this is likely to continue to limit cultural adaptation and dissemination of evidence based interventions such as NET.

Ultimately, our difficulty in providing sufficient post training practice and supervision for our local counsellors to use NET in LMICs is constrained by the number of people we must serve in order to get the funds to be there in the first place. The reality for us in places such as Nairobi, Dadaab, and Gulu (where we face overwhelming numbers of individuals in need) is that we have a clear mandate from our funders to provide services to a very large number of individuals relative to staff resources. These *'numbers reached'* outcomes practically mandate short term *group* approaches, regardless of research considerations. This is also true for us within middle income contexts such as Jordan, where we are grappling with the Syrian refugee crisis. Thus, outside of our USA programmes, NET remains a luxury tool to learn for the very few clients we treat via individual modalities. If there were a way to adapt narrative exposure work to a group format, we could foresee greater use of it in LMICs, as this would better fit our funder mandates and needs within those contexts.

References

Kaysen, D., Lindgren, K., Sabir Zangana, G., Murray, L., Bass, J. & Bolton, P. (2013). Adaptation of cognitive processing therapy for treatment of torture victims: Experience in Kurdistan, Iraq. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(2), 184-192.

Mundt, A. P., Wünsche, P., Heinz, A. & Pross, C. (2014). Evaluating interventions for posttraumatic stress disorder in low and middle income countries: Narrative Exposure Therapy. *Intervention*, this issue.

Neuner, F., Schauer, M. & Elbert, T. (2014). On the efficacy of Narrative Exposure Therapy: A reply to Mundt et al. *Intervention*, this issue.

Zoellner, L. A., Feeny, N. C., Bittinger, J. N., Bedard-Gilligan, M. A., Slagle, D. M., Post, L. M. & Chen, J. A. (2011). Teaching trauma-focused exposure therapy for PTSD: Critical clinical lessons for novice exposure therapists. *Psychological Trauma: Theory, Research, Practice, & Policy, 3*(3), 300-308.

Andrea Northwood, Ph.D, is a clinical psychologist and director of client services at the Center for Victims of Torture in the USA, Jordan, Kenya and Uganda. She has conducted research and has clinical experience in the assessment of post-traumatic stress disorder, cross-cultural issues in assessment, and adolescent identity issues in trauma survivors.
email: anorthwood@cvt.org
Paul Orieny, Ph.D, is a psychotherapist and international services clinical supervisor at the Center for Victims of Torture in the USA, Jordan, Kenya and Uganda.

A short reaction to invited commentaries on Mundt et al., this issue

Adrian P. Mundt, Petra Wünsche, Andreas Heinz & Christian Pross

The authors would like to thank Neuner et al., Yule, Fernando, Rasmussen, Pedersen, Northwood & Orieny for their elaborate comments. Pedersen comments in this issue on the wider discussion situated between two poles. Our paper was written with the

awareness that it may raise attention and evoke positions that correspond to positivism and cultural relativism, with their respective focus on quantitative models aimed at restoring brain function on the one hand, and specific cultural and political contexts on the other. We hope that the evolving discussion can help to bridge this gap.

In the following commentary we would like to address a few specific points raised in this debate. Firstly, we feel that the allegiance effect described in the commentary of Fernando can possibly bias randomised controlled psychotherapy trials, and thereby also limit the validity of the effects reported so far. Therefore, it is promising to read about the use of Narrative Exposure Therapy (NET) as a module placed within a more comprehensive approach (Northwood & Orieny). This comment by Northwood & Orieny describes the problems facing the implementation of treatment methods in real life. We welcome the notion that NET in real life is *'client led'* and hope that the authors will continue to report their experiences with this approach.

