

7. Base counselling and therapy on a human/child/woman's rights based, testimonial approach, acknowledging past injustice and favouring social change toward the implementation of those rights.
8. Ensure a stringent form of evidence based project evaluation, which is best in the form of RCTs with variation protocols and longer-term follow-up of beneficiaries.
9. Finally, challenge the nihilism of global health planners regarding the role of mental health, especially as it relates to a global commitment to the provision of adequate funds for mental health implementation research.

Vertical trauma focussed interventions versus broader horizontal psychosocial interventions

Duncan Pedersen

Despite an influx of agencies conducting psychiatric and psychosocial interventions worldwide, there is scarce agreement regarding treatment goals and best practice to deal with trauma related mental disorders. A systematic review of posttraumatic stress disorder treatments concluded that scientific evidence on treatment modalities did not reach the level of certainty that would be desired. This commentary ends by outlining the kind of evidence that would be required.

Keywords: Narrative Exposure Therapy, posttraumatic stress disorder treatment, psychosocial, trauma focused interventions

The discrepancies between Mundt et al. (this issue) and Neuner et al. (this issue) regarding Narrative Exposure Therapy (NET) are part of a wider discussion based on persistent differences and substantial variance among researchers, mental health experts, clinicians, first responders and practitioners, over best practice to reduce the mental health burden in war torn and post war societies (Shalev, 2002; 2006; Gersons

& Olf, 2005; Hobfoll et al., 2007; Allden et al., 2009).

These differences and variance, regarding best practice, may be situated within a range or gradient between two poles. At one end, we find a group of authors who seem to argue that the response to traumatic events and stressors involves universally recognisable patterns, including diagnosable medical conditions such as acute stress disorder and posttraumatic stress disorder (PTSD), that are amenable to trauma focused interventions and standardised treatments derived from Western traditions (Mollica et al., 2004; de Jong, Komproe & van Ommeren, 2003, among others). At the other end, we are likely to find a more sceptical and critical position, coming from a sector of health and social scientists, suggesting that traumatic events have far broader, more varied and complex meanings and effects than those recognised by conventional psychiatric nosology or practice (Bracken & Petty, 1998; Summerfield, 2004; Kirmayer, Lemelson & Barad, 2007; Pedersen et al.,

2008). These effects, it is further argued, evoke a wide range of culturally specific, adaptive strategies that continue to be poorly understood and, therefore, are more inclined to adopt broader psychosocial interventions (Williamson & Robinson, 2006).

Also, within this range of views and positions, many of those results that have claimed to be successful for trauma focused treatments (such as NET), should be accepted with caution as they often fail to demonstrate that they are more effective than natural recovery (Ehlers et al., 2010; Rabaia, Nguyen-Gillham & Giacaman, 2010). Overall, it has been further recognised that clinical evidence is lacking on: a) who should (or should not) receive specialised treatment when confronted with psychological trauma; b) what kind of intervention is best to be prescribed and what should be the optimal duration of treatment; and finally c) how and why a clinical intervention may work in some cases and not in others (Yehuda, & Hyman, 2005). Randomised controlled trials (RCTs) of bona fide interventions, such as single sessions of individual debriefing, showed not only insignificant results in reducing PTSD symptoms when compared to no treatment, but in some cases made the patients worse (Rose, Bisson & Wessely, 2003a; 2003b), and in addition, may have even been harmful (Raphael & Wilson, 2000).

What kind of evidence is needed?

In order to outline the kind of evidence needed to strengthen interventions for traumatised populations in low income settings, we should begin by acknowledging the work of a committee, appointed by the Institute of Medicine (IOM), to conduct an evidence based review of best treatment practice, treatment modalities and treatment goals for specific interventions for individuals with PTSD (IOM, 2008). After conducting a

systematic and comprehensive search of the literature (N = 2,771 studies), the committee reviewed 89 RCTs meeting the inclusion criteria (37 on pharmacotherapies and 52 on psychotherapies), in a variety of patient populations, with both combat and non combat related traumas. The committee concluded that, for all drug classes and specific drugs reviewed in each of the classes, the evidence was inadequate to determine their efficacy in the treatment of PTSD. Scientific evidence on treatment modalities for PTSD has not yet reached the level of certainty desired. With regard to psychotherapies, the committee stated that evidence remained inadequate or insufficient to determine the efficacy of all psychotherapeutic modalities, with the exception of exposure therapies (such as cognitive behavioural therapy), where the evidence was sufficient to conclude its efficacy in the treatment of PTSD. This rigorous assessment of exposure therapy, conducted by IOM, may favour NET as one of the few psychotherapeutic treatments with enough evidence to assume its efficacy. Interestingly, this is in convergence with the conclusion of the review conducted by Mundt et al., that in spite of the caveats '*...there is very promising evidence emerging from this treatment method*'. I would tend to agree with this statement, and with the conceptual issues discussed in the second section of their paper. I would further agree with the core message of the IOM Report, and of Mundt et al., in the sense that we do need better quality research, and this is true not only for exposure therapies, including NET, but also for every PTSD treatment modality. In addition, we need to examine the most important '*active*' components of both exposure therapy and NET, in order to determine optimal length of treatment, individual versus group delivery formats, and efficacy and relevance to different sub populations.

