

# Narrative Exposure Therapy: An Innovative Short-Term Treatment for Refugees with PTSD – Interview with Dr. Morton Beiser

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### ABSTRACT

Dr. Morton Beiser is a Professor of Distinction in Psychology at Ryerson University, as well as Founding Director and Senior Scientist at the Centre of Excellence for Research on Immigration and Settlement (CERIS) in Toronto. After obtaining his medical degree from the University of British Columbia in 1960, he interned at the Montreal General Hospital, completed residency in Psychiatry at Duke University Medical Centre and pursued post-doctoral training in Psychiatric Epidemiology at Cornell University. Dr. Beiser was appointed as Associate Professor of Behavioural Sciences at the Harvard School of Public Health from 1967 to 1975, before returning to Toronto to assume a David Crombie Professorship of Cultural Pluralism and Health, and professorship in Psychiatry. Given his extensive research experience on immigration and resettlement work, we interviewed Dr. Beiser to gain further insight into how Narrative Exposure Therapy (NET) can be an innovative short-term option to treat refugee patients with post-traumatic stress disorder (PTSD). Dr. Beiser is currently conducting a randomized trial to assess the effectiveness of NET among refugee children and youth in Toronto.

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### RÉSUMÉ

Dr Morton Beiser est un professeur distingué en psychologie à l’Université Ryerson, ainsi que directeur fondateur et scientifique principal au Centre d’excellence pour la recherche en immigration et en intégration (CEREI) de Toronto. Après avoir obtenu son doctorat en médecine à l’Université de la Colombie-Britannique en 1960, il a fait son internat à l’Hôpital général de Montréal, a complété sa résidence en psychiatrie au centre médical de l’Université Duke et a suivi une formation postdoctorale en épidémiologie psychiatrique à l’Université Cornell. Dr Beiser a été nommé professeur agrégé en sciences du comportement à l’École de santé publique de Harvard de 1967 à 1975, avant de retourner à Toronto pour occuper la Chaire David Crombie sur le pluralisme culturel et la santé, et la chaire de psychiatrie. Compte tenu de sa vaste expérience en recherche sur l’immigration et la réinstallation, nous avons interviewé Dr Beiser pour mieux comprendre comment la thérapie d’exposition descriptive (TED) est une option novatrice à court terme pour traiter les patients réfugiés atteints de trouble de stress post-traumatique. À l’heure actuelle, Dr Beiser mène un essai randomisé pour évaluer l’efficacité de TED chez les enfants et jeunes réfugiés de Toronto.

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### WHAT IS NET? CAN YOU DESCRIBE TO US HOW NET FUNCTIONS AND THE LINK BETWEEN PTSD AND NET?

My understanding of Narrative Exposure Therapy (NET) from the people who have developed it, is that it is based on the neurophysiology of memory and they tend to think of memory as comprised of a couple of different elements: physiological-emotional and rational-cognitive components. So when we remember an episode, we remember both the sensations and feelings that were part of that episode (i.e. physiological-emotional component); but there is also a narrative framework around that experience which helps put it in context, so we recall when it happened (i.e. rational-cognitive component).

**Keywords:** Narrative Exposure Therapy; Refugees

One of the signature symptoms of PTSD is “intrusion” - memories will intrude in situations in which they do not belong, so that people actually re-experience a terrible event that had happened, long after the threat has actually passed. It is not that they are imagining themselves back in the situation, but that they really are re-experiencing the whole thing. That is because at the time the memory is being laid down, there is so much fear and so much terror that only the “hot memory” gets laid down without the sufficient cognitive overlay to place that memory where it belongs - which is in the past. So instead of experiencing it as a past thing, people will re-experience it as if it were in the present, where it no longer belongs.

# Interview

The idea of “hot memory” is that when we experience an important event, there are physiological and emotional components (e.g. if you won an award then you may be in a flush of excitement and have a pounding heart). Then there is “cold memory,” which is the more cognitive aspect (e.g. what exactly was the award for, who presented it, what was the context, what was in the room, who was there, what was the speech like, etc.). For a person with PTSD, the past events can be so traumatic and fear-inducing that he/she does not comprehend all the details. It is counterintuitive because one would think that someone with such a bad overriding experience would have a clear memory of it. On the contrary, people often cannot recall the details, which are the cognitive aspects (i.e. cold memory), because there was so much fear at the time of the experience. As a result, the person is left only with hot memory — the physiological aspect of the memory.

NET aims to reattach the cognitive aspect of the experience (cold memory) to the emotional, physiological part of the experience (hot memory), so that it can be appropriately located in the past and not intrude into present day situations. That way I can recall that the memory happened 20 years ago and it is not happening now; hence not re-living the event daily. That is the kind of neurophysiological theory that underpins NET. An essential component of therapy in general is to be able to construct a narrative that makes sense for the individual and allows them to get on with their lives.

