MI-01 Psychological trauma after collapse: what the evidence says works and what harms

HEALING after the FALL, research library, MI-01

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Findings by section

1. How to read this report

This is the foundation document of the mind domain. It asks how many are harmed when a population loses its world, for how long, and what those around them should do in the first days, the first month and the first season. MI-02 takes the lay healer and the training, MI-07 children, MI-10 indigenous and traditional healing on its own terms, MI-12 what this work does to the healer. FO-10 and TR-16 carry the mechanism and are assumed throughout, the first for the meaning response and the placebo and nocebo evidence, the second for ritual and community, the Frattaroli meta-analysis, the Friendship Bench and the grief rites (THRIVING library, FO-10 and TR-16). Three things are kept apart. **The traditional claim** is what a practice says it does. **The record** is what observers, surveys and trials saw. **The inference** is what can be concluded.

Two errors frame the subject. The first assumes everyone exposed is damaged and needs treatment, which is false and, as policy, has harmed people. The second concludes that because the most popular early intervention failed, nothing works. One distinction carries most of the practical weight. **Distress is not disorder.** Fear, sleeplessness, tears, anger, numbness and preoccupation after catastrophe are the ordinary response of an intact mind to an extraordinary event, and in most people they fade. Disorder means symptoms that persist beyond a month and stop the person working, feeding a family or living with others. Where a people holds a rite, a song or a stage of an initiation restricted, this report says it exists and does not reproduce it (THRIVING library, SY-04, category 4).

2. How many are hurt, and for how long

Exposure is near universal. Disorder is not. Roughly 50 to 60 per cent of the United States population is exposed to traumatic stress but only 5 to 10 per cent develop the disorder (Bonanno 2004, citing Ozer and others 2003). In the World Mental Health surveys, 24 countries and 68,894 people, risk after a randomly chosen traumatic event was about 4 per cent, rising to about 19 per cent after rape (Kessler and others 2017, abstract and secondary summary). Conflict populations are worse. Steel and colleagues pooled 181 surveys of 81,866 refugees and conflict-affected people in 40 countries and found rates of 0 to 99 per cent for the disorder and 3 to 85.5 per cent for depression, with the number of traumatic events predicting depression (odds ratio 1.64, 1.39 to 1.93) and time since the conflict predicting lower rates (0.80, 0.69 to 0.93) (Steel and others 2009, abstract and secondary summary). **The range is the finding.** Method, instrument and translation drive it as much as suffering does. The survey preceding the Nakivale trial found 884 of 1,422 randomly sampled refugees, 62 per cent, meeting criteria (Neuner and others 2008, read in full).

The curve falls steeply without treatment. After 11 September 2001, an estimated 7.5 per cent of Manhattan residents met criteria at one month. Prevalence related to the attacks fell to 1.7 per cent at four months and 0.6 per cent at six months, and over 40 per cent reported no symptom at all (Galea and others 2002 and 2003, as reported in Bonanno 2004). In London seven days after the bombings of 7 July 2005, 25 per cent of a random sample of just over 1,000 Londoners reported substantial upset, while 1 per cent sought professional help and 1 per cent thought they needed it, both unchanged at six months (Wessely 2009, lecture transcript read in full).

The trajectories. Galatzer-Levy, Huang and Bonanno pooled 54 studies yielding 67 trajectory analyses. Resilience, meaning stable low symptoms, averaged 65.7 per cent (61.6 to 69.8), recovery 20.8 per cent and chronic dysfunction 10.6 per cent, and a delayed-onset trajectory appeared in 22 of the 67 (Galatzer-Levy, Huang and Bonanno 2018, search summary of published figures). Bonanno put delayed reactions at roughly 5 to 10 per cent of the exposed and found delayed grief never clearly demonstrated (Bonanno 2004). Bereavement runs on the same shape. Chronic depression follows in about 10 to 15 per cent of the bereaved, and in a study measuring people on average three years before the spouse died, 46 per cent had low depression before the loss and through 18 months after (Bonanno and others 2002, as reported in Bonanno 2004). Prolonged grief disorder was found in a pooled 9.8 per cent of bereaved adults across 14 studies (6.8 to 14.0) (Lundorff and others 2017, abstract and secondary), and after unnatural deaths, a pooled 49 per cent (Lundorff and others 2020, secondary summary). **The Fall's deaths are mostly unnatural deaths.** That contrast is the strongest argument for treating grief as a village problem, not a private one.

