

**Current issues and controversies in
rehabilitation of war and torture survivors:
Reflections on past work and prospects
for brief treatment**

Metin Basoglu, MD, PhD

***Section of Trauma Studies, Institute of Psychiatry
King's College London &
Istanbul Centre for Behaviour Research and Therapy –
ICBRT / DABATEM***

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Issues in rehabilitation of torture survivors

Year 1988

- Current rehabilitation programmes lack evidence of effectiveness
- Evidence-based approach in choice of treatments and outcome evaluation essential

Basoglu & Marks (1988) Torture. Research needed into how to help those who have been tortured. *British Medical Journal*, 297,1423-4.

Issues in rehabilitation of torture survivors

Year 2006

- Current rehabilitation programmes lack evidence of effectiveness
- Evidence-based approach in choice of treatments and outcome evaluation essential

Basoglu (2006) Rehabilitation of traumatised refugees and survivors of torture - After almost two decades we still do not use evidence based treatments. *British Medical Journal*, 333:1230-1231.

17 years later

A study finding from Rehabilitation Centre for Torture Victims in Denmark:

No improvement in torture survivors in traumatic stress problems and torture-related chronic pain in parts of body after 9 months of multi-disciplinary rehabilitation.

Carlsson et al (2005) A Follow-Up Study of Mental Health and Health-Related Quality of Life in Tortured Refugees in Multidisciplinary Treatment. *Journal of Nervous and Mental Disease*, 193, 651-657.

Olsen DR. (2006) Prevalent pain in refugees previously exposed to torture [PhD Dissertation], University of Aarhus.

EU sponsored evaluation of torture rehabilitation centres

Evaluated centres:

- Primo Levi (France)
- Medical Foundation of the Care of Victims of Torture (UK)
- EXIL – Centre médico-psychosocial pour des personnes exiles et pour des victims de torture (Belgium)
- Medical Rehabilitation Centre for Torture Victims (Greece)
- CVICT - the Centre for Victims of Torture (Nepal)
- CAPS – Centro de Atencion Psicosocial (Peru)
- Human Rights Foundation (Turkey)

Evaluators:

van Willegen et al (2003), Guillet et al (2005) & van Willigen (2007)

Conclusions of an evaluation report

- *“lack objectively verifiable indicators to monitor the work undertaken...*
- *there is some reluctance and / or lack of knowledge on how to identify evaluation tools and indicators to measure and assess the impact of the work...*
- *the impact on patients is difficult to assess in quantitative terms” and*
- *...in most cases the centres have very little impact on primary prevention [of torture].”*

Guillet et al (2005) Torture rehabilitation centres Europe. Human European Consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights.

[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

A learning theory model of torture trauma

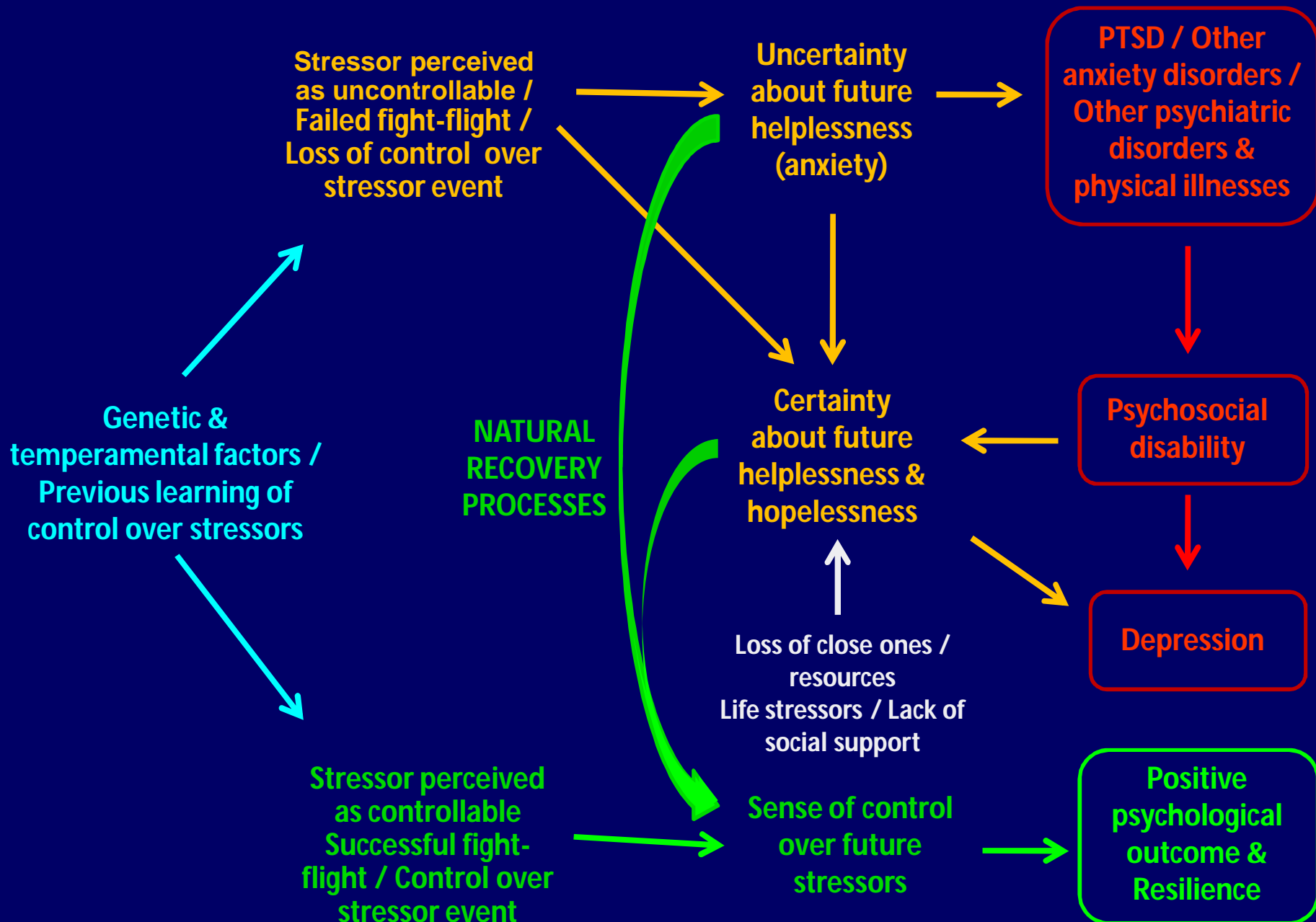
Basoglu & Mineka, 1992, The role of uncontrollable and unpredictable stress in post-traumatic stress responses in torture survivors. *In Torture and Its Consequences: Current Treatment Approaches*. Cambridge University Press.

[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Before trauma

During trauma

Post-trauma Outcomes



5 studies of Control-Focused Behavioural Treatment (Total 339 cases)

- Generalised improvement in PTSD / depression and functional impairment in 80%-90% of survivors in 3 months after a single session
- Increased resilience
- Treatment can be delivered by a self-help manual

Baçoğlu et al. Psychological Medicine, 2003; American Journal of Psychiatry, 2003; Journal of Traumatic Stress, 2005; Psychological Medicine, 2007; Journal of Behaviour Therapy and Experimental Psychiatry, 2009

Feared or distressing situations in torture survivors

- authority figures
- electrical appliances
- medical investigations or procedures
- interviews resembling interrogations
- police officers / military personnel
- people that resemble the torturers in some way
- police cars
- crowded places
- staying alone at home
- news about violence, etc
- Objects, smells, tastes, tactile sensations that act as reminders of torture experience

**Implications of findings for
rehabilitation of torture survivors:**

Brief treatment of torture survivors is possible

[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Debate on torture rehabilitation
British Medical Journal, 2006-2007

Main argument:

Relative to other traumas, torture is more complex
and therefore more difficult to treat.

[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Criteria for comparison between traumas

- Mechanisms of traumatic stress: How they exert their impact
- Duration and severity of trauma exposure
- Mental health outcomes
- Phenomenology, e.g. symptom profile, severity of symptoms, other comorbid conditions
- Response to treatment

Mechanisms of traumatic stress in war, torture, and natural disaster trauma

Strongest predictor of PTSD and depression:

Loss of control (helplessness) during and after trauma

Basoglu et al, American Journal of Psychiatry, 1994

Basoglu et al, Journal of American Medical Association, 1994

Basoglu et al, Psychological Medicine, 1997

Basoglu et al, Journal of American Medical Association, 2005

Basoglu et al, 2007, Archives of General Psychiatry

Salcioglu, PhD thesis, 2004

Severity of trauma exposure

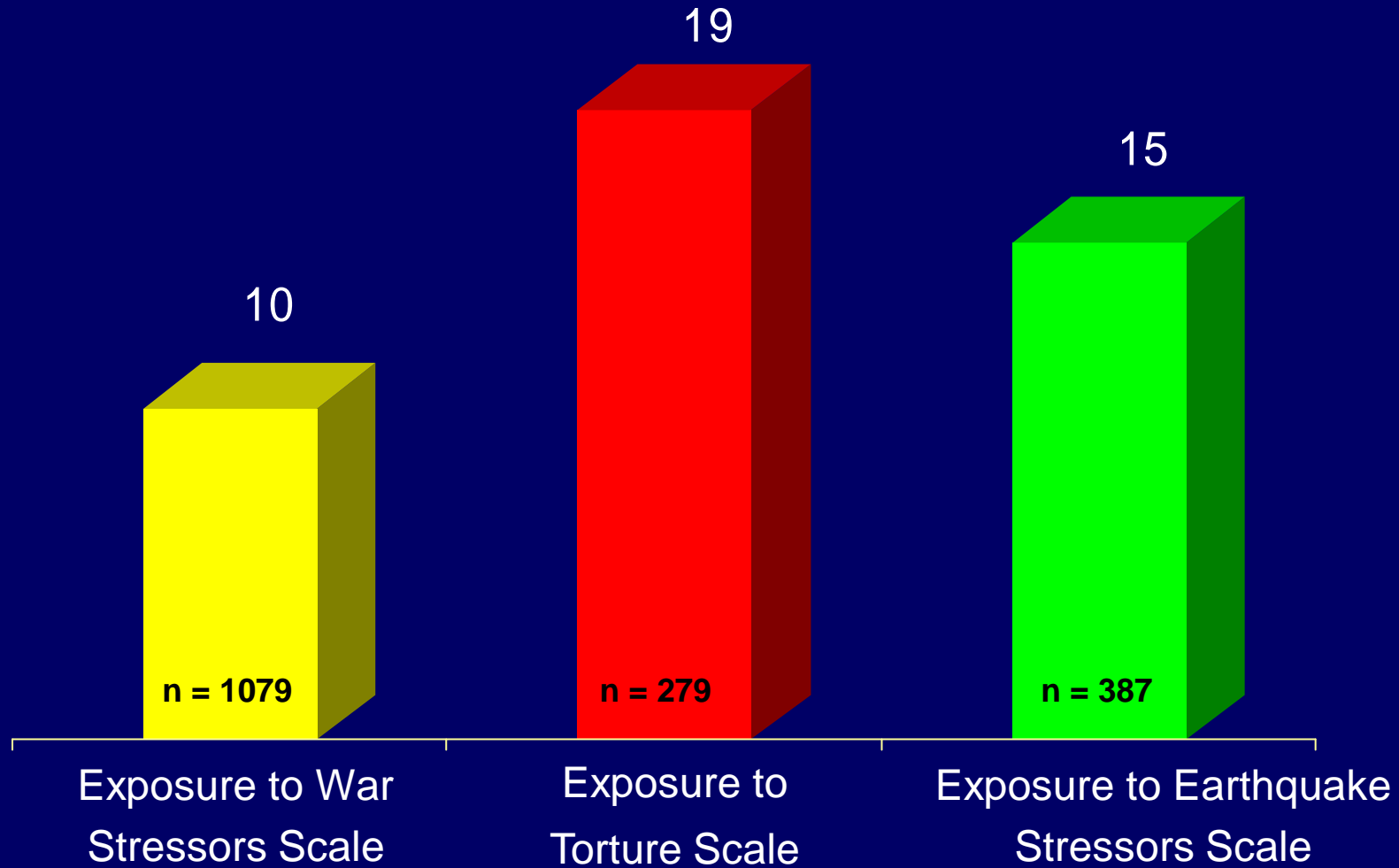
Argument:

- Earthquake is a single trauma event.
- War / torture survivors endure more severe and prolonged trauma.

An important point overlooked

Perceived uncontrollability of stressors more important predictor of traumatic stress than mere exposure to stressor events

Number of stressors reported



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Mental health outcomes of trauma

Argument:

PTSD is only one of many outcomes of trauma
and thus should not be focus of treatment.

(Official WHO position)

