Refining an Ecological Model of Refugee Mental Health

Derrick Silove

Scientia Professor,
University of New South Wales
Do Something!
CHALLENGES: Clouds on the horizon

Unresolved policies on asylum seekers; informed acts of cruelty cannot be used as a policy instrument.
Ambiguity in western commitment to the prohibition of torture since WoT.
General attenuation of commitment to human rights (indefinite detention of suspects, etc).
(“The person who is willing to exchange his/her liberty for security doesn’t deserve either”: Thomas Jefferson)
Boundary between refugees and voluntary migrants “blurred”.
Rise of anti-immigration, ethnocentric forces in traditional recipient countries (Who can be righter than far right?).
Challenges in funding support for services; loss of commitment?

The Mental Health Challenge

65 million refugees worldwide
Majority in low income countries: limited professionals and resources in mental health.
PTSD and Depression: broadly defined 30%; narrowly defined: 15%.
Yet ongoing controversies in the field:
1. Don’t treat – cultural imperialism:
2. social interventions are all that is needed – natural recovery.
3. social therapy vs clinical: avoids stigmatization;
4. Treat trauma or psychosocial resilience building?;
5. PTSD or range of disorders?;
6. individual, couple, family, special groups?;
7. severe mental disorders?

Steel, Z et al. (2009). JAMA
The Challenge

*Diversity of needs*: general psychosocial (shelter, food, water, general health); special/vulnerable groups (torture survivors, women survivors of GBV, child soldiers, asylum seekers, etc); traumatic stress, moderate to severe/complex; severe mental illness; drug and alcohol; brain injury/disorders.

*No single approach and no single agency* can meet all these needs: requires comprehensive models, coordination and networking of helping agencies working in close partnerships with refugee communities.

Need for a shared organizing framework
Assets: 1. Our strengths

Solidarity, identity and commitment.
Growing consensus and cooperation globally.
Evolving ecological model, supported by research providing a firm foundation for the field:
Transition from a pioneering movement driven by ideals, passion and commitment in an evidence free environment, to one strengthened and consolidated by an increasingly shared model buttressed by supportive data.
Assets 2: Growing international cooperation

UNHCR, WHO, BINGOS (big international NGOs): SPHERE, IASC, mhGAP, specific guidelines for humanitarian emergencies: multisectoral approach emphasized

Greater consensus and convergence in models, priorities and approaches across torture and trauma services (see successful IRCT conference in Mexico/strong, visionary, and inclusive leadership).
Assets 3: Convergence around an Ecological Model

Draws on a wide range of disciplines: systems theory, social ecology, human rights, developmental theory, traumatology, anthropology, evolutionary theory, mental health...

Consensus around a multi-systems approach: reciprocal, dynamic interaction involving individual, the small group (family, kinships), and larger systems (institutions, national, geopolitical).

**Bronfenbrenner Ecological Systems Theory:** The ecology of human development is the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded.
COMPREHENSIVE STARTTS MODEL

- Traumatic experiences in the context of organised violence
- Exile, Migration & re-settlement process
- Normal life cycle
- Emotional, psychological, cultural, educational and experiential baggage (individual, family or community)
- Suprasystem (Australia)
A bio-psycho-social systemic approach

- Training service providers
- Advocacy
- Awareness raising
- Liaison with media/other agencies
- Consultancy
- Community education

- Family therapy
- Family support
- Youth program
- Workshops for parents

- Support groups
- Community development projects
- Settlement information workshops
- Youth program
- Excursions
- English & craft classes

- Community development projects
- Advocacy support
- Consultations
- Information/community education

- Assessment and Counselling
- Physiotherapy
- Psychiatric assessment/treatment
- Group therapy/treatment
- Neurofeedback therapy
Assets 4: Developing an Evidence Base

PRTU-STARTTS partnership:
From a static epidemiology towards a dynamic, ecological model drawing together theory, policy, clinical and psychosocial observations and priorities.
1. RECOGNIZING AN UNFOLDING AND INTERRELATED SEQUENCE OF TRAUMA
Largest cohort of antenatal women studied in a post-conflict country: 10 years after major conflict; 3-4 years after internal conflict in Timor-Leste
Depression on Edinburgh Depression Scale