Natural recovery shows up inside the trials. The untreated Nakivale monitoring group improved by 0.8 and 37 per cent no longer met criteria at nine months (Neuner and others 2008), and in northern Uganda the waiting-list arm improved by 0.81 (Ertl and others 2011, abstract read). A village that does nothing will see most people get better, and a village that does something will credit itself. FO-10 names this trap. **The working numbers:** two of every three exposed come through without lasting disorder, one in five is ill and then recovers, one in ten is still ill a year later, and grief after violent sudden death is far more persistent.

3. The traditional claim, and where early telling came from

Across many traditions the claim is the same. What is not spoken festers. Ndembu doctors drew out the biting tooth while the village spoke its grudges aloud. Hawaiian families practised ho'oponopono. The penitent confessed. The returning fighter was cleansed and received back. TR-16 presents these on their own terms. Western practice took the claim, stripped it of the community and the rite, compressed it into one session with a stranger and called it psychological debriefing. From the early 1980s it was routine after disasters, accidents and assaults, delivered to everyone exposed within days and often compulsory for emergency workers.

The traditional claim and the debriefing protocol are not the same act. Chosen, private, repeated disclosure has a small positive effect, r .075 across 146 studies and 10,994 people, and TR-16 gives the conditions (Frattaroli 2006, as reported in THRIVING library, TR-16). **The benefit does not require a listener.** Compulsory early telling to a stranger is a different act with a different record.

4. Debriefing: what the record shows

The Cochrane review. Rose, Bisson, Churchill and Wessely reviewed the randomised trials of single-session individual debriefing (Rose and others 2002, abstract read through two independent summaries). Debriefing did not reduce distress and did not prevent the disorder. At three to five months there was no significant difference (odds ratio 1.22, 0.60 to 2.46). At one year a single trial reported significantly increased risk among the debriefed, given as an odds ratio of 2.88 (1.11 to 7.53) in one rendering of the abstract and 2.51 (1.24 to 5.09) in another [VERIFY: I could not open the full Cochrane text to settle which belongs to which version. Both point the same way]. The 2010 re-edit reported no reduction in severity at 1 to 4 months (standardised mean difference 0.11), 6 to 13 months (0.26) or 3 years (0.17), all in the direction of worse. The authors concluded that compulsory debriefing of trauma victims should cease. Grade X.

The trials behind the verdict. Bisson, Jenkins, Alexander and Bannister randomised 133 adult burn victims to debriefing or no intervention, and a blind assessor interviewed 110 at 3 and 13 months. At 13 months 26 per cent of the debriefed met criteria against 9 per cent of controls. The debriefed began with higher symptom scores and more severe burns, both predicting worse outcome, so the trial is confounded, and the authors said so while concluding that the findings seriously question one-off interventions after trauma (Bisson and others 1997, abstract and secondary summary). Mayou, Ehlers and Hobbs followed 106 consecutive road accident admissions, 54 debriefed and 52 not, for three years. The debriefed were worse on psychiatric symptoms, travel anxiety, pain and overall functioning, and among those with high intrusion and avoidance at baseline, the debriefed stayed symptomatic while the rest recovered (Mayou, Ehlers and Hobbs 2000, abstract and secondary summary). Van Emmerik and colleagues likewise found debriefing did not improve the natural course and did worse than no intervention (van Emmerik and others 2002, bibliographic record and secondary summaries, full text not read).

Why it may harm. Four explanations are offered and none is proven. It may come too early, raising arousal without time to settle it. It may interrupt a decline already happening. It may medicalise ordinary distress, so the person concludes something must be wrong with them. And it may displace what people actually do, which is to talk to those who knew them before and will know them after. On the last there is direct evidence: in London after 7 July people talked a great deal, to family, friends, colleagues, a doctor or a vicar, and 1 per cent to a professional (Wessely 2009).

What is and is not condemned. The verdict covers compulsory, single-session, early, structured recounting, usually with a stranger, to everyone exposed. It does not cover listening to someone who wants to speak, practical help, company, or treating people still ill a month later. The book must make that distinction, because the lay reader who learns that talking is dangerous will do the opposite harm.