The actual conduct of the therapy is based on the idea of a lifeline (i.e. timeline) and you literally will hand the person (who is getting the therapy) a rope and the person will lay out that rope on the floor of the therapy room. That rope signifies the lifeline of that person to date, and you ask the person to divide the rope into a manageable period of time, such as a 10-year or 20-year interval, so that the person can identify all events on the lifeline.

Then we have 2 baskets: one is a basket of flowers and other is a basket of stones. And the therapist explains to the person that the stones represent bad events or bad circumstances in their life while the flowers represent really good events. Then the task is to lay out stones and flowers on the lifeline indicating when the events occurred and describe why and what each stone and flower represent. The job of the therapist is to note when these events occurred and to go through each of these stones and get the person to describe each event exactly. This is not to provoke the experience again, but rather to get the person to lay a cognitive framework around the experience. The emphasis is not based on the actual feelings at the time, but rather trying to contextualize the experience. So the goal is to locate the situation and try to recall the events surrounding the experience (i.e. exactly when it occurred, what the settings was, who was

in the room, what the sensations were at the time). The whole thing is an attempt to try to re-attach the cold memory to the hot memory so that it becomes easier for the person to place it appropriately in the past.

## WHAT IS INNOVATIVE ABOUT NET?

NET was developed by a group of colleagues in Germany to use in a refugee population in very difficult situations — mostly at camps in Africa and South East Asia, which was very successful. The whole approach of using the neurophysiology of memory framework, a technique involving symbols such as the rope, flower and stones, is extremely powerful and innovative given the current climate of being culturally appropriate in treatments. There is never any difficulty in explaining the elements of this therapy because flowers and stones have a universal significance. People easily understand what stones and flowers represent, so it is a technique that is culturally sensitive. Besides that, NET is also innovative because it is relatively brief, usually 8 sessions 1 hour in length. Moreover, you do not need to be a highly trained mental health professional in order to administer NET. It is something that people can be trained to do in a relatively short period of time. If you are thinking of introducing the therapy on a large scale basis for a healthcare system, NET is largely inexpensive to develop.

## WHAT INSPIRED YOU TO BE INVOLVED WITH REFUGEE HEALTH AND THE CREATION OF NET?

I’ve been involved in migration and refugee studies for most of my career. My first major involvement with refugee studies was in the late 70s — early 80s when Canada was accepting the Southeast Asian “boat people.” That was the largest single refugee wave that we had in Canada and was a very important event historically. I started a study of 1300 Southeast Asian refugees in 1981 and followed them for 10 years — studying how mental health affected integration, and conversely how integration affected mental health [1-6].

I read about NET and the work of my colleagues in refugee camps in Africa. What really surprised me was that they were doing really good first-class evaluations, despite the fact that doing that kind of work in terrible situations was very tough. They had data to show its real effectiveness [7-10]. One of the things that was very striking was that in the early publications they talked about not being able to achieve a lot of symptom reduction using NET, but what they did was to overcome some of the apathy or lack of motivation that is part of PTSD. People were more likely to get re-engaged in life, try to get on with their life, and to create alternatives for themselves regardless of symptoms. I think that is very important because we always emphasize symptom reduction but there is more to recovery than symptom reduction.

## Interview

### **YOU ARE CURRENTLY LEADING A PILOT RANDOMIZED CLINICAL TRIAL IN TORONTO TITLED “LENDING A HAND TO OUR FUTURE” TO ASSESS THE EFFECTIVENESS OF NET IN REFUGEE CHILDREN (7–18YRS) WITH PTSD [11]. COULD YOU COMMENT ON WHY YOU DECIDED TO FOCUS YOUR STUDY ON YOUTH AND ON THE SIGNIFICANCE OF STUDYING NET?**

We know from the literature that 20% of refugee youth have PTSD when they arrive in a refugee receiving country, while 12–15% of refugee adults have PTSD. Therefore, the effects of PTSD on children and youth tend to be greater than the rest of population. We know that PTSD affects 1 in 5 people, and is clearly a public health problem — so how do you address it? The approach we are using fits nicely with our concept of secondary prevention (of early diagnosis and treatment). It involves assessing people for PTSD and then offering them treatment that will help alleviate the problem and prevent further long-term complications. It also helps people overcome the other problems, such as challenges of resettling, and helps speed up the integration process. Our goal is to develop a public health approach to a major public health problem among newly arrived refugee people. We are obviously going to continue to receive more refugees even after the Syrian refugee crisis is over because we have come to define ourselves as a country that is compassionate, and one that cares about its international obligations towards refugees. We would need to be able to offer people not only safety but also help address their needs.

