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Introduction to a Special Debate: the role of brief trauma focused psychotherapies (such as Narrative Exposure Therapy) in areas affected by conflict

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This journal, while focused on mental health and psychosocial support in (post) conflict settings, has had surprisingly few specific studies focused on posttraumatic stress disorder (PTSD) and the therapies geared to treating it. This is remarkable, especially given the fact that over the last few decades a heated debate has unfolded between those who see psychological trauma as a major (perhaps even *the* major) mental health issue in conflict affected populations and those who prioritise non trauma related mental health or psychosocial issues that manifest themselves *between people*, rather than in the minds of sufferers. The authoritative *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (Inter-Agency Standing Committee, 2007) remain largely silent on this issue, which has prompted criticism (see e.g. Cardozo, 2008; Yule, 2008). While this journal has chosen not to take an explicit position in this debate, it has regularly been a platform for authors with critical views on psychological treatments for trauma (e.g. Rabaia, Nguyen-Gillham, & Giacaman, 2010; Tawil, 2013). Authors with more favourable views on PTSD treatments seem to have preferred to publish their papers in other journals. The divide between the worlds of western trauma specialists and of humanitarian mental health and psychosocial support is unfortunate. However, in the last few years we have witnessed attempts to develop comprehensive, conceptual frameworks that situate the effects of psychological trauma within a wider social and existential context (Silove, 2013). Improved communication would, no doubt, advance the field of mental health and psychosocial support (MHPSS). Fruitful collaboration between trauma focused experts and other MHPSS workers is very well possible, as is demonstrated by the newly issued Mental Health Gap Action Programme (mhGAP) module on *Assessment and Management of Conditions Specifically Related to Stress* (WHO & UNHCR, 2013), which incorporates systemic, scientific evidence on trauma related disorders within a public mental health framework relevant for low resource settings (Tol, Barbui & van Ommeren, 2013). One of the recommendations in this module is to consider referral for individual or group therapy with a trauma focused, cognitive behavioural therapy (TF-CBT), or eye movement desensitisation and reprocessing (EMDR), if trained and supervised therapists are available. This may be seen as a conceptual breakthrough, but the devil is in the last phrase: '*if trained and supervised therapists are available*'. In low and middle income countries, fully licensed mental health specialists are unable to do the job, because they are simply not

available in sufficient numbers. Thus, we need to evaluate whether it is possible to train non professionals to deliver such trauma focused, psychotherapeutic interventions in a safe and sustainable way. The work of a German group of clinicians and a researcher, led by Frank Neuner, Maggie Schauer and Thomas Elbert, has been instrumental in developing a brief psychological intervention for psychotrauma, (Narrative Exposure Therapy or NET) to be delivered by lay workers. NET can be qualified as brief form of behavioural therapy that is '*packaged*' in a way that makes it acceptable for people who may otherwise not be inclined to participate in psychotherapy. A novel element of NET is the explicit weaving of traumatic events into the life narrative of the person, through the use of life testimonies. Some of the early work on NET, when it was still in its initial stages of development, has been published in this journal (Onyut et al., 2004; Schauer et al., 2004). At that time, it raised some concerns, for example that such brief therapy would lead to: 1) a narrow focus on predefined symptoms, while ignoring the context in which they occur and that produce them; and 2) bypass local explanations and understandings of suffering, and consequently silence local response and disempower clients (Pérez-Sales, 2004; Igreja, 2004). Since then, the developers of NET have done systematic research on the efficacy of their method.

This *Special Debate* on NET was prompted by the submission of a critical review on the evidence around NET. The authors, *Adrian P. Mundt, Petra Wünsche, Andreas Heinz & Christian Pross* (this issue) have scrutinised the randomised controlled efficacy trials on NET in low and middle income countries. While acknowledging the pioneering work around NET, they remain cautious on its potential. One of the points they raise is that the effects of NET were often not clear immediately after the treatment, but only at later follow-up points, which they find puzzling and incompatible with the proposed treatment mechanism of NET. More in general, they warn against the use of short term psychotherapies for complex forms of PTSD and seem to be wary of NET as an attempt to alleviate PTSD through a small number of sessions. Mundt and colleagues resist the idea that psychological trauma, particularly in its severe and sequential forms as often found in complex humanitarian emergencies, as something than could easily be '*undone*' by a few sessions of psychotherapy.

As a result, the Editorial Board invited the developers of NET to respond to these criticisms. *Frank Neuner, Maggie Schauer & Thomas Elbert* used this opportunity to write an extensive and thorough rebuttal, in which they vigorously defend their therapy, and argue that, compared to any other type of psychotherapeutic or psychosocial interventions in post conflict settings, the evidence base of NET is solid, and that it can and should be recommended for wider use (Neuner, Schauer & Elbert, this issue). The evidence around NET is impressive indeed, and moreover, recent trials with trauma-focused psychotherapies concur that such interventions can be highly effective, even in desperate settings devoid of formal resources, such as the violence torn Kivu provinces in the Democratic Republic of Congo (Bass et al., 2013).

