Do we really have enough evidence on Narrative Exposure Therapy to scale it up?

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This invited commentary reflects on utilising Narrative Exposure Therapy protocols in very different cultural setting than those they were originally developed for, and is a response to Mundt et al. (this issue) and Neuner, Schauer & Elbert (this issue). The author discusses several key issues that should be considered, including: the allegiance effect, demand characteristics, clinical efficacy, and ecological validity. Although randomised controlled trials have demonstrated impressive support for Narrative Exposure Therapy in conflict settings, several issues remain to be addressed prior to large scale use of the therapy within traditional cultures.

Keywords: culture, Narrative Exposure Therapy

Introduction

Much has been written about whether post-traumatic stress disorder (PTSD), as a construct developed in high power individualistic (HPI) cultures,[1] is a universal response to trauma. However, there is far less discussion about the utility of specific treatments for PTSD that have been developed in HPI countries and implemented in low power collectivistic (LPCO) cultures. In this commentary, the focus is on the following issues that should be helpful when considering implementing therapies, such as Narrative Exposure Therapy, in LPCOs. These are discussed in detail below and include: a) the allegiance effect, b) demand characteristics, c) clinical efficacy and d) ecological validity.

The allegiance effect

The allegiance effect[2] refers to the robust research finding that a significant proportion of variance in psychotherapy outcomes can be explained by the therapist's preferred mode of therapy and refers to the allegiance of a therapist to a particular mode of therapy. For example, examining 17 meta-analyses of two active types of therapy (e.g. cognitive behavioural therapy versus psychodynamic therapy) for several mental disorders (including anxiety disorders, such as PTSD), Luborsky et al. (2002) found only small differences in effect size for any one therapy. When the allegiance effect of the therapist was taken into account, the difference in effect size decreased even further, and the differences between therapies became insignificant. The strength of the allegiance effect is also often demonstrated when proponents of the therapy make claims for the therapy that go beyond the data. For example, in a paper by Neuner et al. (2004) the authors provide evidence for the efficacy of NET compared to supportive counselling and to psycho-education. In conducting the follow-up evaluation, the outcomes for the NET group were far better compared to the other groups. It was also found that many in the NET group had been offered housing and other resources, which the authors suggest might have led to these better outcomes. Up to this point, the authors maintain scientific objectivity. However, rather than considering the hypothesis that the better outcomes were due as much (or more) to the receipt of housing and its concomitant resources, the authors suggest that it was the receiving of NET that led to these participants obtaining such housing. This kind of post-hoc formulation amounts to reverse causality, and

goes far beyond the results. It is unfortunate that such a formulation remains theoretical, since the authors could simply have asked participants this question about housing during the follow-up assessment. In the absence of such data, this particular claim for NET is unwarranted.

In this issue, Neuner, Schauer & Elbert, responding to the critique of Mundt et al., claim advantages for NET that seem, to this author, to be well outside the scope of what has actually been measured in their studies. Thus, providing further evidence for allegiance to their preferred mode of therapy. For example the researchers postulate that '*the memory restoration and reorganisation of brain structures … as well as behavioural and interpersonal changes due to the narrative reprocessing in NET continue to have an ongoing curative effect for many months and years, even in complex trauma survivors*' (Neuner, Schauer & Elbert, 2014). It is unclear which of the researchers' studies on NET have measured memory restoration and reorganisation of brain structures, and which studies have examined such long-term effects several years post therapy. In my opinion, such claims only serve to undermine the objectivity and scientific stance of the developers of NET.

To my knowledge, the '*active ingredient(s)*' of NET has/have yet to be assessed. That is, when two groups are randomly assigned either to receive NET, or to receive no treatment or alternative treatment, and those receiving NET have better outcomes, it is (reasonably) assumed that NET itself *is* the active ingredient. Yet, these key aspects of NET have not yet been '*dismantled*.' The rationale for NET is that '*PTSD results from an excessive and uncontrolled sensory/perceptual memory representation of the traumatic event that is accompanied by fragmented, verbal autobiographic, contextual information*' and that '*narrative exposure reorganises this memory distortion by constructing a life story that includes a coherent autobiographic memory of the traumatic events*' (Neuner et al., 2004). However, I do not believe that studies of NET have assessed participants' original and/or final narrative for variables such as fragmentation, memory distortion, or coherence. Such dismantling might help to uncover if NETdoes include the key ingredients as set forth in its rationale, and if these key ingredients are necessary for healing post trauma, thereby giving NET an advantage over healing rituals and interventions already available in the culture. With regard to reducing the allegiance effect, at least one study needs to be conducted where NET is not the '*preferred*' mode of therapy, before it is freely used in LPCOs.