No IPV or patriarchal: 14%

Severe psychological IPV alone: 16%

Physical IPV alone: 14%

Severe psychological and physical IPV: 25%

Severe psychological and physical IPV + >4 conflict-related trauma: 48% (OR 9.8)

2. Recognition of the interaction of past trauma and ongoing impact of post-traumatic stresses.
SEEKING ASYLUM-TRAUMA, LOSS AND IMMIGRATION DETENTION
Symptom trajectories of refugees and persons on TPV

NB1: All means adjusted for age, NB2: All axes display minimum and max values for measure
3. Impact of DAMAGED PSYCHOSOCIAL PILLARS
War destroys more than lives and property. It destroys the psychosocial fabric of societies...
Community Recovery and development

Safety Bonds Justice Identity/roles Meaning

Clinical Traumatology

Human Rights
Examining the broader psychosocial effects of mass conflict on PTSD symptoms amongst West Papuan refugees

4. WHO TO TREAT?: Differentiating high levels of distress which may be self-limiting from frank mental disorder.

Cross-sectional and short-follow-up studies in adverse conditions (immediate post-conflict/postmigration) inadequate.

Critical for public health/planning to allocate scarce mental health resources to those who are least likely to recover spontaneously.
6 year follow-up in Timor-Leste: Distinction between persisting, new onset and recovery classes

**Persisting morbidity** (n=74, 7.2%)
- High Conflict-related trauma during Indonesian times/Emergency
- Poverty
- Sense of injustice
- Family conflict

**Incident/New Onset** ((n=380, 37.2%)

5. Guiding Policy and Social Programs: Reinforcing the importance of potentially modifiable social determinants of mental distress to guide policy.
Representative, nationwide study in post-conflict Sri Lanka (>20,000 persons): focus on *modifiable factors*: Population Attributable Factor or RISK indicates the extent to which modifying risk factor may avert mental distress

Risk factors for anxiety and depression:
- Food insecurity
- Unemployment/job loss
- Lack of access to health services
- No educational opportunities

**Protective factors (overwhelming)**
- Increased security in the community

One year follow-up: almost 50% remained symptomatic.
- (past trauma a risk factor)
- Access to health care an important protective factor
- Job loss a major risk factor

6. MAKING MENTAL HEALTH KNOWLEDGE RELEVANT TO THE OVERALL RECOVERY MISSION: LINKING PERSONAL RESPONSES TO TRAUMA TO IMPACTS ON FAMILY AND (POTENTIALLY) RECOVERY OF SOCIETY AS A WHOLE
THE NEXUS BETWEEN INJUSTICE AND CHRONIC EXPLOSIVE ANGER (3rd PILLAR OF ADAPT MODEL): Towards a Cycle of Violence Model
The Salience of Anger

• Reconciliation process in Timor Leste: Angry widow: “They made P pay me five chickens for burning down my house...but what about the big fish who tortured and murdered my husband...they are living without any punishment in Indonesia!”

• Policy advisor, major donor: Yeah, I don’t know much about PTSD but what we have here is a major problem with anger and aggression: in the home, on the street, at work, and between communities – this is a powderkeg waiting to erupt...can you do anything to help? (civil conflict occurred 3 years later).
Epidemiological study of two villages in Timor-Leste

High rates of explosive anger: approx 40%: Angry subpopulations 1. Young urban adults, unemployed, high levels of trauma during humanitarian crisis; 2. Older men, very high levels of trauma (past resistance fighters); 3. women of various ages.

Study done in 2004: internal conflict 2006-7, chief actors were veterans of resistance war and disaffected urban youth!
Prevalence of Post-traumatic disorder (PTSD), Severe psychological distress (K10) and Explosive anger at baseline (2004) and follow-up (2010)

![Bar chart showing prevalence of PTSD, severe psychological distress, and explosive anger at baseline and follow-up.](chart.png)
Testing a cycle of family violence model in conflict-affected, low-income countries: a qualitative study from Timor-Leste.