Beyond the discrepancies about NET as a proven or unproven efficacious therapy, the

collected evidence far from supporting a specific intervention model, reiterates the need for interventions to remain flexible and adaptable to the prevailing social and cultural context and specific circumstances of the traumatic experience (Silove, 2013; Hobfoll et al., 2007). Notwithstanding, there are a few promising pathways to follow,

which may incrementally contribute to build-up empirical evidence for more efficacious, compassionate and sustainable interventions across the response chain. These pathways include: devising more sensitive tools for screening and early detection and treatment of those in need; examining specific interventions to promote resilience

Box 1: Psychological interventions in areas affected by violence, an example from Peru

In Peru, after two decades (1980–2000) of political violence and a wide spread internal war between Shining Path and the military, which left about 70,000¹ people dead or disappeared, including massive numbers of internally displaced, substantial variance remains between governmental and nongovernmental organisations (NGOs), religious driven relief and advocacy organisations (including public health experts, psychiatrists and clinical psychologists), over the nature, structure and content of medical and public health interventions aimed at reducing the mental health burden among affected populations. In the late 1990s, the Ministry of Health (MOH), the University of San Marcos, and two large psychiatric hospitals, launched an intervention, with support from the Japan International Cooperation Agency and the US based Harvard Trauma programme. This was a trauma focused clinical intervention, consisting of weekly visits by psychiatrists to provide clinical services, targeting mostly indigenous populations in the Sierra region. The proposed clinical intervention was assumed to be widely applicable, but remained of limited social and cultural relevance to the target groups, engendering poor acceptability and uncertain therapeutic efficacy. This initiative was followed by many other short lived initiatives by nongovernmental organisations, community based and self-supported groups, religious and civic associations, a few more longer lasting local organisations², and some university based or church driven organisations³, which emerged with bilateral support from various donor agencies from high income countries.⁴ Each local organisation followed a different approach, most often influenced by the donor or guidelines written by international or governmental organisations, or by their own initiative. While there were a handful favouring a trauma focused intervention, addressing distress and trauma primarily within the medical or psychological paradigms, a larger group advocated the application of wider, more holistic psychosocial approaches, adopting a ‘collage’ of different therapeutic and psychosocial paradigms. While many of these efforts have been reported as successful, and were important sources of support, bringing relief and creating hope among victims and survivors, most interventions were conducted with no reliable baseline data against which to measure progress, and lacked specific outcome measures for assessing their effectiveness, and in some cases remained of doubtful cultural validity. The various governmental sectors, such as the Ministries of Health and the Ministry for Women & Vulnerable Populations, the Comisión Multisectorial de Alto Nivel (CMAN); the Programa Integral de Reparaciones (PIR), the NGOs, and the various communities affected, have a major challenge ahead of them in terms of dealing with the long term social and mental health consequences of two decades of political violence and internal war.

and strengthen the process of natural healing; and focus our attention in both primary and secondary prevention domains, in order to develop preventive measures and early interventions for reducing the overall burden of chronic illness among survivors. In addition, in the mid and long term, we need to move beyond the narrow psychological scope in order to restore the sense of safety, equity and social justice (Tawil, 2013), while promoting agency and social cohesion among survivors. This then aims to normalise and resume everyday life, with the ultimate goals of reconstructing the social tissue and rebuilding of local economies negatively affected by mass violence, protracted conflict and war. Moreover, we need flexibility to adapt RCT design where necessary, and apply innovative research designs when RCTs are not feasible, or the field conditions impose major limitations (Tol et al, 2011).

The difficulties of designing and evaluating psychosocial interventions within a war affected context are illustrated by a case example from Peru, below (Box 1).

Conclusion

We must acknowledge that developing a rigorous clinical evaluative framework for assessing psychosocial interventions in areas affected by violence is extremely difficult, given the complexity of mass trauma, the heterogeneity of trauma and its victims, and the array of potential outcomes of most interventions. In addition, psychosocial interventions studies are most often expensive and complex undertakings, requiring careful planning, clear definition of expected outcomes and a solid evaluation design, including standardisation of treatment and outcome measures, clearance for potential financial or intellectual conflicts of interest (i.e., pharmaceutical industry), careful follow-up of clinical trial drop outs, proper handling of missing data, different treatment lengths and long-term follow-up.

These conditions represent a great challenge, and many are seldom applicable because of hectic, and at times chaotic, prevailing field conditions in the conflict or post conflict scenarios, and even more in scarce resource settings.

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¹ Of this total number of victims, more than 75% were Quechua-speaking, or had another native language as their mother tongue.

² Such as the *Asociación Wiñastin the Centro de Atención Psicosocial (CAPS)* and the *Asociación Pro Derechos Humanos (APRODEH)*.

³ Such as the *Centro Amazónico de Antropología y Aplicación Práctica (CAAAP)* and the *Comisión Episcopal de Acción Social (CEAS)*.

⁴ Such as Canada, the European Commission, Germany, the Netherlands, Norway, Spain, Sweden, UK and the USA.

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