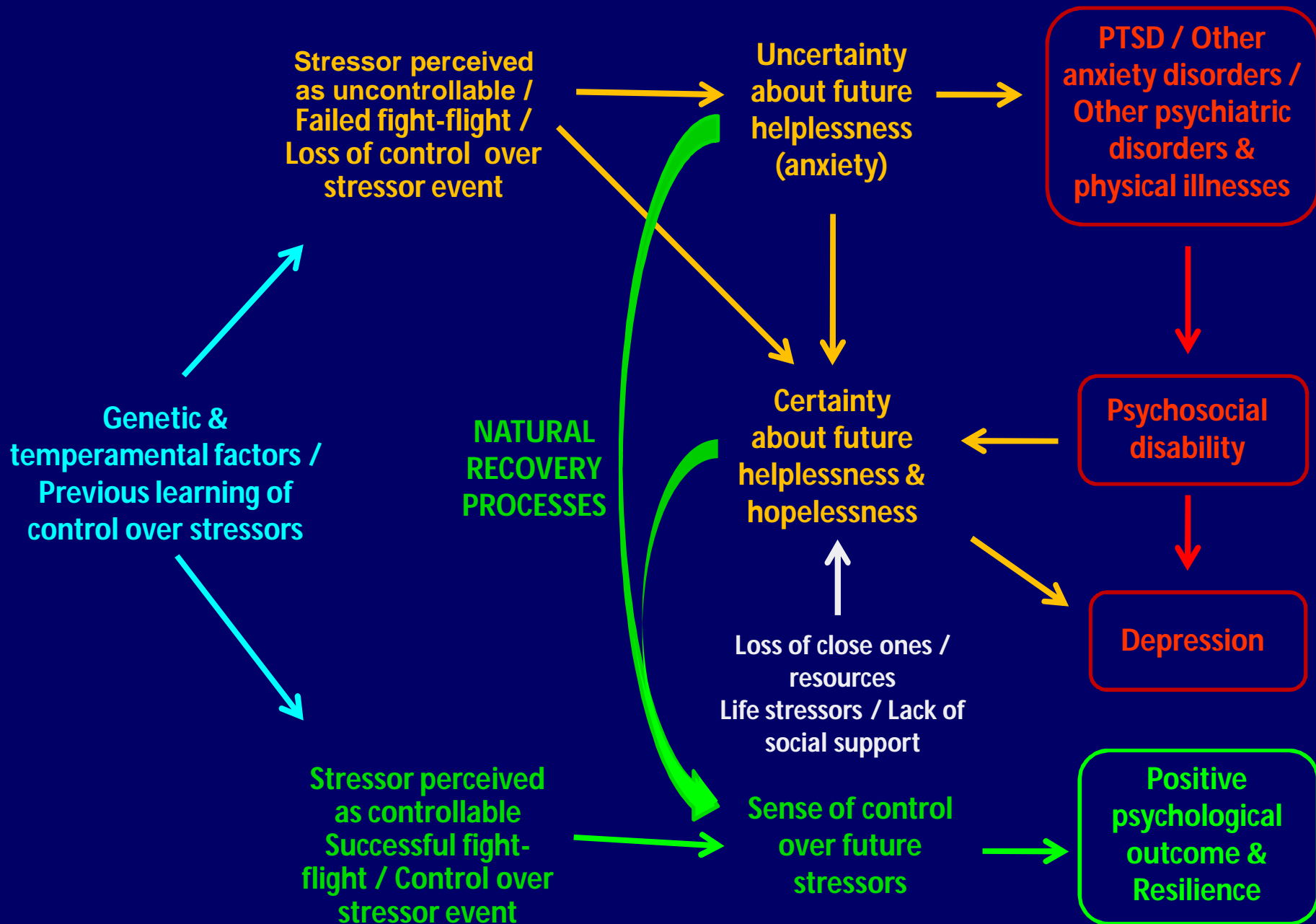
Common error in thinking

Traumatic stress = PTSD

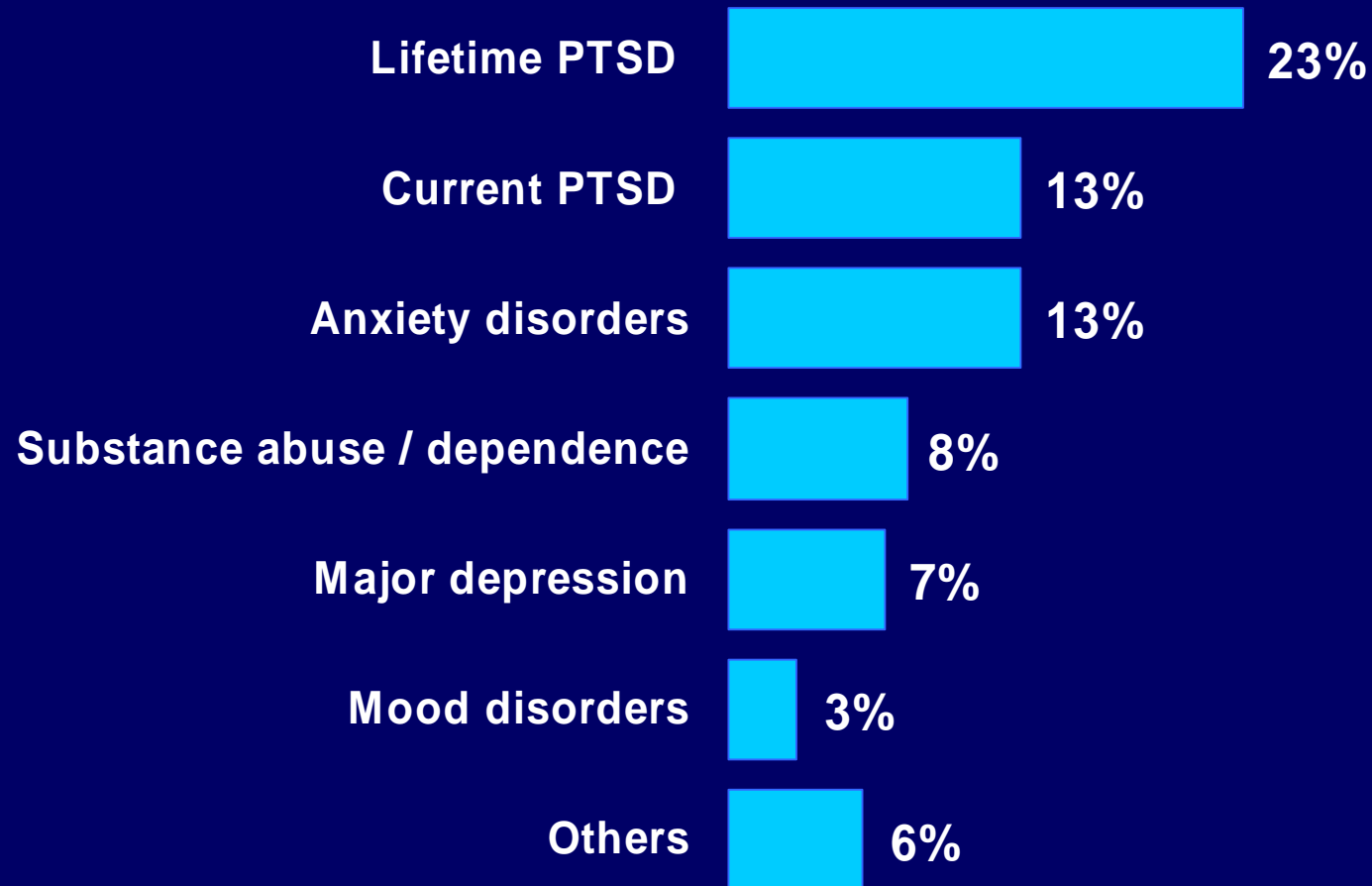
Before trauma

During trauma

Post-trauma Outcomes

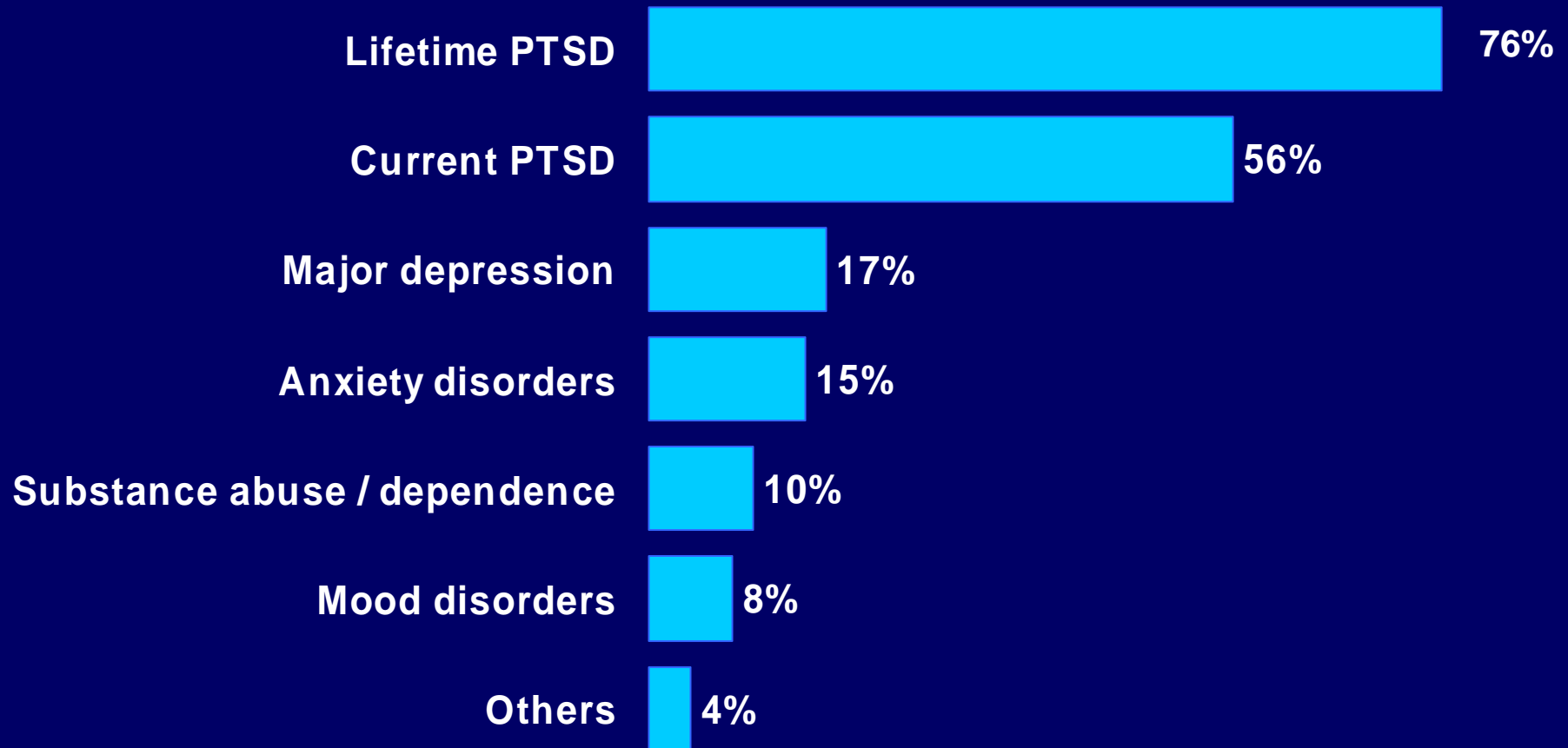


SCID diagnoses in war survivors (n = 1,079)



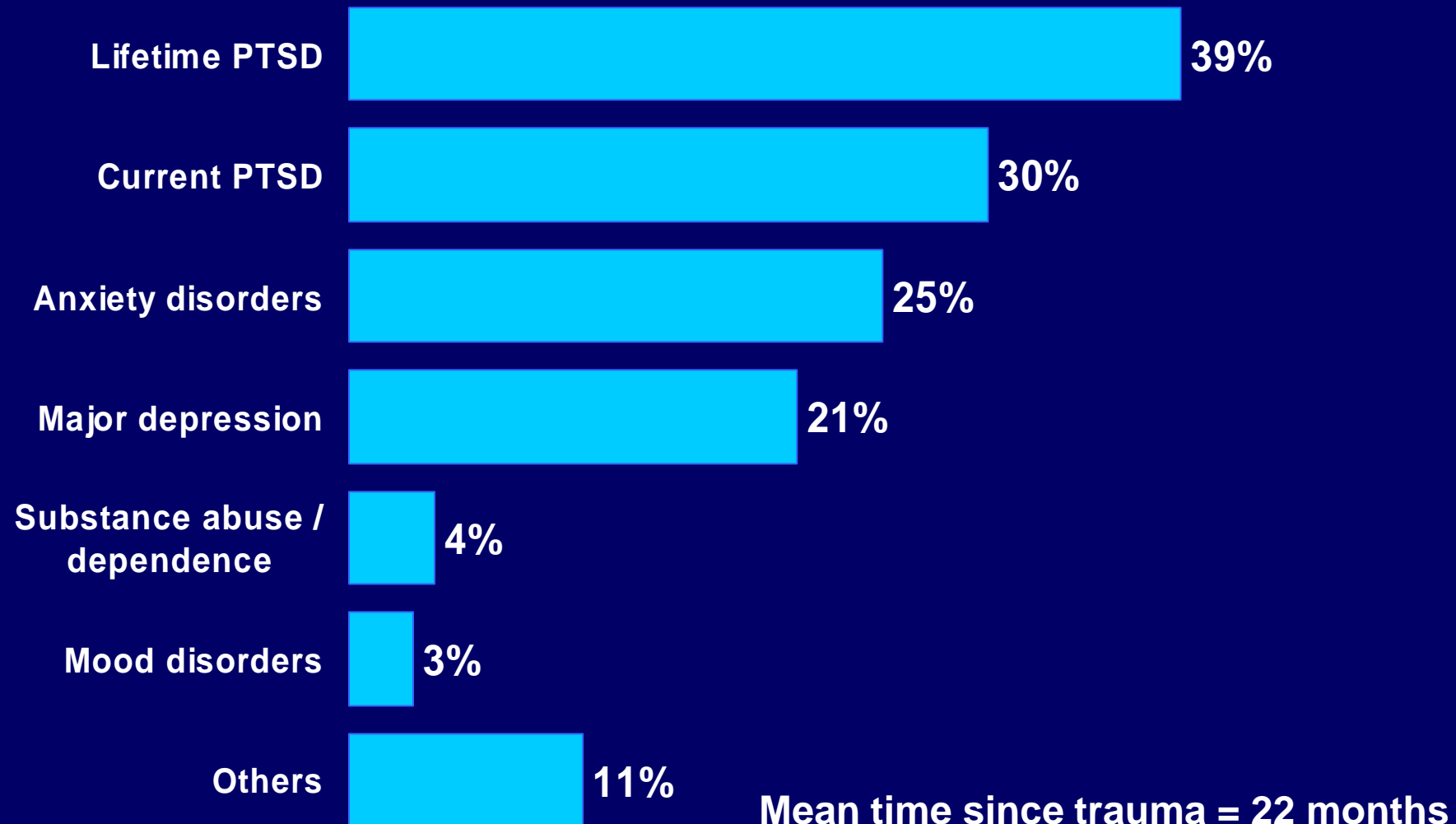
[M Basoglu, 11th European Conference on Traumatic Stress, Oslo, June 17, 2009] **Mean time since trauma = 77 months**

SCID diagnoses in torture survivors (n = 230)