5. The first days: what to do instead

The consensus package. Hobfoll and a panel of disaster researchers set out five elements for the immediate and mid-term period: promote a sense of safety, calming, self-efficacy and community efficacy, connectedness, and hope. The panel took this route because trials covering the diversity of disaster circumstances were not going to exist, and stated that most people affected by disasters do not develop pathology and need support and resources rather than diagnosis and treatment (Hobfoll and others 2007, abstract and secondary summary). Grade D as a package, with the elements independently supported, connectedness most of all (THRIVING library, TR-16).

Psychological First Aid. The World Health Organization guide, written with the War Trauma Foundation and World Vision, is the operational form (WHO 2011, read in full). It runs on Prepare, then Look, Listen and Link: learn the event and its risks before entering, check for safety, urgent needs and serious distress, approach those who may need support and help them feel calm, then help with needs and services and connect people with loved ones. Four groups need more at once: the seriously injured, those too upset to care for themselves or their children, those who may hurt themselves, and those who may hurt others. Its list of what not to do matters as much. Do not force help on people, be intrusive or pushy, pressure people to tell their story, share a person's story with others, make false promises, exaggerate your skills, judge the person for their actions or feelings, or ask for money or a favour in return. Allow for silence (WHO 2011).

The honest state of the evidence. Dieltjens and colleagues, for the Belgian Red Cross, screened 11,237 references and took 102 to full text, concluding that the literature gave no evidence of effectiveness and that evidence-based guidelines could not be written (Dieltjens and others 2014, abstract and secondary summary). PFA is therefore Grade D as a tested intervention, and still the right default, because its components are supported elsewhere, its harms are low, and its principal instruction, do not press people to speak, is the one the trial record most firmly supports. Two items carry their own evidence. Disturbed sleep at two and six weeks predicts later disorder across accident victims, refugees, veterans and disaster survivors, though no trial shows that treating it early prevents them (Grade B for the

prediction, D for the treatment). And in London those who could not find out whether family were safe were more distressed, and still more so six months later (Wessely 2009, Grade C).

What not to give. Gelpin and colleagues treated 13 recent trauma survivors with benzodiazepines soon after the event and matched them to 13 untreated survivors on sex and early symptom severity. At 6 months 9 of the treated met criteria against 3 of the controls, with no difference on symptom scales (Gelpin and others 1996, abstract and secondary summary). With 13 per group that is weak, and it points the wrong way for the drug. A later review concluded benzodiazepines are relatively contraindicated in the disorder and in recent trauma (Guina and others 2015, secondary summary). Grade B against. Alcohol falls under the same rule by the same logic, though I found no trial [VERIFY: my inference]. The English guideline likewise advises against drugs to prevent the disorder (NICE 2018, secondary summaries only).

How a district organises it. The Inter-Agency Standing Committee pyramid runs from basic services and security at the base, through community and family supports such as family tracing and assisted mourning, to focused support for those at risk and specialised services for the few. All layers run at once (IASC 2007, secondary summaries).

6. The four-week gate and the three-month offer

Watchful waiting with a date. The English guideline advises practical support and active monitoring with follow-up arranged within one month for subthreshold symptoms, reserving early trauma-focused cognitive behavioural therapy for acute stress disorder or clinically important symptoms, and advising against debriefing and drug prophylaxis (NICE 2018, secondary summaries only). The arranged follow-up distinguishes active monitoring from simply waiting. Roberts and colleagues reviewed multiple-session early interventions in 27 trials with 3,963 participants and found low-certainty evidence that they may prevent a diagnosis at three to six months against usual care, no difference at other times, and higher dropout (Roberts and others 2019, Cochrane CD006869, search summary of published findings).

The crucial split. The same team's separate meta-analysis reported that among trauma-exposed people **not screened for symptoms** there were no clinically important differences between any intervention and usual care, while among the **already symptomatic** there were clinically important benefits for trauma-focused cognitive behavioural therapy, cognitive therapy without exposure and eye movement desensitisation and reprocessing (Roberts and others 2019, European Journal of Psychotraumatology, search summary, full text not reached [VERIFY: effect sizes not obtained]). This is the most useful finding here for a village. **Treating everyone does nothing. Treating the symptomatic works.**

Screen and treat in practice. After the London bombings the Trauma Response Programme obtained contact details for 910 people, of whom 596 completed a screening questionnaire, 334 went on to assessment and 217 needed treatment. Effect sizes exceeded those usually seen in trials, the gains held at a year, and case finding depended on outreach (Brewin and others 2010, abstract and secondary summaries). **The ill will not come forward. Someone must go and ask.**