Secondly, Neuner et al. argue that the rationale of NET goes far beyond overcoming phobic avoidance and includes the correction of fragmented and distorted memory. They also speak of exhaustive reprocessing and meaning making. We appreciate these clarifications, however, it may be important to further elucidate who corrects fragments and distortions, and who creates meaningful narratives in this brief therapeutic relationship. This is even more important, given our impression that recent *National Institute for Clinical Excellence Guidelines* [1] and neuropsychological findings are guided by the NET approach (National Institute for Clinical Excellence, 2005). Neuner et al. are correct to point out that we did not exhaustively write on the strengths of the NET trials in particular, also, Rasmussen emphasises an important point when stressing the importance of randomised controlled trial (RCTs), in general. Nevertheless, we would like to remind all of us that these methodologically valid approaches also have their limitations. While RCTs became state of the art in psychotherapy research, in our view it is at least as important to examine the contextual embedding and sociocultural effects of any therapeutic approach – a topic of the recently developed field of *'critical neuroscience'*.

Thirdly, there is an interesting analogy between psychotherapy and medication raised in the commentary by Yule. This analogy elucidates one of the problems of standardised therapeutic approaches, because they require applying the same standards for testing medication and for testing psychotherapy, even in complex social settings. Our clinical and research experience suggests that testing medication requires a high level of standardisation, blinding and control. We are afraid that trying to establish such rigid standards comes at a price, in that it can detract attention from the complex social effects, interactions and hierarchies that influence the behaviour of therapists and clients in war torn regions. So, while standardised testing is important to assess treatment outcomes, it may not justify superiority claims in such diverse situations.

Fourthly, Yule suggests that *'even effects of medication may well take time to effect a change in an organism'*, referring to the delayed onset of action of, for example, antidepressants. This point addresses our questions regarding variable and inconsistent time points used to assess the effects of NET. We feel that in hypothesis testing pharmacological studies, it is key to know when an effect is to be expected and to adjust testing schedules accordingly. Studies assessing psychotherapeutic interventions may not know beforehand when effects are to be expected. However, in this case they are exploratory and results require independent confirmation. This is one of the major points we would like to emphasise. This is, of course, even more important if a series of largely

uncontrollable life adversities occur within the observation period. Hence, further studies will have to identify the most adequate time point to assess the effects of short term psychotherapeutic interventions. Possibly, the answer is somewhere inbetween immediate effects (measured at the end of treatment as suggested by us) and the one year delay proposed by Neuner and co workers. We agree that there can be pragmatic reasons to delay post treatment assessments, however, we feel that one year after the end of treatment may be too long, particularly within fast changing social situations with multiple stressors.

Altogether, we agree that our field should further strive for effective interventions. It remains to be seen to what degree they should focus on social contextualisation or universal models of neuropsychological brain function. In any case, we would not be able to discuss these points without the ground breaking studies of Neuner and co workers, to whom we express our deepest respect.

References

National Institute for Clinical Excellence (2005). *Post-traumatic stress disorder (PTSD): The management of PTSD of adults and children in primary and secondary care, Clinical guidelines, CG26.* London: Gaskell and the British Psychological Society Retrieved from http://www.nice.org.uk/CG26.

Adrian P. Mundt, M.D., Ph.D., Research fellow at the Unit for Social & Community Psychiatry, Barts & The London School of Medicine & Dentistry, Queen Mary University of London, UK holding a European Union Marie Curie International Outgoing Fellowship at the Escuela de Medicina sede Puerto Montt, Universidad San Sebastián, Chile
email: a.mundt@qmul.ac.uk

A beneficiary's voice: a concluding commentary on NET by Ismael O.

Frank Neuner, Maggie Schauer & Thomas Elbert

As shown in our previous paper in this debate (this issue), we have used the best scientific standards to evaluate Narrative Exposure Therapy (NET). However, in concluding this debate we realised that the one voice missing here was that of those who have benefitted from NET.

Within a variety of conflict settings, survivors have turned to us to help them overcome their suffering and pain. Yet, how can we communicate what it means to be able to put the unspeakable into words, have symptoms decreased and go on with life? How can we quantify the effect of the trauma being reflected and integrated into one's biography, when survivors tell us: *'life does not just consist of fear, anger, shame and guilt any more*', or: *'this is my story, finally, I have a feeling of identity!*' For this reason, we would like to conclude with the testimony of Ismael O., one of the many clients who has experienced NET, and who represents the experience of many other Sudanese refugees in an Ugandan settlement. Ismael O. participated in one of the first NET treatment trials. In the Posttraumatic Diagnostic Scale, Ismael O. scored 39 before