

Comment

Related to 'Follow-up study of the treatment outcomes at a psychiatric trauma clinic for refugees' and 'Cognitive behavioral psycho-therapeutic treatment at a psychiatric trauma clinic for Refugees: description and evaluation' by Buhman et al. (Volume 25, No 1, 2015)

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Both articles are based on an outcome study of combined 6 month pharmacological (10 meetings with physician prescribing Sertraline and Mianserin) and psychological treatment (“Trauma Focused Cognitive Behavior Therapy” –TFCBT- delivered for a maximum of 16 and an average of 13.5 sessions of 45 minutes each). 49% of the patients were in need of translation, and in those cases TFCBT comprised only about 5 hours of real treatment time. From before to after treatment an improvement was observed in four self-rating instruments measuring quality of life, level of functioning, PTSD, anxiety and depression suggesting that TFCBT might be effective. Given the dearth of empirical research within the field, the work underlying the articles is highly welcome. There is however a need to pinpoint a number of issues which hopefully can move future research into an appropriate direction.

Both articles are part of a dissertation¹ that also includes an article on a subsequent experimental trial in which a wait list control group was compared with patients receiving the same combined treatment as addressed

in the first and second article, and two groups receiving either pharmacological or “TFCBT” only. The primary outcome (PTSD) relative to the control group is negative ($d = -.20$) for the conditions including “TFCBT”. Also for the secondary outcome, no improvement is observed. This throws into question the results of the two published articles -that highly symptomatic torture survivors can profit from minimal psychological treatment.

The labeling of the applied treatment as “TFCBT” and as “Cognitive Behavioral Treatment” (CBT) is open to question. The negative outcome of the experimental trial might leave the wrong impression that trauma focusing CBT might not be adequate for the treatment of torture survivors. However, the applied “TFCBT” intervention does not, either in content or “dose” represent an established CBT treatment. The “TFCBT” manual is rather a collection of 21 single CBT-elements that have been taken out of their therapeutic contexts; on average 11 of these elements have been applied per treatment. For patients requiring interpreters, that leaves less than 30 minutes for each element. The 21 treatment methods include therapeutic strategies which can be contradictory; for example, the “thought records” method belongs to a cognitive strategy intending to change thoughts and the

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“defusion” method belongs to an acceptance strategy intending the opposite – to accept thoughts. There is a risk for inducing confusion in the patients with such a large number of partly contradictory interventions during such a short available treatment time.

The ambition as expressed in both articles was to provide evidence based CBT-treatment and it is correct that “exposure” is such an evidence based treatment principle for PTSD. Given that refugee patients have more complex and severe problems than usual CBT-clients, it is also correctly concluded that conventional CBT has to be adapted. Adapting standard CBT to more complex patients suggests the need to increase the treatment “dose”. For example, 24 hours of PTSD treatment with Narrative Exposure Therapy (NET) is given for torture survivors with complex problems compared to 8 hours for less complex cases². However, the TFCBT-adaptation implies the opposite. The maximally available time for the entire treatment makes it impossible to deliver a sufficient amount of exposure treatment. Instead of delivering an even minimal amount (8 hours) of NET, only the “life line” (a single specific NET-intervention applied during one early session of this treatment) has been taken out of its context and integrated as one of the 21 “CBT treatment methods” in the “TFCBT” manual.

It is important to realize that appropriate exposure therapy demands treatment sessions long enough (approximately 90 to 120 minutes being a usual standard) to assure time to reduce high levels of arousal before the session is terminated; otherwise negative effects are possible. To apply exposure in sessions comprising an actual treatment time shorter than 30 minutes (for the patients in need of an interpreter) is not enough to do this.

It would be of interest to better understand a) why a complete CBT, NET or other exposure treatment was not provided, b) why, patients in need of an interpreter did not receive more sessions in order to achieve the same amount of real treatment time as those without that need and c) why patients who missed sessions were not offered additional “make up” therapy sessions. A possible explanation could be that the main premise has been to apply a minimal cost treatment that nevertheless includes as many evidence based interventions as possible. Irrespective of the true reasons for it, this practice obviously failed as expected by conceptual reasoning and as indicated by the outcome of the experimental trial. Contrary to the impression given by the two articles under discussion, the common sense rule is that the degree of comprehensiveness of a treatment has to increase with the degree of multiplicity and severity of patients’ problems. This premise should guide future clinical practice and research.

References

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Response to the commentary

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Dr Harlacher and Prof Polatin comment on the naturalistic follow up study published here in *Torture*^{1,2} as well as a Randomized Clinical Trial subsequently published in the *British Journal of Psychiatry*.³ They make a number of points that we would like to comment on.