The persistent case. Bisson and colleagues pooled 70 studies with 4,761 participants. Individual trauma-focused cognitive behavioural therapy against waiting list or usual care gave a standardised mean difference of -1.62 (-2.03 to -1.21) in 28 studies with 1,256 people, and eye movement desensitisation and reprocessing -1.17 (-2.04 to -0.30) in 6 studies with 183 people. Trauma-focused and non-trauma-focused approaches did not differ immediately after treatment, with trauma-focused ahead at one to four months. The authors rated every comparison very low quality, with small underpowered samples, high or unclear risk of bias and greater dropout in active treatment (Bisson and others 2013, Cochrane CD003388, abstract read). Grade A for a large effect, with the quality caveat stated plainly.

7. Can lay people deliver it, and on how much training

The Nakivale trial, read in full. Neuner, Onyut, Ertl, Odenwald, Schauer and Elbert randomised 277 Rwandan and Somali refugees with the disorder in the Nakivale settlement in southern Uganda, a camp of 14,400, to narrative exposure therapy, flexible trauma counselling, or no-treatment monitoring. Nine refugees from the community, five women and four men, mean age 27, were trained as counsellors on a six-week course in counselling skills plus both methods. None had prior medical, psychological or social training. Treatment was six sessions, usually two a week, each one to two hours, and at the end of narrative exposure therapy the patient received a written account of their own life in their own language. Dropout was 3.6 per cent in the narrative arm against 19.8 per cent in the counselling arm. At nine months, assessed by expert interviewers blind to allocation, the diagnosis could no longer be established in 70 per cent of the narrative group, 65 per cent of the counselling group and 37 per cent of the monitoring group, with effect sizes of 1.5, 1.4 and 0.8 (Neuner and others 2008, read in full).

Three details matter more than the headline. **Supervision never stopped**, with close tutoring before working alone and weekly case and personal supervision thereafter, including observation of sessions and review of the testimonies. **Cases were excluded**, for drug abuse, obvious intellectual disability and psychosis. And **the camp was stable**, each registered household receiving 5 kg of beans, 10 kg of maize meal and 5 litres of cooking oil a month, with land to farm and basic health care. The authors attribute the monitoring group's spontaneous improvement, absent in their earlier and hungrier Imvepi trial, to that stability.

Former child soldiers, northern Uganda. Ertl, Pfeiffer, Schauer, Elbert and Neuner identified 85 former child soldiers with the disorder from a survey of 1,113 people aged 12 to 25 in camps for the displaced, randomising them to narrative exposure therapy (29), academic catch-up with supportive counselling (28) or a waiting list (28). Eight sessions were delivered in the communities by trained local lay therapists, and within-treatment effect sizes over the following year were 1.80, 0.83 and 0.81 (Ertl and others 2011, abstract read).

Group therapy by village workers, eastern Congo. Bass and colleagues randomised 16 villages to group cognitive processing therapy, one individual session and eleven group sessions, or to individual support, for women survivors of sexual violence. One village was dropped over concern about its psychosocial assistant's competence, leaving 7 therapy villages (157 women) and 8 support villages (248 women). At six months, 9 per cent of the therapy group and 42 per cent of the support group met criteria for probable depression or anxiety, roughly three women treated per additional recovery [VERIFY: my arithmetic] (Bass and others 2013, abstract and secondary summaries).

Problem Management Plus, Nairobi, with the training documented. Bryant and colleagues randomised 421 Kenyan women with a history of gender-based violence to five weekly 90-minute home sessions from community health workers, or to enhanced usual care. The 23 workers had about ten years of schooling and no prior mental health training, and training was 64 hours over 8 days plus one day of psychological first aid. **Three of the twenty-three failed competency assessment and did not take part.** Each then received two hours of weekly group supervision. Distress fell by 3.33 points more than usual care, an effect size of 0.57 (0.32 to 0.83), while the post-traumatic symptom effect was small at 0.21 to 0.26. Exclusions were imminent suicide plans, psychotic disorders and severe cognitive impairment (Bryant and others 2017, read in full).