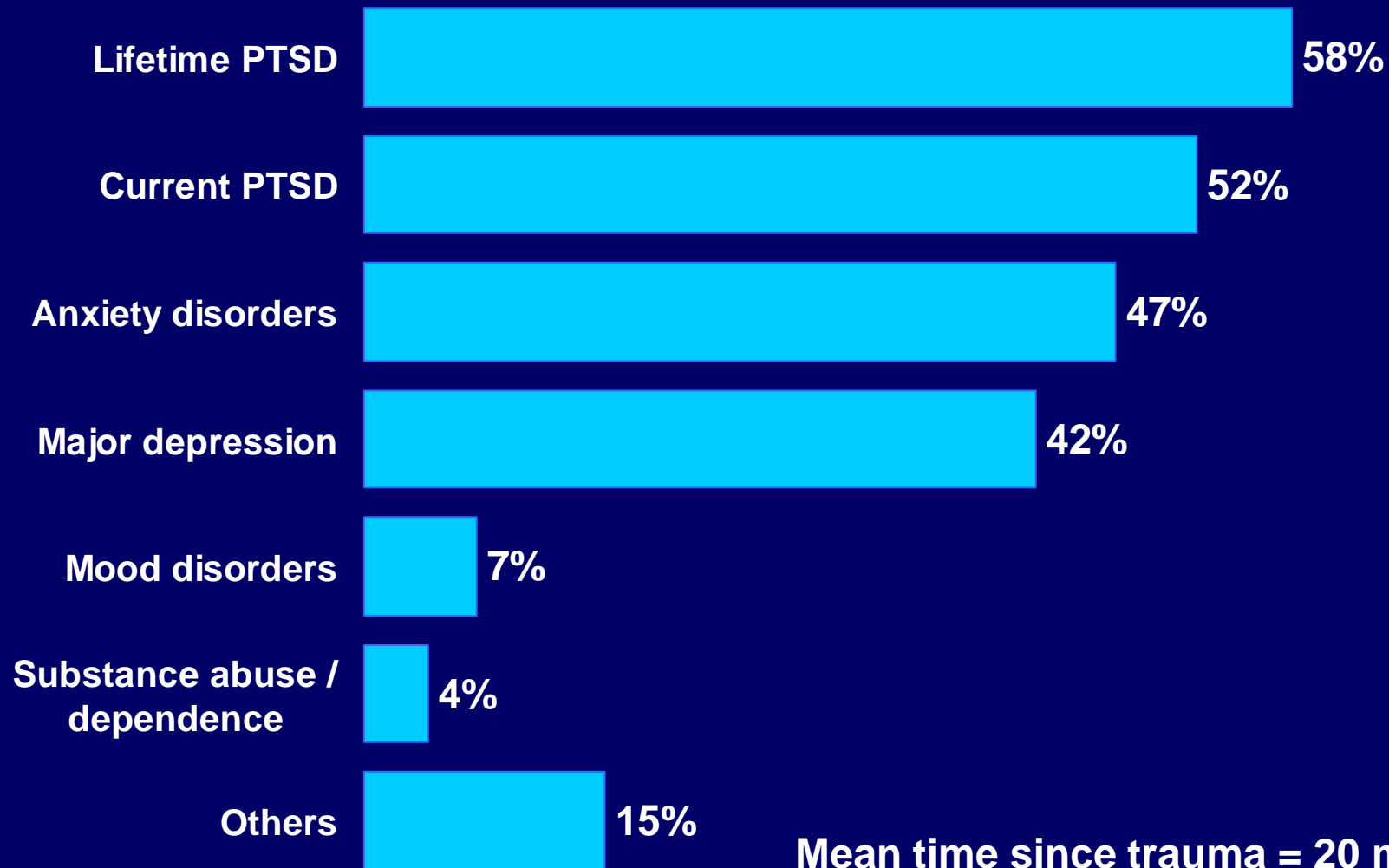
Mean time since trauma = 95 months

SCID diagnoses in non-treatment-seeking earthquake survivors (n = 188)



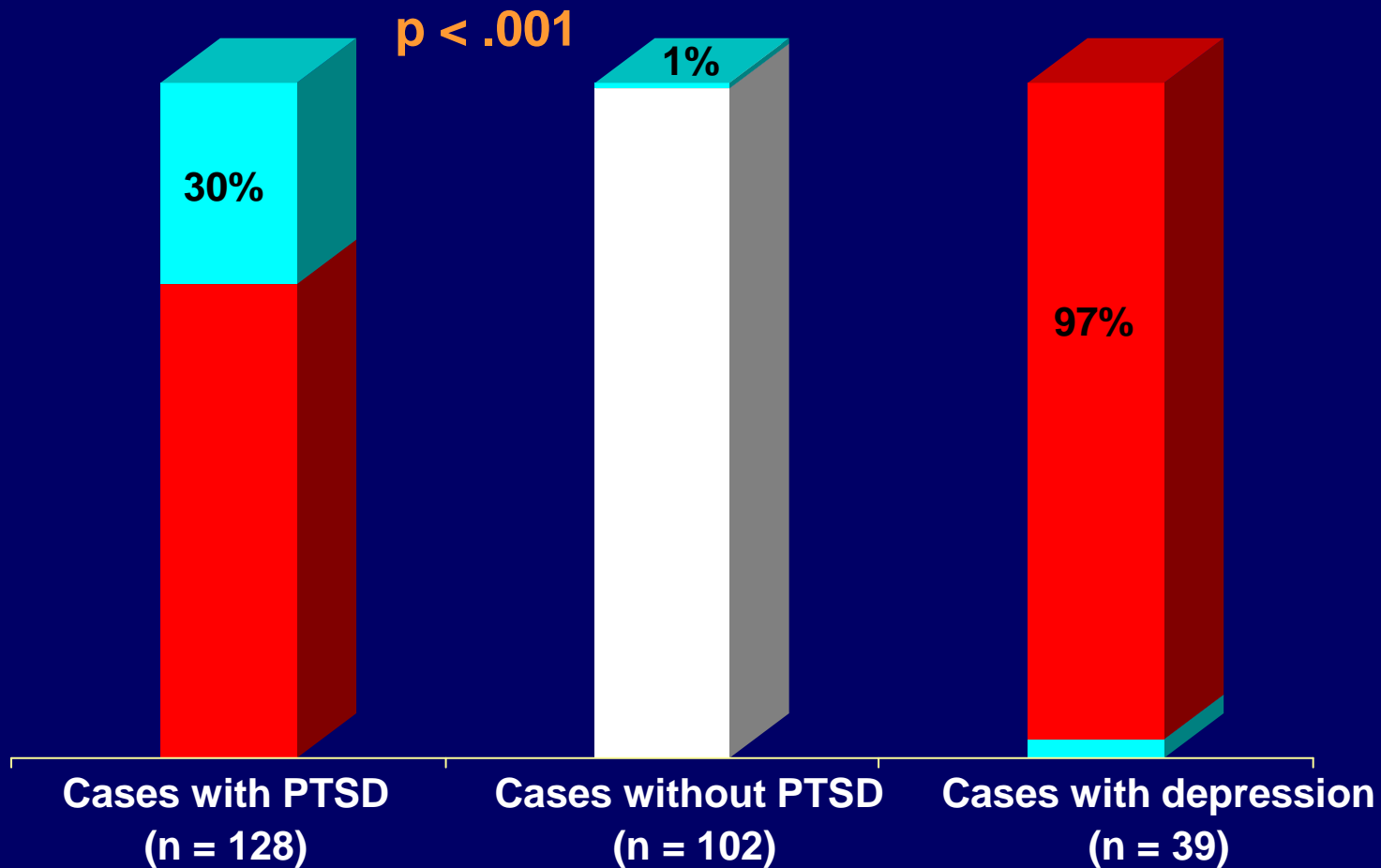
[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

SCID diagnoses in treatment-seeking earthquake survivors (n = 199)



Traumatic stress is associated with depression in torture survivors (n = 230)

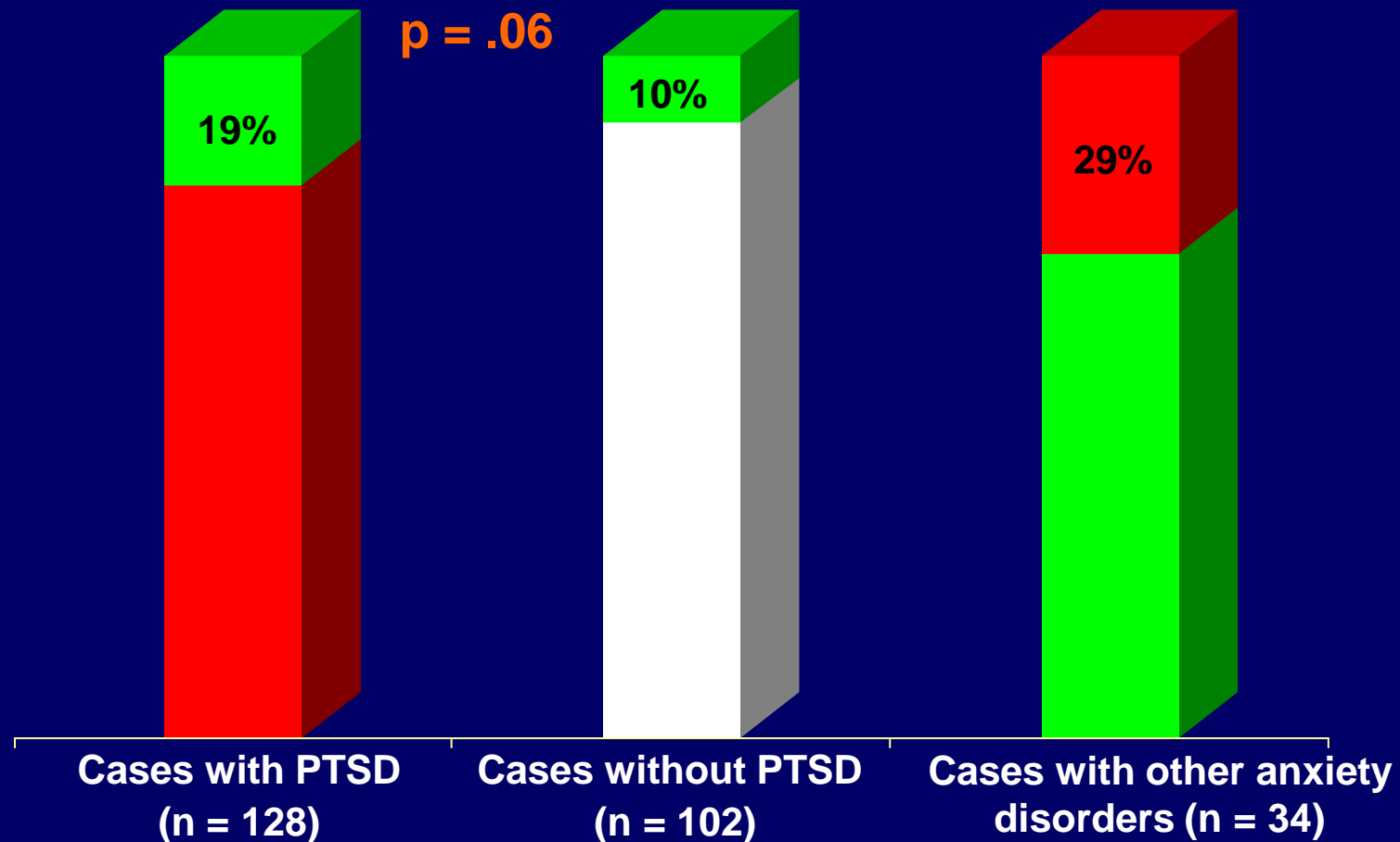
■ PTSD ■ Depression ■ Non-PTSD



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Traumatic stress is associated with anxiety disorders in torture survivors (n = 230)