Mothers with explosive anger reported high rates of IPV. Anger attacks seen as an illness with physical and emotional symptoms, requiring treatment. Patriarchal attitudes and husband’s trauma were held responsible. Uncontrollable anger was associated with harsh parenting (sometimes justified).

In press: Women with grief and anger: extensive exposure to atrocities/traumatic losses; deprivation and poverty; past and current sense of injustice; and family conflict.

A cycle of attachment trauma: traumatic loss of family in setting of gross human rights violations (in collectivist society) \(\rightarrow\) persisting grief and anger \(\rightarrow\) future family conflict (and potentially further damage to primary relationships).

A DYADIC ANALYSIS

Study of couples in Timor-Leste

1. Where one survivor with severe trauma ➔ partner had higher rates of grief and explosive anger.

2. Where man had severe trauma ➔ woman partner had very high rates of PTSD (but not vice versa).

3. In path model, the man’s preoccupation with injustice ➔ woman partner’s PTSD (but not vice versa)

Injustice (m) 

During Indonesian occupation 

Post-independence 

Current 

PTS symptoms (m) 

Anger attacks (m) 

Witnessing murders (m) 

Injustice (f) 

During Indonesian occupation 

Post-independence 

Current 

PTS symptoms (f) 

Anger attacks (f) 

Witnessing murders (f) 

Family conflict (m) 

Family conflict (f)

A well-recognized sequence of brooding, withdrawal, resentment/grief, and potential for explosive anger which is damaging to self (suicidality, alcohol abuse, risk taking) and others (family, wider network).

Customary law specified resolution of grievances by reparation, reconciliation rituals, penalties, restricted warfare. Where total society is dominated by external oppressors, no recourse to justice → chronic Sakit Hati.
Culturally Adapted, Trauma Focused Explosive Anger Therapy, Hewage et al.

- FIRST THERAPY SESSION; Introduction; Therapist Assessments; Rationale for Treatment Components; Psycho-education; Introduction to Anger Management Techniques;
- SECOND THERAPY SESSION; Mapping Anger and Trauma, Introduction to Simple and Brief Trauma focused Cognitive Behaviour Therapy (TF-CBT), Psycho-education; Mindful Breathing Exercise
- THIRD THERAPY SESSION; Introduction to the “Life Line Technique”; Introduction to Resilience and Self-healing; Atoi’s Story – Discussion and Analysis; (Continuation of Simple and Brief TF-CBT); Mindful Breathing Exercise
- FOURTH THERAPY SESSION; Psycho-education on resilience building and self-healing; Continuation of Simple & Brief TF-CBT; Mindful Breathing Exercise
- FIFTH THERAPY SESSION; Further review of the worst anger episode/s and related trauma through Simple and Brief TF-CBT using Atauro Dolls; Mindful Breathing Exercise
- SIXTH THERAPY SESSION; Simple and Brief TF-CBT using Atauro Dolls-Finalization; Discussion of the emergency plan and goal setting post therapy
- SEVENTH THERAPY SESSION; Discussion with the client and the trusted family member/ friend; Conclusion of Simple and Brief TF-CBT; Finalization of the emergency plan and therapy
Challenges ahead

Strive to achieve consensus in our comprehensive frameworks of understanding, capturing the full experiences of torture/trauma survivors, their families and communities – makes sense to survivors, communities, service providers, donors and wider world (sensitive balance between simplicity and complexity).

Align theoretical framework, design and implementation of therapies/rehabilitation with this framework.

Demonstrate direct and indirect links between the focus and outcomes of rehabilitation services and the broader goals of promoting community cohesion, family harmony, prevention of transgenerational effects, peace-building, reconstruction and development.

Speaking not only in “our” language but also the language of policy-makers, donors, program designers and implementing partners.

AIM: To place the promise of the right to rehabilitation for ALL survivors of torture and mass trauma at the centre rather than the periphery of humanitarian/recovery programs.
Constellation of Grief and Anger in Timor-Leste

Grief class (25%) and Grief-Anger class (25%):
Women
Witnessing atrocities
Traumatic Loss
(Not general trauma)
poverty
Injustice in past

Grief-Anger only:
Extreme deprivations during time of conflict
Injustice now
Family Conflict