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

(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 el 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

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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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