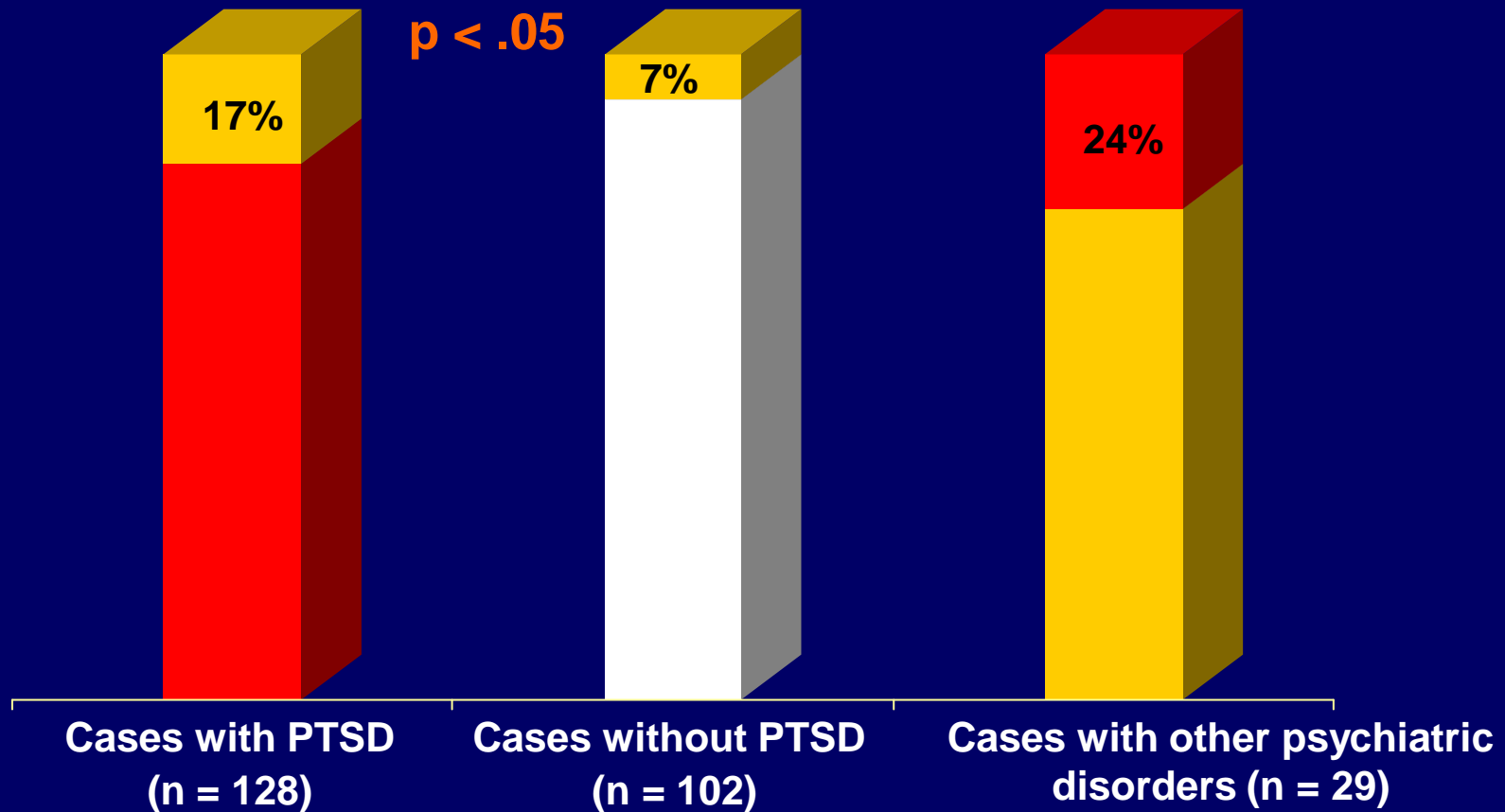
■ PTSD ■ Other anxiety disorders ■ Non PTSD



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Traumatic stress is associated with other psychiatric disorders in torture survivors (n = 230)

■ PTSD ■ Other psychiatric disorders ■ Non PTSD



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Implications for treatment

Interventions that reverse traumatic stress
would reduce all psychiatric and physical
outcomes of trauma.

Thus,

a trauma-focused approach is essential.

Nature and severity of cognitive effects of trauma

Argument:

In contrast to natural disasters, traumas of human design have severe cognitive effects (e.g. sense of injustice, loss of faith in people, etc).

Cognitive profiles of war, torture, and earthquake survivors

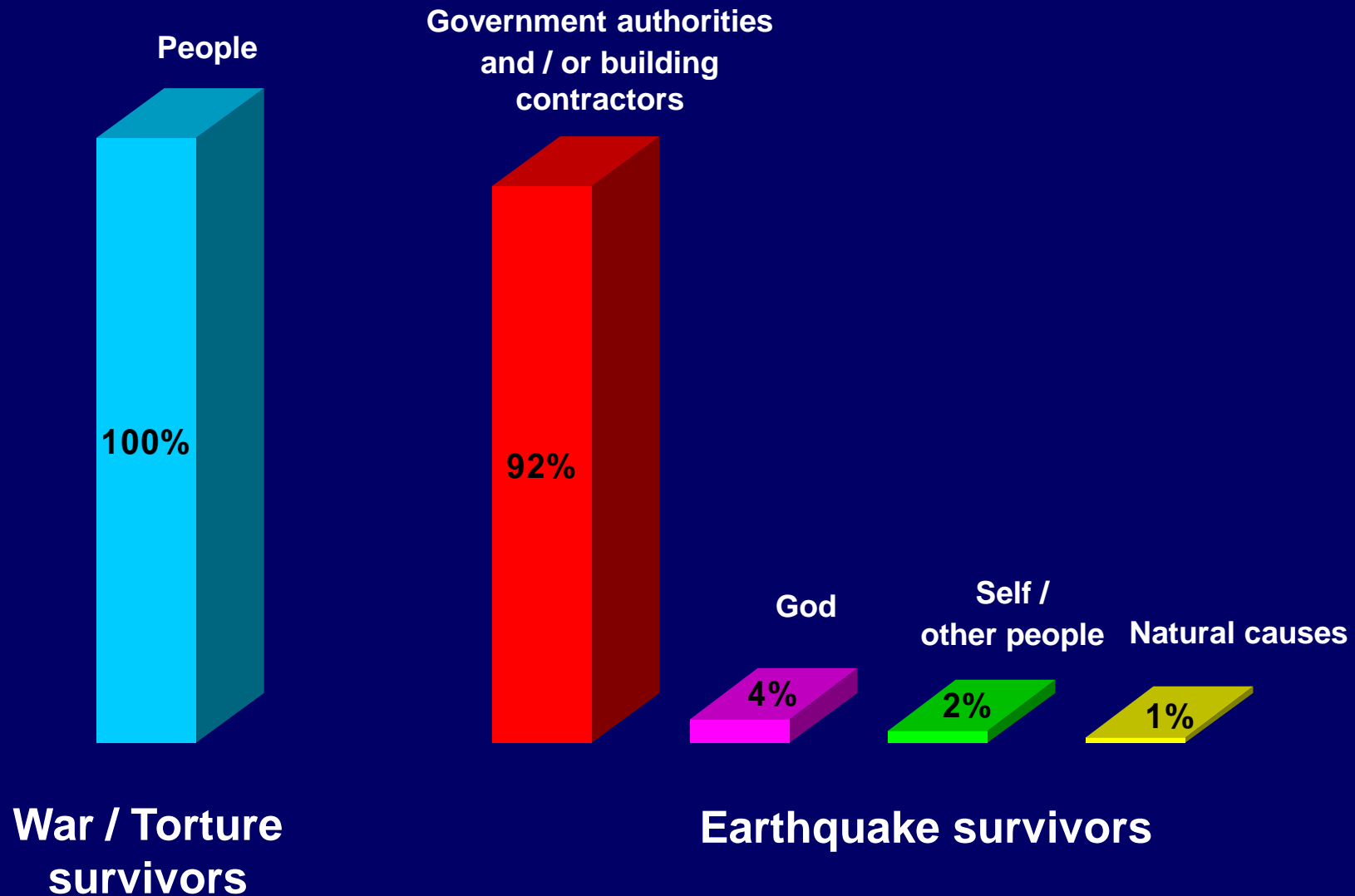
Groups compared on Emotions and Beliefs After Trauma Questionnaire data:

- 1,079 war survivors in former Yugoslavia countries
- 279 torture survivors in former Yugoslavia countries
- 62 torture survivors in Turkey
- 387 earthquake survivors in Turkey

No differences in cognitive and emotional effects of war, torture, and earthquake trauma

- Fear and loss of control over life
- Sense of injustice and related emotions: anger, distress, demoralisation, pessimism, helplessness
- Desire for vengeance / punishment
- Loss of faith / trust in people
- Fatalistic thinking / increased faith in God and religion

Attribution of responsibility for trauma



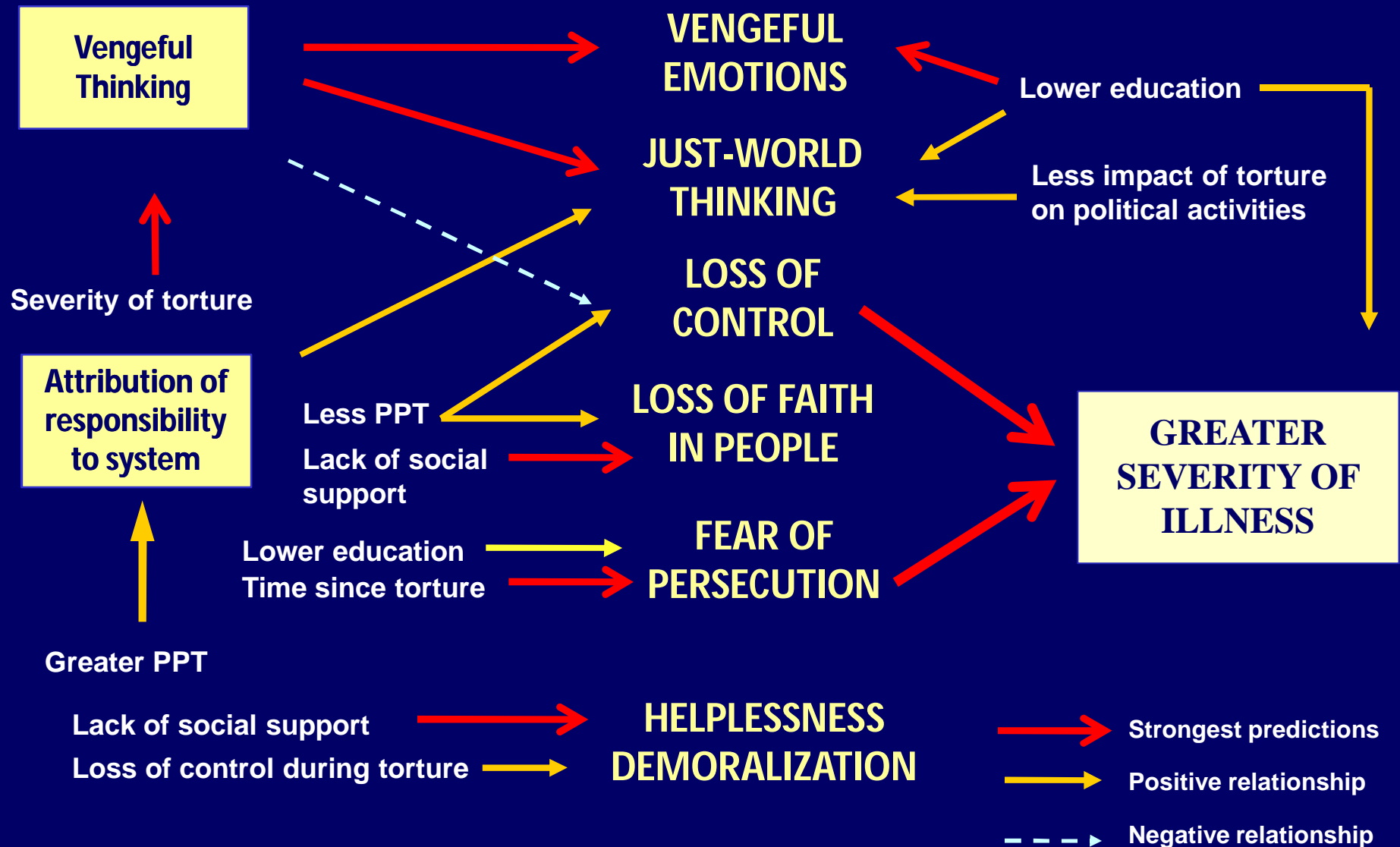
[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Associations between cognitive effects of trauma and outcome

