

## Letters to the editor

### **Some critical notes on Onyut et al: *The Nakivale camp mental health project: building local competency for psychological assistance to traumatized refugees* (1)**

In the above mentioned article the authors propose a model (Narrative Exposure Therapy), but fail to clearly articulate the exact details of what this model is (although some facts can be deduced from their previous paper *Narrative Exposure Therapy in Children: a Case Study* published in a previous issue of *Intervention*).

The paper left me with conflicting feelings. On the one hand, I appreciate the authors' effort and courage in developing a model such as the one proposed. Mental Health and Psychosocial programmes with refugee populations are often constrained by limitations of resources and outreach. What is the usefulness of a mental health clinic with two or three Western-trained professionals in the middle of a 50.000 person refugee camp?. What is the usefulness of a wonderfully designed and incredibly expensive torture victims centre in a nice place in the capital of a country, providing treatment for a select group of people who know, accept, acknowledge and can access the resource, as we have repeatedly seen in many countries under the influences of international institutions promoting the creation of such centres? The last decades have seen the design and implementation of new ways of working which put more emphasis on capacity building and training the trainers models than on direct provision of services to a select group of people (e.g. Lavelle et al, 1996; De Jong (ed), 2002). I understand that the NET model is a worthwhile effort following this line, and in this sense it should be warmly welcomed.

I must also acknowledge the appropriateness of adopting some of Lira and Weinstein's

ideas (Lira & Weinstein, 1984) when working using the testimony method as a frame of reference. Latin American work in human rights and mental health has a long standing tradition unknown to many English-speaking colleagues (e.g. Martin-Baró, 1990). The theoretical models developed under circumstances of war and state-sponsored violence during the last 50 years are an invaluable source of knowledge and wisdom. They should deserve more attention and I welcome the authors' effort to develop this line of work.

On other matters, Onyut's et al paper leaves me with some questions and doubts that I would like to point out briefly.

1. Psychological consequences of chronic trauma have to do with (a) the breakdown of basic schemes regarding the self and the self relation to the world, which are closely connected to the meaning given to life, confidence and trust ties and the sense of dignity. (b) the breakdown of the social fabric, that is, the network of human, economic and social relations in which life takes place and makes sense, the capacity to feel able to rebuild it as an individual, but also the sense of agency as a community and as a group. (c) the grieving process interwoven with all the above mentioned (specially with refugee population, where multiple losses are the rule).

These issues seem not to be addressed, apparently, by their programme, although it must be acknowledged, as Weinstein herself does (Lira & Weinstein, 1984) that the work of recounting one's history is, partially, an attempt to make sense of one's own experience.

The authors' programme is mainly focused on the alleviation of PTSD symptoms through net therapy. Even accepting the transcultural validity of PTSD symptoms

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(something that not everybody would fully accept, and the subject of a different debate), and while acknowledging the importance of decreasing these symptoms, an intervention based solely on this goal may not be an integral response to the problem as far as:

- It does not seem to address the *meaning* of the personal narrative, and how this affects one's views of himself and the world and how to rebuild a sense of life.
  - It seems to approach the person as isolated from the context (not in the *causes* of suffering, something the authors acknowledge, but in the *therapy*). Maybe a programme of community and collective analysis, and reconstruction of historical memory in small groups, organized by ethnical or by geographical areas of origin could be a good complement to their work. This is what many of us have been doing in Chiapas (Mexico), Guatemala and Chile, where individual (top-down) and community (bottom-up) focuses have been utilized in a complementary and interactive way. For instance, in the work with displaced and refugee people from Acteal (Chiapas), where conflicts and violence were appearing among the refugees, we used a combination of participatory techniques with an historical reconstruction through drawings and talks of the process of displacement and sheltering, grieving group work with widows and individual therapy (with a similar testimony methodology) with the most affected people. Similar work was done after the earthquake in El Salvador (Vazquez et al, in press, Pérez-Sales et al, in press).
2. Testimony with therapy is a sensible alternative that might be problematic in some instances. I have had the pleasure to work with Elizabeth Lira and I can hardly

remember a patient in her consultation who had been seen for just 3 or 4 sessions, as the authors seem to propose. Most of her patients were followed for months and testimony therapy was used as one of a wide array of therapies. Follow-up was assured.

The availability of follow-up is one of the doubts that arise when reading Onyut's et al paper. *Mohammed's* case, as described in their previous paper (Schauer, 2004) is not an uncommon case. I can now remember S., a child-soldier recently attended by a colleague with a personal history that resembles that of Mohammed. After an initial *honeymoon* reaction, problems have been recurrently appearing over the following two years every time his personal circumstances worsened (unemployment, legal status in Spain...); these events trigger a re-enactment of his trauma symptoms, a phenomena often described in therapy (i.e. Silove, 1997)

Brief therapies with unusually good results (like EMDR) should be considered with caution. I am not saying this is the case for NET, but I would like to know how the authors address this key issue. Pre-post PTSD measures taken in the days before discharge may not be enough to ensure a long-term sustained positive outcome. It would be wonderful to have one and two-year follow-up data for their work, and I will be excited to read that report.