Part of the “Lending a Hand to Our Future” project mandate is to assess the effectiveness of NET among refugees in Canada. However, a more important part of this project is to see whether it is possible to introduce a way of increasing the capacity of the healthcare system to respond to refugee mental health needs, without incurring all kinds of terrible expenses. Most mental health advocates talk about neglecting refugee and immigrant mental health and the need for more psychiatrists and psychologists — and sure we do need them but you can’t keep spending. There has to be a realistic solution. So the question is — is there some way to be able to train people who will themselves be front-line workers as well as train others to assess people for PTSD? We want to be able to do this in a cost-effective way — by training medical students, nursing students, social work students, teachers and other providers. We need to promote an understanding that a child acting out in class could be an expression of PTSD, which requires exploring the possibility of an underlying mental health problem. So we are interested in having partnerships with healthcare provider groups and policy people involved as well — since they will all have to deal with the public health problem.

### **CAN YOU DESCRIBE A CHALLENGE YOU HAVE FACED WHILE IMPLEMENTING NET FOR REFUGEES WITH PTSD?**

Some of the challenges have to do with professional skepticism and the concern about causing further harm to refugees by re-traumatizing them. I think that is a perfectly understandable concern and frankly one of my personal concerns before I actually was able to see what happens during the course of assessment and treatment — and see that empirically we don’t have re-traumatization. If anything, people are relieved and they say, “this is the first time I have been able to talk about this.” I think part of the reason that we do not see re-traumatization is because there is so much work done to put everything into context, to be able to recognize that the event is not happening now — and we do not want you to have a catharsis by re-living the experience. Instead, we want to be able to contextualize the experience and put a thick coating of memory around it (i.e. cognitive memory).

### **WHAT IS YOUR FUTURE PLAN FOR YOUR STUDY ON NET? DO YOU THINK NET COULD BE A REFERRAL SERVICE OR BE INCORPORATED INTO FAMILY PRACTICE?**

We haven’t completed the study yet that we had funding for. We have now assessed about 1600 refugee youth and identified those who have PTSD in lots of different community settings (e.g. schools, resettlement agencies, healthcare settings) and have administered NET therapy with a good proportion of those people. What we still have to do are follow ups to assess outcomes. We have a total of 3 follow-ups which will take place at 3, 9 and 12 months after the completion of NET therapy.

I think that the less we rely on a process of referral, the better off we are, because people always get lost in the referral process. The more we can equip the people who have first-line contact with refugees with the tools to assess and to help treat PTSD, the better off we are. I don’t know if we will ever have family physicians who will do NET. Perhaps we’ll have healthcare professionals that are better informed about mental health issues among refugees and who feel more comfortable dealing with it, either directly or perhaps by supervising other people who would do the actual therapy. I think you can train almost anyone who has empathic abilities. It is important to have ongoing support and supervision. So, again I don’t know whether it would be possible for people in primary health care, family practice units or in clinics to have a service available that would be an assessment and treatment service for PTSD. I think that would be ideal because as I said, once you start the whole process of referrals people drop out, people get confused and it can end awfully. Whereas if people have a setting where they feel comfortable and know they will receive treatment or help for their mental health problems, I believe this would be an asset.

# Interview

## HOW CAN WE, AS MEDICAL STUDENTS, BE TRAINED IN NET AND WHAT POTENTIAL ROLE COULD WE PLAY TOWARDS REFUGEE HEALTH?

Ideally, we want to have a cohort of people who are trained and experienced in NET therapy, to ultimately become trainers and supervisors. This is a big challenge we are trying to deal with right now. We are developing a partnership with CARE (Cooperative for Assistance and Relief Everywhere) Canada, where we are training and recruiting senior nursing staff who will be trained in NET and who will subsequently be able to train and supervise more junior nurses in the technique.

Another way we have been thinking about trying to improve the NET training itself and its availability is by developing videos of the training session. As can be expected, there are problems that occur over the course of NET therapy (e.g. experience of dissociation, problems with resistance) and there are ways of dealing with that. One way that we deal with that now is experientially — such that when patients have an experience of dissociation or resistance issues, then the supervisor will help them work through it. What we want to do is develop a more consistent course which will incorporate some of the didactic elements (e.g. lectures about the physiology of memory) but also will include components of the clinical experience using simulation. The goal would be to have a simulation of an experience where the therapist has confronted someone who is dissociating and then be able to demonstrate how such a situation should be managed. This is going to be a big advantage because the use of simulations will allow for training to be more consistent. Everyone will receive a uniform training in terms of how to deal with different situations and there will be a more ubiquitous availability. We have received some funding from Ryerson University for these additional components and are currently working on the program. There is a training workshop held by our colleagues in Italy and we will be filming part of the workshop as part of this.

I think that it is important as physicians to be both involved in helping people and advocating for them. Thus, I hope medical students will help become part of the voice of advocacy by being attentive to refugee mental health. As a result of receiving the NET training and seeing the effect of PTSD on refugees and youths I think that should help fuel a kind of advocacy and that would be important for supporting refugees amidst the ongoing crisis.

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research projects, please visit: <http://stmichaelshospitalresearch.ca/researchers/morton-beiser/>.

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