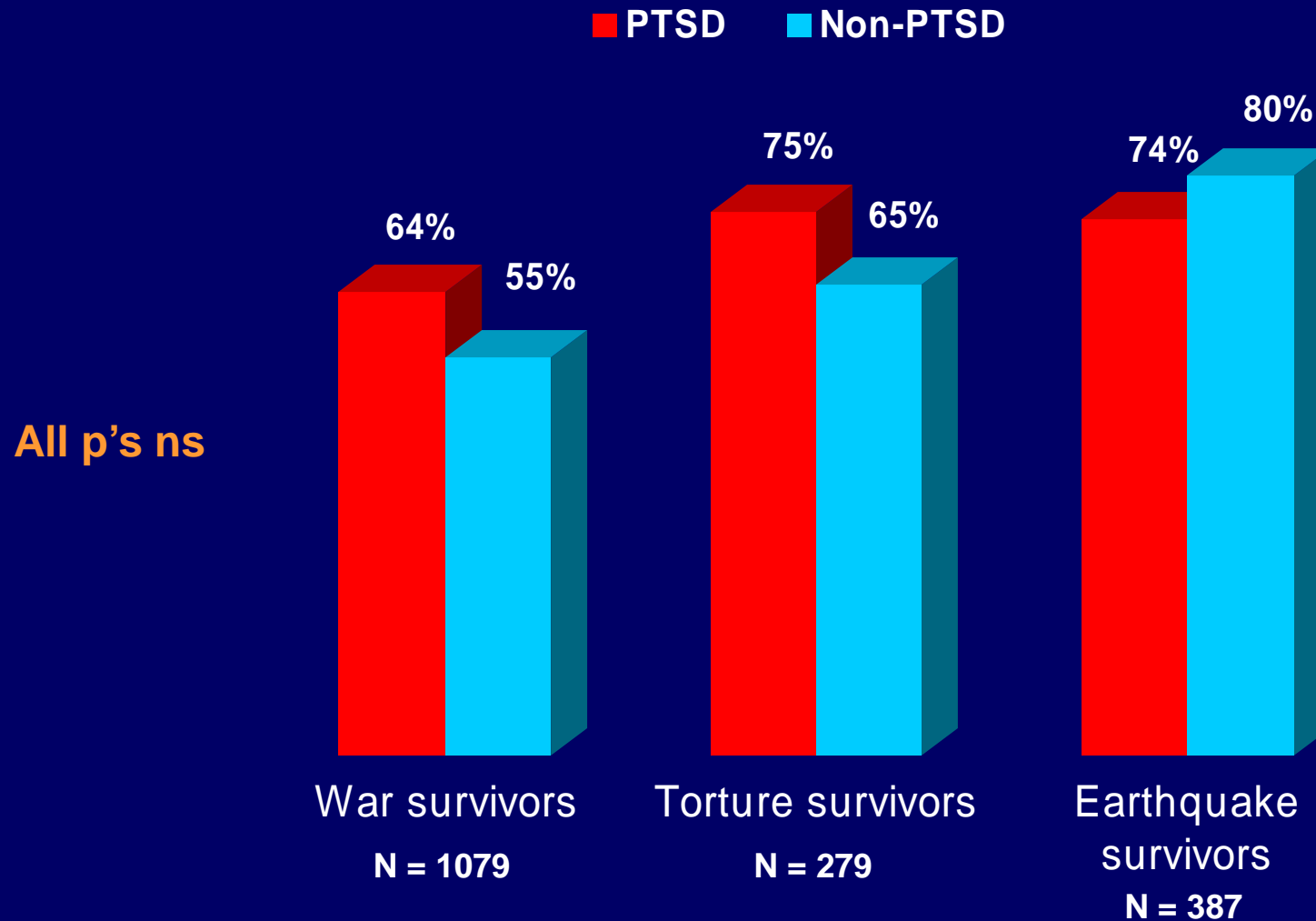
Argument:

Cognitive effects of trauma lead to more severe PTSD and depression.

Cognitive effects of torture do not relate to PTSD and depression (n=110)



Dissatisfaction with those held responsible for trauma not having been brought to justice



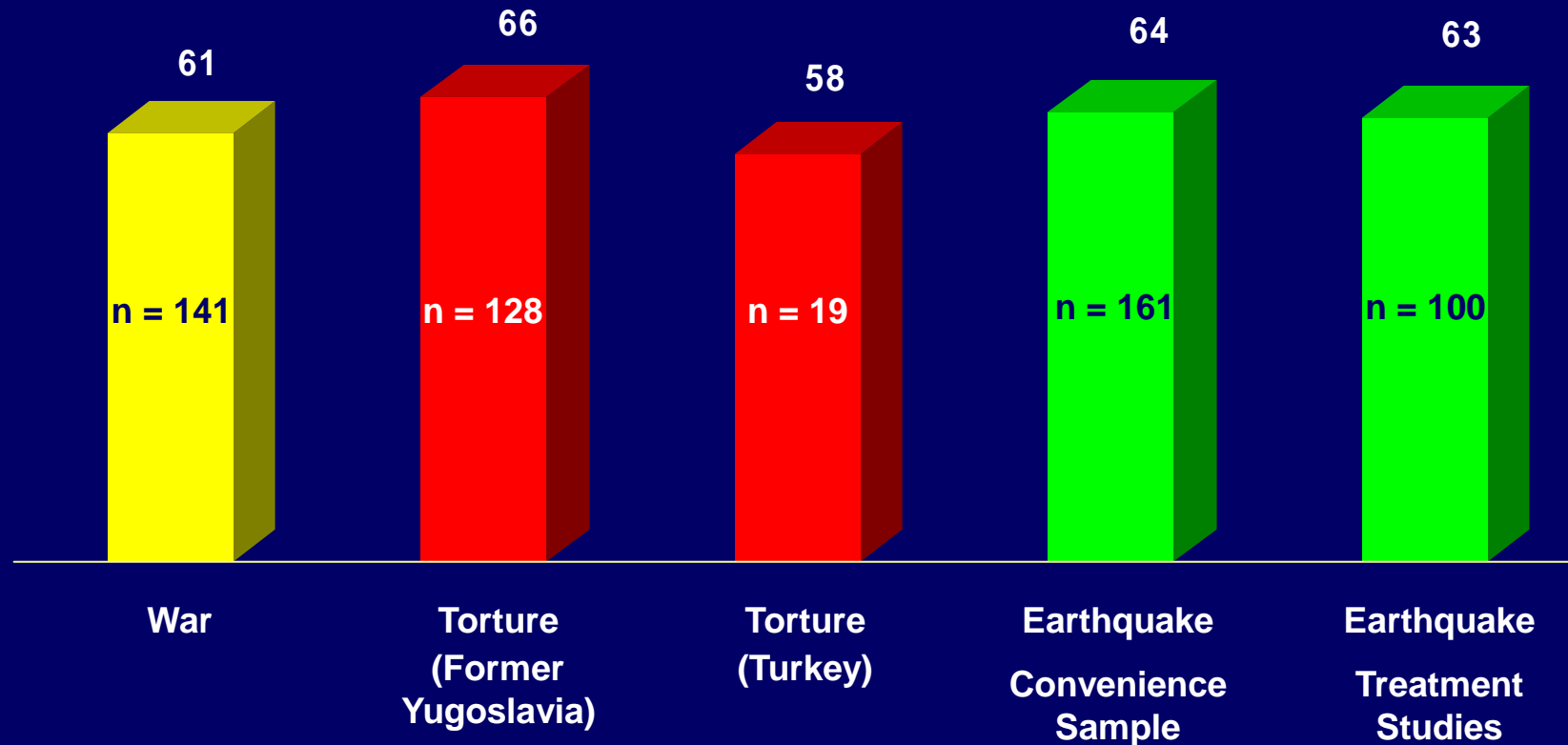
[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Severity of mental health outcomes

Argument:

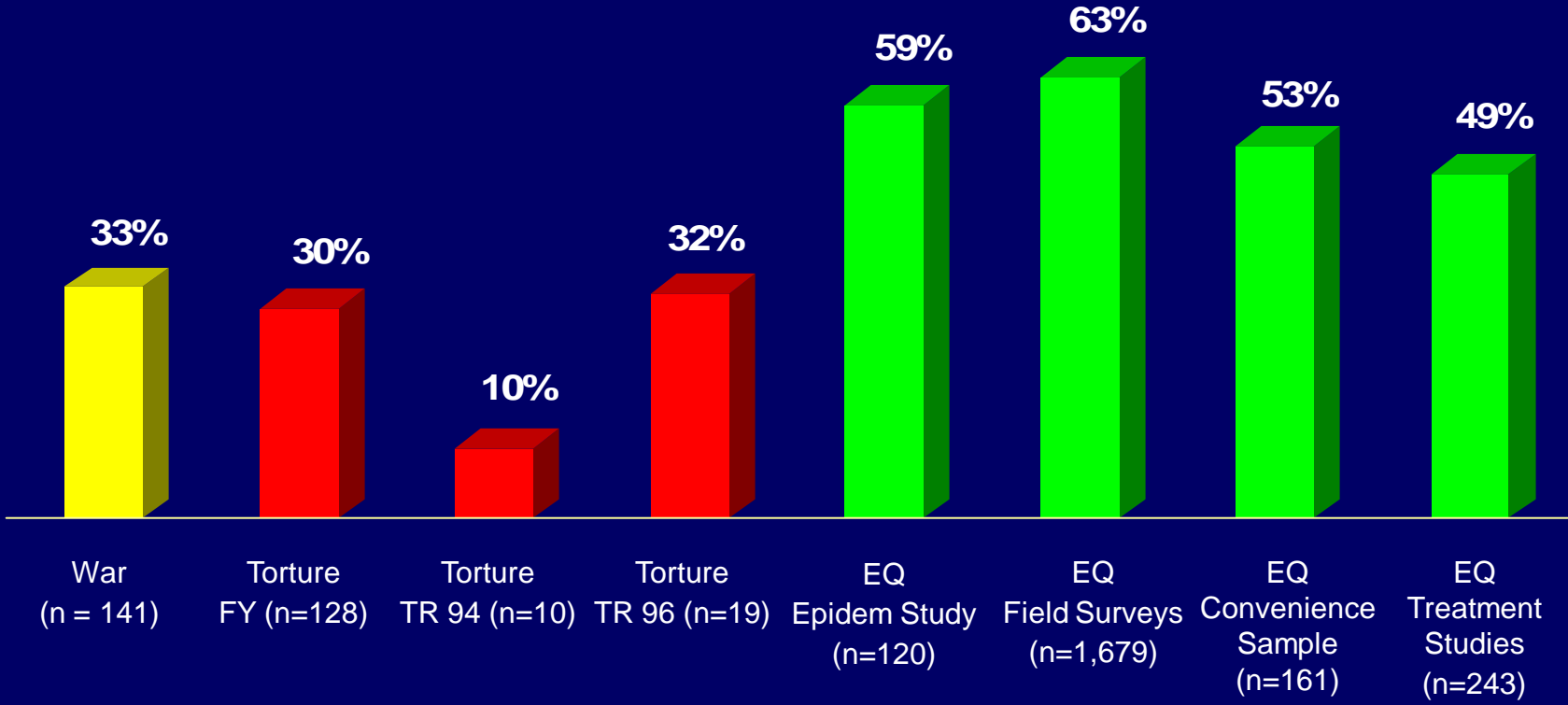
Torture leads to more severe and complicated PTSD than does natural disaster trauma.

Comparison of severity of PTSD – Total CAPS scores in survivors with PTSD



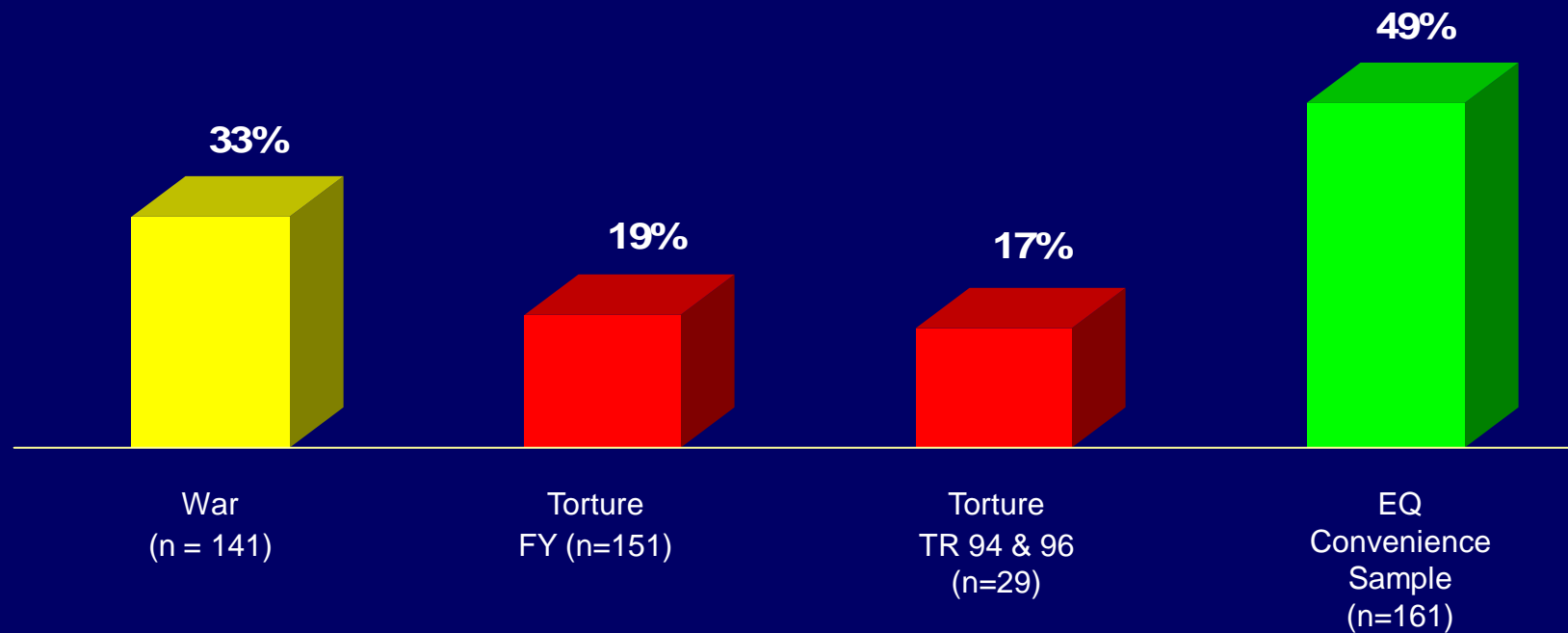
[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Rates of depression comorbid with PTSD



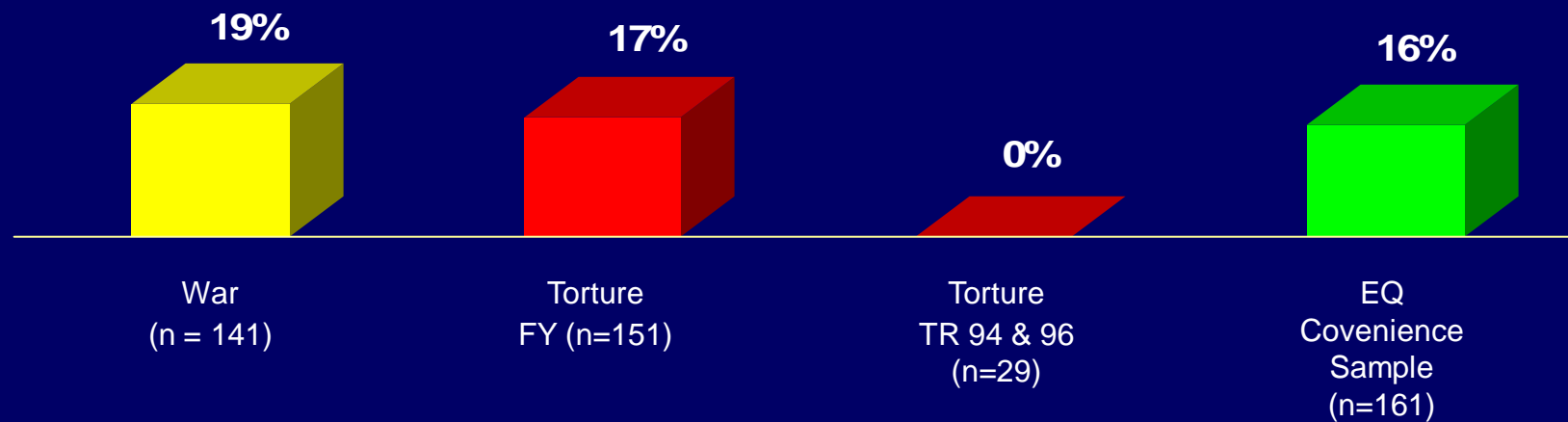
[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Rates of anxiety disorders comorbid with PTSD



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Rates of other psychiatric disorders comorbid with PTSD



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Response to treatment

Argument:

Torture survivors are more difficult to treat than earthquake survivors.

No comparative studies available to support this argument.

Available evidence suggests that torture survivors respond well to exposure-based treatments.

Evidence

- Paunovic & Öst (2001) Cognitive-behaviour therapy versus exposure therapy in the treatment of PTSD in refugees. *Behavior Research and Therapy*, 39, 1183-1197.
- Basoglu et al (2004) Cognitive-behavioral treatment of tortured asylum seekers: A case study. *Journal of Anxiety Disorders*, 18(3),357-369.
- Basoglu & Aker (1996) Cognitive-behavioural treatment of torture survivors: A case study. *Torture*, 6,61-65.

Conclusion

Argument that torture is different from other traumas is not supported by available evidence. Lengthy and costly treatments cannot be justified, particularly in light of

- (a) lack of evidence of their effectiveness,
- (b) recent advances in brief treatment of trauma.

Possible reasons for slow progress in the field – I

Two examples of lack of evidence-based thinking in understanding torture trauma and choice of treatments: Quotations from BMJ debate on torture

A quotation from BMJ debate

“In times of evidence-based medicine it has become very easy to advance a position in a medical debate and to refute another. One has to put forth his / her empirical evidence and then claim for the opponents’ evidence. Like in a boxing match, the points are added up finally and the one who scores more points is the winner. While the loser has to remain silent henceforth. Owing to this type of argument, more and more medical debates are in danger to degenerate into cockfights, especially when predominantly based on auto quotations...”

Maier T. Treatment of torture survivors: Some observations on the current debate. BMJ, 24 February 2007.