3. Testimony collection implies a pact between the witness and the advocacy personnel. a pact on the goals (what is to be achieved), the real beneficiaries (for whom), and the process (how). The confidentiality of data is mandatory, specially when a person can have serious security problems within his/her country. The person providing testimony should be clear that the therapist is not going to undertake any legal process against the perpetrators. In other words, it is important not to create false

expectations in the sense that “someone” (especially if he is a foreigner) has already collected my testimony, and therefore, “my duty” has been done. If the testimonies are to be handed to a human rights organization for advocacy or legal proceedings, this should be clearly explained. Written consent is mandatory prior to using the testimony for any publication or report. Testimonies should be used exclusively in the manner that the witnessing person wishes. He/she is the owner of his/her testimony, not the person collecting it. Where the information is to be kept, and under which security and anonymity measures, must also be known and agreed upon beforehand. All these issues were clearly addressed by the team of the *Vicaría de la Solidaridad* in Chile and I would be interested to know how they are addressed in NET. They mention in their previous paper (Schauer, 2004) that they give a written copy of the testimony to the person. I would also like to learn more about how they address the other sensitive points that I have highlighted.

4. Exposure is not a universal technique for all PTSD cases. It has very precise indications (see, for instance, APA Guidelines, Foa, 1999). To put forward an example, exposure therapy is not recommended when intense guilt, shame or rage feelings or suicide ideation are present, although some authors may defend it (Astin, Rothbaum, 2000). Even in the case of doing a systematic appraisal of them, guilt, rage or suicide ideas may not always be so evident as to be detectable in an initial interview, even for a trained therapist. Exposure therapy is an option to be taken when less intrusive techniques are not achieving their objective, and once the therapist is sure that all inclusion and *exclusion* criteria are fulfilled. I would be pleased to learn from the authors how they take these risks into account. Perhaps the

point is that one of the potential problems of NET therapy is the name itself. I understand that their methodology is entirely based on Foa’s recommendations for implementing exposure therapy (Astin and Rothbaum, 2000), but this is just one model, one way of doing things, with interesting ongoing debates surrounding it. In summary, a concern remains as to how do they control the existence of exclusion criteria, especially when using trained *barefoot* therapists.

5. In human rights work a key consideration is who has the power in the interview. In the case that someone felt compelled to tell her life account (not forgetting what it means to be the subject of attention of a foreign NGO), story-telling, a useful culturally-sensitive procedure for most persons and cultures, may reproduce situations in which the person was *forced* to talk, reproducing the traumatizing experience. To again offer an example based on our work: among the Maya people in Guatemala, talking about negative experiences and feelings can produce illnesses and damage. Speaking openly, reconstructing one’s experience of *violencia*, is uncommon although it happens. Once again, universal rules are a problem. The appropriateness of reconstructing one’s personal history as a therapeutic tool may obviously depend on culture, the moment and personal needs (there is a moment for everything), and who is listening and how, as Pennebaker (2004) and others have demonstrated.

All these are doubts and questions which I am sure that the authors have already thought about, and I would like just to enrich a debate on how to make contemporary developments in trauma therapy accessible to the vast majority of neglected populations of the world.

I began by stating my support and encouragement to their work and I would like to end

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by making it clear again that I feel very familiar with their concerns. No programme is a panacea and suitable for all contexts and populations. Their proposal is surely one to be taken into account, and allow the dialogue to continue.

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## References

Astin MC, Rothbaum, B. (2000) Exposure therapy for the treatment of posttraumatic stress disorder. *National Center for post-Traumatic Stress Disorders Clinical Quarterly* 9:4, 49-54

De Jong J (2002). *Trauma, war and violence*. Public mental health in socio-cultural context. Plenum Press. New York.

Foa EB, Davidson JRT, Frances A, eds. The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60 (suppl 16).

Lavelle J, Tor S, Mollica R.F, Allden K, Potts L. (1996) *Harvard Guide to Khmer Mental Health*. Harvard Program in Refugee Trauma. Boston. USA

Lira E, Weinstein E (1984). *Psicoterapia y represión política*. Sg XXI editores. México. [*Psychotherapy of political repression*]

Martín-Baro I (ed) (1990). *Psicología social de la guerra. Trauma y Terapia*. UCA Editores. El Salvador. [*Social psychology of war : Trauma and Therapy*]

Pennebaker, J.W. (2004). *Writing to Heal: A Guided Journal for Recovering from Trauma and Emotional Upheaval*. Oakland, CA: New Harbinger Press.

