Preface

How safe and effective is it to offer trauma-focused treatment to traumatised asylum seekers and refugees? After all, from a clinical point of view asylum seekers and refugees constitute a complex population, with many suffering from an accumulation of traumatic and current stressors. Consequently, there are fears that with this population trauma-focused interventions may cause unmanageable distress, if not harm, and may prove ineffective. These questions and considerations have played a major role in the scientific and clinical debate on treatment with asylum seekers and refugees who have resettled in western countries. Despite the recommendation proffered by some clinicians that said population should be treated with present-centred or phased treatment rather than stand-alone trauma-focused treatment, trauma-focused interventions such as narrative exposure therapy (NET) and culturally adapted cognitive behavioural therapy (CA-CBT) have in recent years been shown effective with asylum seekers and refugees. To this day, however, there has been no high-quality research into the safety and effectiveness of another trauma-focused treatment of choice, eye movement desensitisation and reprocessing therapy (EMDR).

The fine book you are about to read goes far to fill this hiatus. Its main focus is on the efficacy and safety of EMDR with traumatised asylum seekers and refugees. In addition, it addresses the questions whether traumatised refugees are prone to develop complex PTSD as has been claimed, and whether traumatised refugees as a population are more difficult to treat than are traumatised non-refugees.

The author of this significant study, Jackie June ter Heide, a clinical psychologist and researcher with Foundation Centrum ’45, has succeeded in determining the efficacy and safety of EMDR on the basis of a pilot study among traumatised asylum seekers and refugees followed by a full trial with a larger sample of refugee patients. Outcomes of the pilot study were promising as EMDR appeared at least as efficacious as stabilisation and no EMDR patients dropped out of treatment due to unmanageable distress. In the subsequent trial with traumatised refugees, exposing patients to traumatic memories through EMDR was convincingly shown not to be harmful. In addition, a substantial number of patients benefited from EMDR, although the effect for the group as a whole was clinically small. These findings tie in with evidence for trauma-focused treatment such as NET and CA-CBT, which have been shown to be both safe and effective with refugees.

In a subsequent search for determinants of treatment response in refugees, Ter Heide investigated response to treatment as usual of refugees in comparison with that of patients who suffer from profession-related trauma.This study showed that even though there was no great clinical difference in treatment response between refugees and non-refugees, symptom severity in refugees was a great deal higher than it was in non-refugees, both at intake and after one year. These findings lead the author to sound a cautionary note to the effect that both therapists and refugee patients ought to have realistic expectations about the effects of treatment as usual. She further recommends that if treatment as usual is offered to refugees with severe PTSD this may need to be supplemented with additional treatment that focuses on enhancing quality of life.

The author of this study also explores the assertion that asylum seekers and refugees with complex trauma are at an increased risk of developing complex PTSD. It is foremost on the basis of this claim that trauma-focused treatment is frequently discouraged in refugees with complex trauma. However, Ter Heide's research, importantly, goes to refute this claim. Comparisons of the prevalence of complex PTSD in refugees with that in other trauma-exposed populations such as survivors of childhood trauma point to the conclusion that refugees are, in fact, more likely to be given a regular or no PTSD diagnosis than a complex PTSD diagnosis.

Ter Heide also extensively discusses the implications her findings have for clinical practice. Since complex PTSD should not be assumed to be present in refugees who have complex traumatic experiences, she not only urges careful diagnosis by means of a validated interview but also advocates that, given its proven safety and efficacy, a course of trauma-focused treatment be offered to all refugees.

It is with a sense of great pride that we present this ground-breaking study and share its important findings. We feel it greatly contributes to our understanding of the pros and cons of not only EMDR but of trauma-focused treatment in general with traumatised asylum seekers and refugees.

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Part I
Departure

The psychological aftereffects of displacement by war cannot be understood simply as the product of an acute and discrete stressor, but depend crucially on the economic, social, and cultural conditions from which refugees are displaced and in which refugees are placed.

(Porter & Haslam, 2005, p. 611)

Chapter 1 Introduction

The 'Refugee Problem'

I come from an area where there was a war, and I was in the war, and during the war I was with my children in a concentration camp. The Red Cross liberated me and I came to the Netherlands. In the beginning I thought: I can handle this, I'm going to work. But after a very long time, I just couldn't, mentally and physically. I slept badly, I couldn't deal with people, I wanted to be alone, to have something to do. And later I got physical problems and I could do hardly anything, I didn't feel like it. But still I wanted to work. Then fortunately my colleague and my daughter said: you can't do this anymore. Because I worked but for years I worked in tears.[1]

Throughout history, people have sought to escape the atrocities of war and organised violence by seeking refuge in other countries. In the 20th century, large-scale displacement after World War II prompted the United Nations to seek international agreement on how to safeguard the rights and well-being of refugees (e.g. Mooren & Braakman, 2012). In recent decades, this agreement has frequently been put to the test as refugee numbers have again peaked as a result of war and armed conflict in the former Eastern bloc, the African continent and the Middle East. Sometimes the refugee problem catches the public eye, such as when boats sink and bodies are washed ashore. Oftentimes, the plight of refugees is hidden. Many refugees struggle to attain the levels of well-being that the United Nations seek to promote. Mental health is an essential element of that well-being, and as such, nation states have a moral obligation to promote mental health in refugees. The desire for mental health and mental healing is shared by people all over the world, regardless of culture (Kleinman, 1980). However, the strategies by which these may be obtained may differ. This thesis is about the effort to help refugees deal with mental trauma through the use of a western method of healing, Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 2001).

Refugee Mental Health

I asked for help at Centrum '45 when my past was bothering me. I was in prison for five years because of my political activities. I remember that I left my work and I called Centrum '45 in tears. I felt powerless, I said I just need help, I have so many nightmares about the past. I also felt so much guilt, because my cell mate was no longer alive, and I was deeply unhappy. That is why I called.

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[1] Excerpts are, with permission, taken from interviews with refugee patients treated at Centrum '45.