The Editorial Board considers the discussion around brief trauma focused psychotherapies very important and wishes to put the discussion within a broader perspective, not just about the merits of NET alone. Therefore, we commissioned five commentaries, representing a range of perspectives on this issue.

Duncan Pedersen, a distinguished anthropologist with a keen interest in trauma across cultures, summarises the debate between those who postulate universal trauma responses and treatment options, and those who see trauma responses as variable within context and culture. He finds it worrying

that most of the research on trauma in conflict affected areas is about *'externally developed interventions'*, without comparing local ways of dealing with trauma and often failing to demonstrate that they are more effective than natural recovery. He emphasises that interventions must be flexible and adaptable to social and cultural contexts, in order to be locally relevant and sustainable. Ultimately, he argues *'we need to move beyond the narrow psychological scope in order to restore the sense of safety, equity and social justice'*.

Gaithri Fernando, a psychologist who has written passionately about trauma in Sri Lanka, remains critical too. She fears that the positive results of NET may be partially biased because the trials were mainly conducted with therapists who strongly believe in this, particular, therapy. She also calls for more research, and particularly research that would compare NET to local healing practices and interventions.

William Yule, an emeritus professor child psychiatry from the United Kingdom, and a lifelong advocate for the rights of children in low and middle income countries (LMIC) to effective treatment for psychological trauma, is much more optimistic. To him the findings that that the effects of NET become measurable only a few months after the therapy has ended is neither surprising nor suspicious *'because psychological interventions, such as Narrative Exposure Therapy, aim to start a process of recovery that may continue long after treatment and eventually result in stronger change'*.

Andrew Rasmussen, a psychologist and researcher from Fordham University in New York, focuses on the criticism that NET may be disconnected from larger health systems. He considers such criticism unfair because randomised controlled trials evaluating whether a specific treatment modality works for a specific problem, are necessarily limited in scope, and this is not a specific problem related only to NET. Empirical health systems research requires a different approach, and Rasmussen suggests that the field of MHPSS urgently needs such research in order to find out how various intervention modalities can be made functional within a system of care.

Andrea Northwood & Paul Orieny, an American and Kenyan/American psychotherapist with the Center for Victims of Torture in Minneapolis, MN (USA), use NET in their daily work as psychotherapists, trainers and supervisors. They have worked with NET and have found it a useful tool that is conceptually sound and adaptable to a variety of contexts. It is not, however, a magical bullet. They found NET to be *'demanding'* and *'challenging the skills of practitioners'*. While they have integrated NET into their psychotherapy programmes in the US for migrants who had survived torture, their experience is that it often takes longer than just a few sessions. In low resource settings, their experience is that NET demands longer training, requires extensive supervision and a certain level of contextual stability. This significantly affects the utility of NET in many conflict affected areas. Rounding off the debate, Adrian Mundt and his co-authors react briefly on all comments and reflections that their article has prompted. Frank Neuner and his colleagues were also asked to provide a final word. They have chosen, quite appropriately, to give the last word to a South Sudanese refugee who tells that after having ended psychotherapy with NET, despite the ongoing hardships of daily refugee life, he feels less haunted by the memories of the past.

I hope the readers of *Intervention* will enjoy reading this section as much as I did. The discussion is rich and multi-faceted, and readers will be able to draw various conclusions for themselves. For me personally, I distil two lessons for future research. Firstly, research into psychological treatment modalities for trauma needs to be broadened to include local perspectives and culturally relevant solutions (Kohrt et al., 2014, Rasmussen, Keatley & Joscelyne, 2014). It is encouraging to see that in their latest publications the

group around NET do explicitly take this avenue (Neuner et al., 2012). Secondly, the emerging evidence on efficacy of specific therapeutic interventions in low resource settings needs to be complemented by health systems research in order to learn how we can build sustainable systems of care in such settings (Jordans & Tol, 2013). '*Scaling up*' from well controlled research settings to routine health care delivery systems is a major challenge for many mental health interventions that are based on skills that need to be well trained and supervised (Belkin et al., 2011; Murray et al., 2011). One concept that is *en vogue* in this regard is '*task shifting*': the delegation to paraprofessionals of circumscribed specialist tasks, after competency focused training and with appropriate supervision. The results of task shifting approaches in global mental health research are promising, particularly for psychotherapeutic interventions such as problem solving therapy (Chibanda et al., 2011), cognitive behavioural therapy (Rahman et al., 2008) and interpersonal therapy (Bolton et al., 2003). In this respect, it is also important to develop interventions that are not too narrowly focused on one specific clinical problem, but to teach non specialised workers skills that are useful and effective for a wider variety of issues that can more flexibly address not only PTSD, but also related co-morbid disorders. It is of critical importance to address urgent questions about requirements and obstacles in resource poor contexts to scale up such low intensity psychological interventions of sufficient quality, and study how they can be delivered as part of standard care. Some exciting work in this area is being done (Jordans et al., 2013; Hanlon et al., 2014, Murray et al., 2013), but much more information is needed. I believe that when perspectives on local meaning making and sustainable systems of care are integrated into the research agenda, we will finally witness the coming-of-age of trauma research in areas affected by conflict.

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