Lay delivery at scale, elsewhere. Rahman, Malik, Sikander, Roberts and Creed randomised 40 clusters in rural Rawalpindi, 903 mothers, to a cognitive behavioural intervention from the existing Lady Health Workers or to equal visits by untrained workers. Major depression at six months was 23 against 53 per cent (adjusted odds ratio 0.22, 0.14 to 0.36) and at twelve months 27 against 59 per cent (Rahman and others 2008, secondary summary), and in conflict-affected northern Pakistan the same method left 30 per cent depressed at three months against 60 per cent (Rahman and others 2016, secondary summary). In Bosnia, Dybdahl gave 87 displaced mothers of young children a weekly group programme of psychosocial support and child development education for five months against matched controls given medical care only, and mothers' mental health and children's weight gain improved (Dybdahl 2001, abstract and secondary summaries). The Friendship Bench grandmothers, with eight days of training and a thirty-day

supervised internship, took depression from 49.9 to 13.7 per cent over six weekly 45-minute sessions (THRIVING library, TR-16, citing Chibanda 2016).

The answer to the brief's question. Can a lay person with two weeks of training deliver narrative exposure therapy safely without a supervisor? Nobody has tested it, and every trial that worked had a supervisor. The training behind the best results was six weeks (Nakivale), eight days plus a supervised internship (Harare), and eight days plus weekly supervision (Nairobi). Two weeks is at the short end but not outside the range. The absence of supervision is outside it. Three of 23 Nairobi workers failed competency assessment, and one Congolese village was excluded over its worker's competence. **Without someone to check, a village will not know which of its counsellors is the one who failed.** Grade B for lay delivery with weekly supervision and a competency check. Grade D, and an open question, for lay delivery with neither.

8. The local practice beside the imported one

The traditions hold that the dead must be properly sent, that one who has killed or been defiled by war carries something that must be removed before re-entry, that hidden grudges sicken a household, and that breath, song and repeated words settle a shaking body. TR-16 and MI-10 carry these on their own terms. What the trial record adds is narrow.

A local practice matched the imported therapy head to head. Catani, Kohiladevy, Ruf, Schauer, Elbert and Neuner randomised 31 children with the disorder in a camp in north-eastern Sri Lanka after the 2004 tsunami to six sessions of narrative exposure therapy for children or six of meditation and relaxation, chosen because breathing exercises and mantra chanting are rooted in Tamil Hindu practice and familiar to children and counsellors alike. At six months recovery was 81 per cent for narrative exposure therapy and 71 per cent for meditation and relaxation, with no significant difference on any outcome (Catani and others 2009, abstract and secondary summary). The sample is tiny and there was no untreated arm, so this is Grade C at best, but the direction is worth more to this book than another Western trial. In Rwanda, Schaal, Elbert and Neuner compared four sessions of group interpersonal psychotherapy with four of individual narrative exposure therapy ending in guided mourning, in 26 orphaned genocide survivors, and found no significant differences at post-test, which with 12 and 14 participants shows only that no difference was detected (Schaal, Elbert and Neuner 2009, abstract and secondary summary). Grade D, the guided mourning worth noting because it joins the trauma work to the grief work.

Cleansing and reintegration rites. A sixteen-year follow-up of 39 boys brought to a rehabilitation centre in Maputo in 1988 found most had become productive, capable and caring adults, and none free of their pasts. Cleansing rites, community acceptance, livelihoods and apprenticeships were present together, and the study cannot separate the rite from the rest (Mozambique child soldier life outcome study, secondary summaries [VERIFY: I did not reach the report itself]). In northern Uganda, Schultz and Weisæth observed an Acholi cleansing ritual and followed one former child soldier for three years, concluding that collective mobilisation of social support, collective forgiveness and the psycho-education embedded in the ritual appeared central (secondary summary). One informant and no control group make that a hypothesis. Grade D for the rite as treatment, Grade C for the package of return, acceptance and work. A 1995 report on the Mozambican ceremonies noted that fasting or purgative elements can harm a malnourished or sick child (IPS 1995, secondary summary). **Where a rite includes fasting, heat, purging or prolonged vigil, the medical rules in TR-16's harm test apply over the rite.** Where a tradition holds a song, a stage or a whole ceremony restricted, it exists and this book does not print it. MI-10 names the peoples, the regions and the community sources.