They argue that the psychotherapy offered was minimal, calculating that patients who needed translation only received a total of 5 hours psychotherapy. They believe this is too short to have any effect on traumatized refugees who have suffered from torture. Firstly, the study was not limited to torture survivors; only 54% of patients in the naturalistic study were torture survivors and we discussed whether the duration of treatment was insufficient in the articles themselves. At this point, it is not an established fact that longer treatment has better results. In fact, longer treatments offered to similar patient populations in Denmark do not show better results⁴ and recent studies on the treatment of PTSD and traumatized refugees do not find evidence to support that more service contacts result in better outcome of treatment.^{5,6} The 16

sessions in our study were greater than the standard treatment for PTSD (which is 12 sessions) and treatment goals were, at least for the majority, reached within this time-frame. The low number of sessions in some incidences are often due to a high rate of cancellation or failure to attend amongst the group studied. Patients were given several options for replacement sessions.

Dr Harlacher and Prof Polatin argue that the maximum treatment time for a patient receiving translation is 5 hours. That calculation is based on the premise that, in translated sessions, only half the time is available for therapy. Psychotherapy is however, much more than talking; Mindfulness exercises were integrated, which included breathing exercises and body scans. This took up to 30 minutes and required little translation time. It is generally recommended that exposure sessions should be longer than 45 minutes and this would be relevant to investigate, but it is our experience that patients find it difficult to do long sessions, especially when they are translated, which requires more concentration on the part of the patient. In conclusion, we agree that sessions might benefit from being longer in the cases where translation and exposure are used, and this would be an important research question to explore in the future. However, the need for longer sessions does not necessarily apply to CBT sessions using other methods than trauma-focused exposure. In the trial, we did not find that the type of psychotherapy method used, the need

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for translation or the duration of treatment had any association with improvement in primary or secondary outcomes in regression analyses. Finally, it is important to remember that this is a pragmatic study and therefore a study of what can realistically be achieved in treatment with traumatized refugees. It is unlikely that 2 months' further treatment (to match the 24 sessions offered in NET) would make a great difference for a group of patients that are as chronically ill as those included in the study.

We disagree with Dr Harlacher and Prof Polatin's argument that, because the trial shows no significant effect of psychotherapy, the results reported in the naturalistic study must be incorrect. In the naturalistic study, we found a significant but small improvement on self-ratings after treatment. In that study, the patients received a combination of psychotherapy and medicine and the inclusion criteria for the naturalistic study were stricter than in the trial with regard to treatment given, so that all patients had received a minimum of four months' treatment and at least 4 sessions of psychotherapy. The same criteria were not applied in the trial as it was a pragmatic study and analyses were made according to randomization group. However, the waiting list group in the trial received a combination treatment similar to that reported in the naturalistic study after six months on the waiting list, and we found the same improvement on self-ratings after treatment as we observed in the naturalistic study, when comparing waiting list time with treatment time. It would therefore be more accurate to say that we found no difference between treatment modalities, but that both studies suggest that the overall condition of patients may improve to some extent over the course of treatment. That is a testament to how ill the patients were and how slight changes in the psycho-

therapeutic approach is unlikely to make a significant difference to outcome.

The terms "trauma-focused" and cognitive behavioral therapy were criticized for not being "an established CBT treatment". We agree that the low percentage of patients who received imaginal exposure treatment does not qualify the term "trauma-focused therapy" and accordingly the terminology has been changed in the reporting of the trial to "flexible CBT". The treatment offered is however CBT. It uses CBT methods systematically and is not a random collection of methods. It includes 2nd and 3rd wave CBT treatments (restructuring of thoughts, exposure, ACT and mindfulness). Both ACT and restructuring of thoughts are CBT methods. It is not unusual that a CBT therapist mainly works with restructuring, but also includes acceptance of thoughts in the therapy. There is to date no agreement on whether this is contradictory and no studies show that using the two methods with the same patient is contraindicated. In psychotherapy studies, fidelity checks are required to ensure the therapy offered is according to the manual. Instead of filming all sessions and having an expert evaluate them, which was not possible, we had the therapists list the main methods used from the manual. The reporting of this may give the impression that they were randomly applied, but that is not the case.

Finally, it has been suggested that a possible explanation for the choice of treatment was the cost of treatment. Cost-effectiveness considerations are indeed relevant when planning treatments for traumatized refugees. The health care system is under strain as it is and the number of traumatized refugees in western settings is increasing, which the recent refugee crisis is a testament to. Long waiting lists for torture and trauma rehabilitation in Denmark have

been a major problem. Some private treatment centers have had waiting lists of more than two years. Being able to offer treatment within a realistic time frame and which is cost-effective is therefore a major concern in public psychiatry and our choice of treatment duration and evaluating the treatment with a pragmatic trial reflects our concern for finding an effective treatment which can be realistically applied in a public health setting. It is accepted that our studies are just the first steps as much research is needed and a study investigating the points made by Dr Harlacher and Prof Polatin regarding treatment content and duration would be very welcome.

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