[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

A quotation from BMJ debate

“PTSD among refugees is too serious a matter to be entrusted [to] psychiatrists only. It is surprising, indeed disrespectful to compare victims of natural disasters like earthquake and victims of torture... I don't see where is the “strong human element” of the trauma linked to earthquake, other than the symptoms of PTSD.”

Durieux-Paillard, S. Re: Facts and myths about torture trauma – II, BMJ, 13 January, 2007

Possible reasons for slow progress in the field - II

- Institutionalised rehabilitation structures with vested interests in maintaining status quo
- Funding support for rehabilitation work with no outcome evaluation
- Inadequate attention to treatment development research

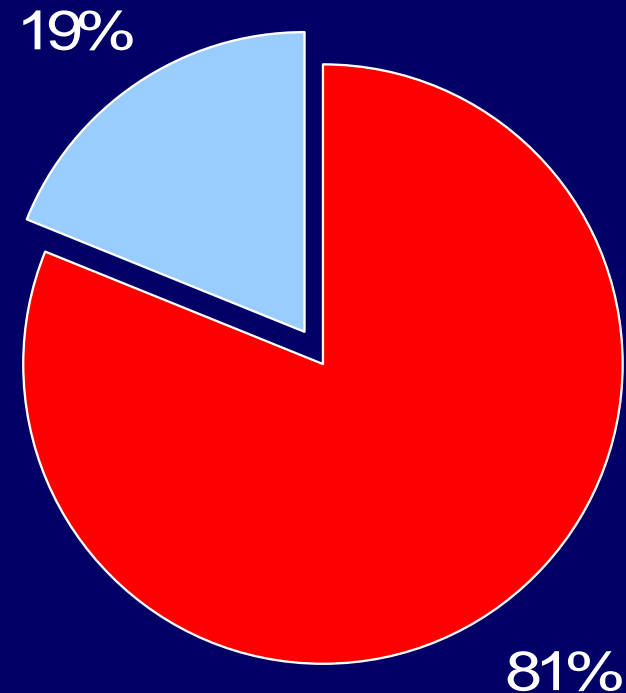
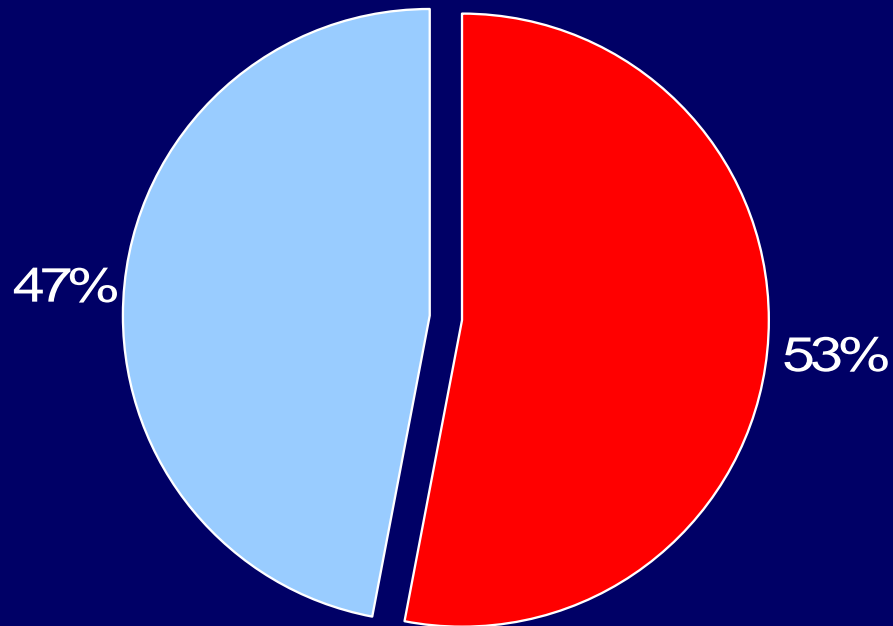
Progress in torture rehabilitation: Future directions

[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Rates of PTSD and need for psychological treatment in torture survivors (n = 227)

■ Torture survivors with PTSD
■ Torture survivors without PTSD

■ Needs psychological treatment
■ Does not need psychological treatment



Study of war survivors in former Yugoslavia
Basoglu et al (unpublished data)

Why the need for brief and cost-effective treatments? Case example 1

Rehabilitation Centre for Torture Victims (Denmark)

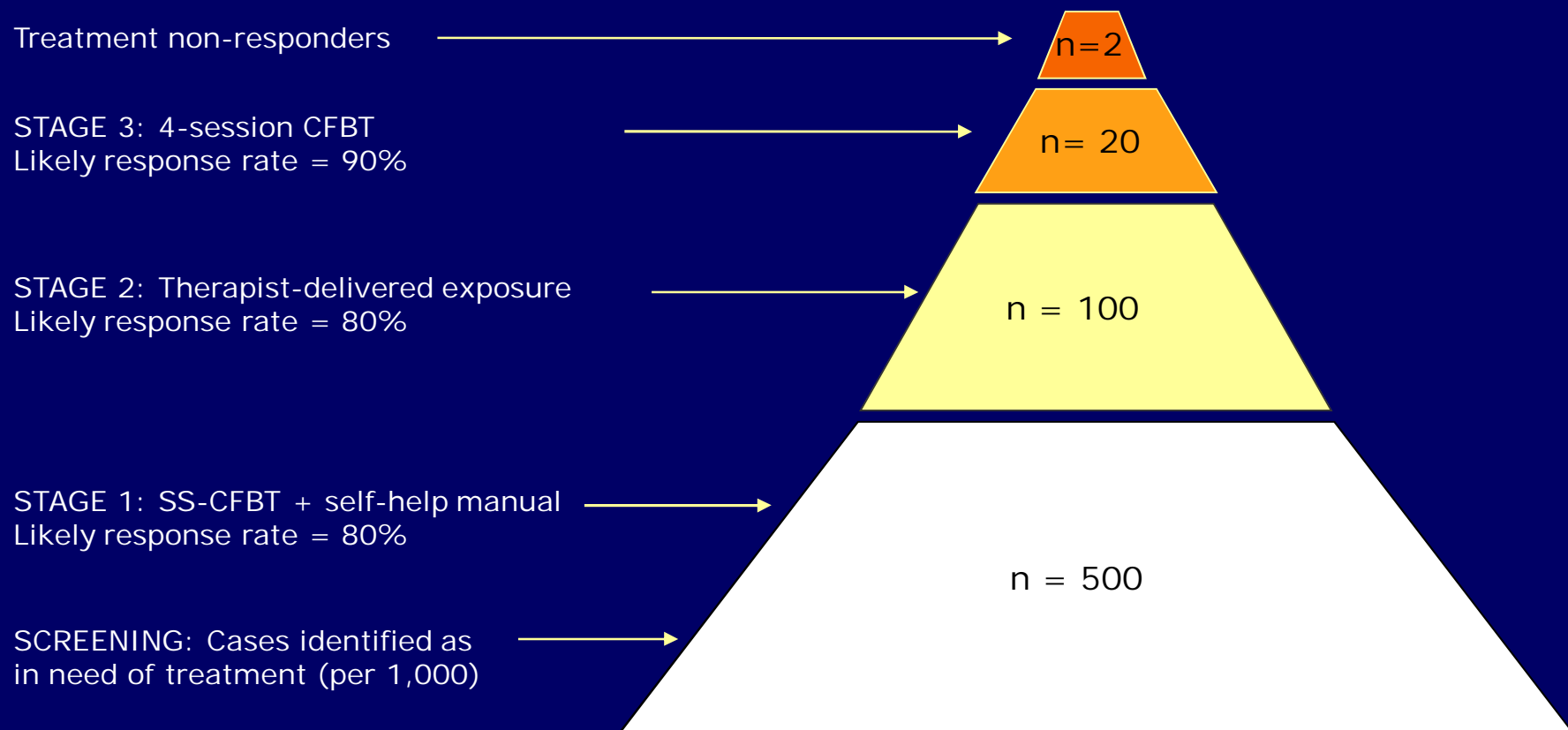
- Annual budget in 2007 = £6.5 million
- Treatment of 129 survivors = £1.5 million
- Cost of treatment per case = £11,628
- Duration of treatment = about 9 months (over 80 therapy sessions)
- Outcome = ?

Why the need for brief and cost-effective treatments? Case example 2

Istanbul Centre for Behaviour Research and Therapy

- 1999-2003 budget for treatment delivery = £125,000
- Number of survivors treated = 6,000
- Total number of sessions = 7,000
- Cost of treatment per session = £18
- Cost of treatment per case = £21
- Duration of treatment = mean 20 days
- Outcome = Improvement in 80% of cases

A cost-effective treatment delivery model in large survivor populations (n = 1,000)



[M Basoglu, 11th European Conference on Traumatic Stress, Oslo June 17 2009]

Therapist time costs of current trauma treatments in UK (Treatment delivered individually)

	Mean N of sessions per case	Cost per case*	Cost ratio relative to CFBT
CFBT	1.36	£112	-
CBT	14.8	£1,221	11
EMDR	4.6	£380	3.4

* Based on cost of 1 hour therapist time in U.K. (figure taken from NICE guidelines) = £82.5

Therapist time costs of trauma treatments in a medium income country (Turkey) (Stage 1 treatment delivered in groups of 25)

	Mean N of sessions per case	Cost per case*	Cost ratio relative to CFBT
CFBT	0.4	\$3	-
CBT	14.8	\$111	37
EMDR	4.6	\$34.5	11.5

- Based on 1-hour therapist time cost in Turkey = \$7.50 (average monthly junior psychologist salary of \$1,200 / 160 work hours per month)

**The only way forward:
Developing interventions that satisfy the following
requirements**

- Based on sound theory
- Proven to be effective
- Brief
- Resilience building
- Easy to train professionals in its delivery
- Practicable in different cultural settings
- Suitable for wide dissemination through lay therapists and self-help tools

None of the current trauma treatments, including CBT and EMDR, satisfy all criteria.

Directions for future work

- Develop self-help tools for war & torture survivors (e.g. self-help, manual, video treatment)
- Test self-help tools
- Test outreach model
- Test alternative treatment dissemination methods (e.g. computerised treatment programmes, Internet, mass media, public campaigns, etc)