9. What the trials assumed that the Fall removes

Every trial above ran inside a structure the village will not have. **A safe place**, since Nakivale had monthly rations, allotted land and basic health care and treatment began after the danger ended, so exposure work while danger continues is supported by no trial here. **Supervision**, weekly, by psychologists, in every successful trial. **Referral**, since

every trial excluded or referred the actively suicidal and the psychotic, and a village has nowhere to send them. **Validated instruments in the local language**, the Nakivale team having translated, back-translated and tested the scales to a two-week retest correlation of .87 and, against expert diagnosis, sensitivity .86 and specificity .88. **Trained assessors**, twelve research assistants given a six-week interviewing course, with blind outcome assessment. And **food**, named here because it is the one the book will most want to skip.

Hunger makes the picture by itself. In the Minnesota experiment of 1944 to 1945, 36 conscientious objectors were fed roughly 1,570 kilocalories a day through a semi-starvation phase and lost about 24 to 25 per cent of body weight, figures that vary between accounts. This produced marked rises in depression, hysteria and hypochondriasis on testing, with most men having periods of severe distress, irritability, social withdrawal and total preoccupation with food, some needing years to settle their eating afterwards (Keys and others 1950, secondary summaries only [VERIFY: I did not read the monograph]). A village looking at apathy, irritability, hopelessness and obsession should count the calories before it counts the symptoms. **Food is a psychiatric treatment.**

And the expected epidemic may not come. In 1939 Hastings Ismay, secretary of the Committee of Imperial Defence, estimated that sustained bombing of London would produce 600,000 dead and 1.2 million wounded, with mass panic and a catastrophic fall in production. Three large mental hospitals outside London, Belmont, Mill Hill and Barnstead, were set aside for the expected flood of civilian psychiatric casualties, and were handed to the military in November 1940 because the casualties did not arrive. Felix Brown wrote in the Lancet that the expected swarms of hysterics had not appeared, and Aubrey Lewis's 1941 Willesden study found a slight increase in neurotic illness after intensive raids, chiefly among those ill before. Over six years more than 35,000 civilians were killed in London, with exceptions such as the Bethnal Green crush of 1943, in which 173 died (Wessely 2009, read in full, drawing on Jones, Woolven and Wessely 2004). Catastrophe does not by itself produce a psychiatric epidemic. Hunger, cold, grief, untreated injury, separation and not knowing produce the symptoms, and those a village can act on.

10. Who must not have exposure work

Never start structured exposure work with anyone in current danger, acutely psychotic, intoxicated or in withdrawal, holding active suicidal intent or a plan, severely cognitively impaired, unable to consent freely, or whose basic needs are unmet. These are the trials' own exclusion criteria (Neuner 2008, Bryant 2017) with danger and hunger added here. The signs a session is going wrong are in Protocol 4, and the counsellor's own share of the damage is MI-12's.

The harm record is reassuring, within supervised trials. Hoppen, Lindemann and Morina pooled 56 randomised trials with 4,230 patients. Incidences of harm ran from 0 to 5 per cent. Psychological interventions carried a lower risk of deterioration than passive controls (relative risk 0.21, 0.15 to 0.28) and than active controls (0.36, 0.14 to 0.92), and trauma-focused cognitive behavioural therapy a lower risk of serious adverse events than other psychological interventions (0.54, 0.31 to 0.95) (Hoppen, Lindemann and Morina 2022, abstract and secondary summary). Grade A for the low harm rate under supervision. The qualifier is everything: these were supervised trials with screening, exclusions and somewhere to send people.

Evidence grades

Practice	Grade	Tradition says	Record shows	Inference
Compulsory single-session debriefing	X	Telling early heals	No benefit, one-year OR 2.51 or 2.88, worse at 3 years	Never compel

Practice	Grade	Tradition says	Record shows	Inference
Watchful waiting with a dated review	B	Time heals	65.7 per cent resilient, 37 per cent remit untreated at 9 months	Default for week one
Problem-solving visits by lay workers	A	None	Distress effect 0.57, depression 23 against 53 per cent	Strong, generic
Psychological First Aid	D	Comfort the stricken	No effectiveness evidence, low harm	Right default, untested
Safety, food, warmth, sleep, reunion, news	B to C	Tend the body first	Hunger alone produces the picture, unreached family stay distressed	Before anything else
Not pressing people to tell	B	Speak when ready	Forced telling harmed, chosen telling helped	Firm rule
Chosen private disclosure	A	Hidden things fester	r .075, best private and unshared	Small, needs no listener
Screening at 4 weeks, treating at 3 months	B	None	Screen and treat exceeded trial effect sizes	Best village structure
Narrative exposure therapy by trained lay counsellors	A	None	70 per cent remission against 37, d 1.5	Strong, with supervision
Group therapy by trained village workers	A	None	9 against 42 per cent caseness at 6 months	Strong, with supervision
Trauma-focused CBT and EMDR for the chronic case	A	None	SMD -1.62 and -1.17, very low quality evidence	Large but shaky
Local meditation, breath and chant instead of therapy	C	Breath settles the spirit	71 against 81 per cent recovery, no difference, n = 31	Promising, tiny trial
Cleansing and return rites for fighters	D to C	Removes what the fighter carries	Good long outcomes in a bundled package	Keep for return, not as treatment
Benzodiazepines or alcohol to prevent the disorder	X	Calm them down	9 of 13 against 3 of 13 ill at 6 months	Do not

