Background

Many refugees resettled in Western countries struggle to attain a level of psychological well-being. Heavily burdened by pre- and post-migration stressors, refugees are at considerable risk of developing posttraumatic stress disorder (PTSD). The accumulation of stressors is also what makes them, in the eyes of many clinicians, complex and difficult to treat.

Although trauma-focused treatment, such as trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing therapy (EMDR), is recommended as first-line treatment for adults who suffer from PTSD, in refugees this recommendation is often contended. Instead, clinicians are advised to focus on psychosocial stabilisation as direct trauma-focused treatment is feared to be ineffective and even harmful. The contradictions between the two approaches have been subject of recent debate.

Aims

An eye for complexity contributes to a clarification of this debate by presenting the outcomes of several studies with refugees. The overall aim of this thesis is to contribute to an improvement of mental health care offered to treatment-seeking refugees. To this end, the thesis addresses three main research questions:

1. What is the safety and efficacy of EMDR compared to that of stabilisation in traumatised asylum seekers and refugees?
2. What is the applicability of the complex PTSD construct to refugees?
3. Can traumatised asylum seekers and refugees be safely and effectively treated with trauma-focused therapy?

Method

These questions are answered through six studies: a systematic review of treatment outcome studies of EMDR in refugees; a pilot study of EMDR (11 sessions) versus
stabilisation (11 sessions) with 20 traumatised refugees treated at a specialised institute; a randomised controlled trial of EMDR (12 hours) versus stabilisation (12 hours) in 72 refugees who suffer from PTSD; a multilevel analysis of the trial data to identify predictors for treatment response in refugees; a naturalistic study comparing the effectiveness of treatment as usual in refugees and non-refugees; and a systematic review of the prevalence of complex PTSD in refugee populations.

Results
In this thesis it is shown that although the acceptability, safety and efficacy of EMDR with refugees are matters of interest, very little research in this area has been done. A pilot study showed EMDR to be safe and efficacious enough with treatment-seeking refugees to warrant the conduct of a full randomised controlled trial. Consequently, in a randomised controlled trial both EMDR and stabilisation were shown to be safe and limitedly efficacious with refugees who suffer from PTSD. Two predictor studies showed that treatment-response in refugee participants appears related to depressive symptom severity and diagnosis as well as PTSD symptom severity at intake. Finally, prevalence of complex PTSD in refugees was shown to be relatively low.

Conclusions
Refugees may be safely treated with a short course of EMDR (9 sessions), but efficacy may be limited. Treatment response may be hampered by depressive symptoms. The construct of complex PTSD may only limitedly apply to traumatised refugees. Current research supports a recommendation of trauma-focused rather than phase-based treatment in refugees who seek treatment for PTSD, including asylum seekers.