Pérez-Sales P, Cervellon P, Vazquez C, Vidales D, Gaborit M (2004). Post-Traumatic Factors and Resilience: The Role of Shelter Management and Survivors' Attitudes after the Earthquakes

in El Salvador (2001). *American J Community Psychology* (in press).

Schauer E, Neuner F, Elbert T, Ertl V, Onyut LP, Odenwald M, Schauer M (2004). Narrative Exposure Therapy in Children: a Case Study. *Intervention* 2(1), 18-32.

Silove, D., I. Sinnerbrink, et al. (1997). Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. *Br J Psychiatry*. 170: 351-357.

Vazquez C, Cervellon P, Pérez-Sales P, Vidales D, Gaborit M (2004). Positive emotions in earthquake survivors in El Salvador (2001): a naturalistic study in refugee shelters. *Journal of Anxiety Disorders* (in press).

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### **Some critical notes on Onyut et al: *The Nakivale camp mental health project: building local competency for psychological assistance to traumatized refugees* (2)**

The globalisation phenomenon has made possible a high-scale flow of information about life in the so-called remote areas of the world. Contemporary news continuously reaches us, portraying stories of life and death, peace and war, prosperity and poverty, innovation and destruction, and stability and disruptive experiences. Despite this rapid spread of information to which principally urban citizens are exposed, it is still difficult to keep the memories of other people's suffering and mobilize support to overcome

the indifference and inaction that prevails worldwide. The indifference is visible in various areas of the human experience but it is particularly evident in the field of mental health. It is seldom that initiatives take place to improve the quality of life, using mental health indicators and related parameters of action. In this regard, the work of Schauer et al (2004) and Onyut et al (2004) in Uganda refugee camps is a welcome initiative.

The work of Schauer et al deals with the case of a 13 old Somali refugee living in Nakivale Refugee Camp. Through a survey in the camp the boy was identified. The diagnosis disclosed that he was suffering from post-traumatic stress symptoms. He then became a client, after giving the formal consent. The young refugee received psycho-education, and then he received treatment using narrative exposure therapy.

After four sessions, the client successfully recovered and the authors suggest that the method can be applied to more children living in similar conditions around the globe. The work of Onyut and colleagues was also carried out by the same team in the same refugee camp. The aim was to establish the usefulness of short-term interventions to build local competency for psychological assistance to traumatized refugees. The study provides remarkable results in the role that capacity building can play in helping larger groups of traumatized people. It is also remarkable that apparently the trainees, named paramedical personnel, did not experience difficulties in understanding the language of the experimental intervention that was based on the PTSD diagnosis criteria and related interventions.

What unifies these two studies is the recognition that there are devastating consequences as a result of war exposure and forced displacement, and the authors' active engagement in helping people in need of

mental assistance through direct or indirect interventions. Although it is not clear whether the authors lived in the camp during the interventions, what is remarkable however, are the efforts made by the authors and the paramedical personnel working in very difficult conditions and being able to generate positive results.

Without contesting the very important specific results obtained by the authors, it is possible to make some comments. First, there seems to be a contradiction between the chronological age of the boy, treated as a 13 old child, and the capacities that the same boy actually has to be able to integrate into the type of therapy that he is exposed to. There is a whole field of studies trying to understand the meaning of being a child in different socio-cultural milieus and related developmental tasks. More recently the individual meaning of being a child (agency) has also been part of several research protocols. Specifically Schauer et al, do not engage in trying to uncover and to portray the meaning of being a child in a war violent environment of Mohamed Abdul. For the sake of science, Mohamed is simply presented as a case that suffers from a disease called PTSD and that consequently Mohamed needs treatment. The good news however is that after the treatment Mohamed got better.

Secondly, the subjects of both studies are presented as if they did not possess a cultural and historical reality. The only history portrayed is the war violence that they went through and the present state of insecurity that prevails in the camp. This type of approach has deep roots in Africa. The history of Catholicism, for instance, was initially based on the rejection and persecution of everything that symbolized the African system of beliefs and norms. It took almost a hundred years for the moderate Catholics to accept that Africans had their own ways of

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professing what is called religion. And more recently different african religious groups, for the sake of their survival, capacity building and sustainability, had to integrate a number of other people's cultural values and norms into their religious rituals. Apparently it cannot be otherwise.