Demand characteristics

The second issue is known as *demand characteristics*: because proponents of this therapy conduct studies of NET, there is a possibility that NET therapists and researchers may be revealing their biases to their clients. This issue may be particularly salient when considering how the therapy is conducted, as clients are provided therapy within their own homes and communities, and therefore may be comparing their experiences with each other. Random assignment does not control for such types of demand characteristics.

Clinical utility and ecological validity

Clinical utility refers to the usefulness of a treatment beyond what is demonstrated through randomised controlled trials (RCTs). Ecological validity refers to the salience and meaningfulness of a given construct or intervention for a particular cultural context. Even if NET were shown to be efficacious in reducing symptoms of trauma in people from LPCO cultures, is it the most effective (useful) or appropriate treatment for use in its current '*acultural*' form, if other ways of dealing with suffering are already available within the culture?

For example, NET has not been compared with healing rituals and other interventions already existent with the local culture. Further, it was developed within a specific context, for a specific cultural group with a shared cultural worldview (more individualistic than collectivistic).

The developers of NET also state that NET occurs within the context of human rights, responding to this context by documenting state sponsored violence and human rights abuses. However, just as with the claims with regard to NET reorganising brain structures, this author does not recall any studies addressing how NET was actually used to document state sponsored violence and/or human rights abuses. If some steps were taken to help victims of human rights abuses seek justice and/or recourse as part of NET, I would venture to guess that NET would become extremely salient to that culture and gain much ecological validity. Until then, I wonder in what ways the developers of NET have ensured ecological validity for their intervention.

One class of variables that is *not* being measured in studies on NET is whether participating might actually lead to a *decline* in resilience that a person from a LPCO country might experience as a function of being connected to his/her culture. Since NET is being conducted with little to no input from gatekeepers of the culture where it takes place, the therapy might actually be '*uprooting*' the client from more culturally accepted ways of handing suffering, leaving the person more vulnerable to distress in the future. There are indigenous forms of resilience yet to be fully documented through RCTs (see, for example, Kirmayer et al., 2011). In a Special Issue of *Transcultural Psychiatry* devoted to this topic (Hinton & Kirmayer, 2013), there are several excellent examples of how victims of large scale traumas cope and recover from their suffering. If NET can be compared against such culture specific healing rituals and found to be superior, it would certainly demonstrate ecological validity for this intervention.

As an example, what if a form of therapy that was extremely effective in Sri Lanka or Africa were tested in Germany with native Germans and found to be slightly better than a more accepted form of therapy in Germany? Would it not be reasonable to argue that, given that the therapies are not startlingly different in outcome, it would be more appropriate to keep the latter therapy in place as it provided a more culturally embedded context? Furthermore, it cannot be foreseen what aspects of culture might have been tampered with by introducing the Sri Lankan therapy?

Conclusion

The developers of NET have attempted the very difficult task of conducting RCTs to demonstrate the efficacy of their intervention. They have used methodological rigor in conducting their studies, and have attempted to increase, as much as possible, the internal and external validity of their findings. The results of the studies are therefore of great importance. However, I do believe that the authors' claims for NET go beyond what are warranted by the current results. Thus, I would argue against a wholesale adoption of NET for use within LPCO cultures until further studies have established it as being superior to healing practices and interventions currently available within these cultures. There may be very little lost in translating the therapy from Germany to other cultures, but that might also be its greatest weakness.

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[1] I have proposed a new terminology that moves away from referring to cultures as *'eastern/western'* or *'low-income/high-income'* as they do not lead to accurate ways of classifying cultures. I use the dimensions of power (high/low) and self concept (individualistic/collectivistic) to group cultures. In this terminology the so called *'western'* or *'high income countries'* of Europe and North America are characterised as high-power individualistic (HPI) cultures, while many *'non-western'* or *'low income countries'* would be relabelled as low-power collectivistic (LPCO) cultures. See Fernando (2012).

[2] The allegiance effect is also known as the *'Dodo bird verdict'* after a scene in the novel *'Alice in Wonderland'* where a competition is ended by the Dodo bird's verdict: *'Everybody has won, so all shall have prizes'* (See Luborsky et al., 2002).

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Further thoughts on evaluating interventions for posttraumatic stress disorder in low and middle income countries

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While agreeing that there are very few studies on Narrative Exposure Therapy, the author responds to the critique of Mundt et al. (elsewhere in this issue), by arguing that psychological interventions should not only, nor primarily, be evaluated by outcomes immediately after the end of the intervention. This is because psychological interventions, such as Narrative Exposure Therapy, aim to start a