In this regard, the use of western concepts and philosophies to understand and to frame the effects of war and displacement among Africans in detriment of their own socio-cultural and historical realities can be contested. One thing is the capacity to diagnose and another thing is the definition of appropriate interventions. Some studies provide indications that it is possible to diagnose the effects of violence among African communities using the PTSD technologies because of the similarity that exists vis-à-vis certain clusters of posttraumatic symptoms. Although neither Schauer nor Onyut give examples of local concepts of expressing certain emotional states among the refugees they studied, from other researches it is known that, for instance, in the cluster on intrusive memories it is not so difficult to find accurate local translations. Most cultures have sophisticated concepts and categories to define, for example, dreams, bad dreams, headaches, intrusive thoughts, intense fear, sadness and several other psychological concepts. That is not the main problem. The confusion lies in the type of meaning and interpretation that it is given to bad dreams and the type of action, or better said, health-seeking behaviour that is pursued to find medical care. It can apparently be easy to diagnose PTSD because local people recognize most of the symptoms. Yet it is questionable whether a treatment protocol can be developed to treat the same symptoms, which have a different practical (institutional), historical and philosophical understanding.

Following this line of reasoning, which is not

new, both studies could benefit, and the general public could benefit too, with more psycho-socio-anthropological focus aimed at understanding the people's perceptions and interpretations of their predicament (Richters, 1994) and to demonstrate whether people have local resources available to deal with the effects of war violence and displacement (Turner, McFarlane, & Van der Kolk, 1996). Even during the 1950s George Devereux had given some inputs to this debate. He stated that "it is one of the main faults of psychiatric thinking that it considers only the absolute intensity of the stress-producing impact and forgets that the individual may have valuable resources at his/her disposal for resisting and overcoming the impact s/he has experienced" (1980, p.9). Devereux extended this view to apply to the socio-cultural level. He asserted that at a "cultural level, events or situations may produce trauma if the culture has no defence mechanisms available for relieving or buffering the shock". Accordingly the individual idiosyncrasies, the socio-cultural and political factors play a key role on whether the war violence will concur to the disruption of the individual and the community in various forms.

Two basic things are important when thinking about violence and its effects in contemporary Africa. First, violence is not a new phenomenon. Historically there have been a lot of different violent conflicts across the continent. The current violence may differ mainly in the intensity of the conflicts based on the kind of weapons and killing strategies that are used and the generalized media publicity that is made out of it. Second, as a result of violence, local cultures tended to creatively provide different forms of response to assist the individuals in great need (De Vries, 1996). The creativity is not confined to the creation of new symbols or

medical tools to assist the people overwhelmed by war traumatic experiences. It can also be, for instance, that war survivors decide to remain mute because in a certain moment of their recovery process it is the most rationale strategy to pursue (Tankink, 2004). The main gap at this level of understanding is the lack of systematic knowledge to portray what has been happening at local level in terms of effective or non-effective responses in relation to short or long-term effects of war violence.

Survivors of war and other forms of violence in the poor areas of Africa as well as the weak and limited public health systems across the continent could benefit with the results of empirical research aimed at investigating not only the effects of violence at different levels. Research could increase knowledge of the potential local resources that can boost the recovery process. Questions need to be raised in relation to the availability of local resources, the nature and type of these resources, their adaptation or innovative capacity in the face of different forms of violence, and their effectiveness to deal with violence and its pervasive effects. Such kinds of studies require multidisciplinary methods in which anthropological techniques can preside over the definition of research strategies. One thing is to recognize that people suffer as a result of the violence inflicted upon them. Another thing, which is also important, is to allow people to build, to develop, or to recreate their own tools, institutions and capacities for their own benefit. Ultimately, even if a certain group or community of war survivors do not seem to have valuable resources at their disposal to deal with the multiple effects, it is also interesting to study the reasons for such apparent dispossession of local resources.

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## References

- Devereux, Georges. 1980 [1956]. *Normal and abnormal. Basic problems of ethnopsychiatry*. Chicago: The University of Chicago Press.
- De Vries, Marteen. (1996). Trauma in cultural perspective. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, (pp. 398-413). New York: Guilford Press.
- Onyut, L., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M. & Elbert, T., (2004). Nakivale camp mental health project: Building local competency for psychological assistance to traumatized refugees. *Intervention*, 2(2): 90-107.
- Richters, Annemiek. (1994). *Women, culture, and violence: A development, health and human rights issue*. Leiden: Women and autonomy centre (VENA) Leiden University.
- Schauer, E., Neuner, F., Elbert, T., Ertl, V., Onyut, L., Odenwald, M. & Schauer, M. (2004). Narrative exposure therapy in children: a case study. *Intervention*, 2(1): 18-32.
- Tankink, Marian. (2004). Not talking about traumatic experiences: Harmful or healing? Coping with war memories in Southwest Uganda. *Intervention*, 2(1): 03-17.
- Turner, S., McFarlane, A., & van der Kolk, B. (1996). The therapeutic environment and new explorations in the treatment of posttraumatic stress disorder. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp. 537-558). New York: The Guilford Press.

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