Means ledger

Capability	Hands and knowledge	Hearth	Garden and still	Village dispensary (300)	District infirmary (3,000)	Hospital before the Fall
First-week care	Sit with people, do not press, help practically	Food, water, warmth, a dark quiet place to sleep	Calming herbs per MI-04, a bath, work to do	Trained helper walks the village daily	Co-ordinated relief, tracing register	Disaster mental health team
Reunion and news	Runners, lists of names	Fixed message point at the hearth	Written notices	Named-person register, posted daily	District register, courier rota	Phones, casualty bureau
Screening at 4 weeks	Five questions, remembered	The same, written down	Ink and a ledger	Written register, one reviewer	Repeat survey, trend over months	Validated instruments
Structured sessions	Not possible alone	One trusted listener, six sittings	A private room, a lamp	Two to four trained counsellors, weekly peer supervision	A supervisor, competency checks, referral	Licensed therapists, audits
Grief rites	The family's own form	Food, fire, a grave, a named day	The same, plus a marker	Village calendar of the dead	Rules for funerals in epidemics	Bereavement services
Suicide watch	Company, remove the means	Never alone, take the rope and knife	The same	Rota, locked store of poisons and drugs	Beds, continuous observation	Psychiatric admission
Psychosis and agitation	Company, quiet, no restraint	Dark quiet room, food, fluids	Sedating plants per MI-04, with great caution	Trained observers, no chains	Admission, salvaged antipsychotic if any	Medication, ward

What each rung changes. Hands and the hearth deliver nearly all of what the first month needs, because the first month is food, safety, sleep, company and not pressing people. The garden and still change almost nothing here. **The dispensary is the rung that changes outcomes**, adding the register, the four-week screen and two or three supervised counsellors, which is the difference between 37 and 70 per cent remission in the Nakivale numbers. The district adds the supervisor, the competency check and somewhere to send the suicidal and the psychotic. The hospital adds drugs and admission for the few, and little else this report can show.

Harm test

Practice	How it harms	Never for	Signs it is going wrong	What to do then	Historical cases
Compulsory debriefing	Interrupts natural recovery, medicalises distress, raises arousal	Everyone, as a routine	Worse sleep, more intrusion, person asks what is wrong with them	Stop the programme, offer practical help and company	Bisson 1997, Mayou 2000
Pressing someone to tell	Shame, retraumatisation, breach of confidence, withdrawal	Anyone who declines, children, the raped	Person falls silent, avoids the helper, distress rises	Apologise, stop asking, stay available	Rose 2002, WHO 2011
Exposure work without supervision	Sessions that open and do not close, counsellor burnout, missed suicide	The psychotic, intoxicated, actively suicidal, those in danger	Loop without new detail, worse sleep across three sessions, self-harm talk	Stop exposure, keep supportive contact, review with another counsellor	Bryant 2017 competency failures
Benzodiazepines or alcohol after trauma	Blocks natural processing, dependence, falls, overdose with other sedatives	Recent trauma generally, the old, the pregnant, the head-injured	Craving, daytime sedation, escalating dose	Taper slowly, never stop abruptly, substitute company and routine	Gelpin 1996
Treating everyone	Wastes scarce hours, diverts help from the ill tenth	Any unscreened population	Counsellors overloaded, the chronically ill untreated	Screen, then treat the symptomatic	Roberts 2019
Rites with fasting, heat, purging, vigil	Dehydration, heat injury, collapse in the malnourished	Children, the malnourished, the old, the pregnant, the sick	Dizziness, confusion, no urine, hot dry skin	Stop, cool, fluids, lie down	IPS 1995, THRIVING library, TR-16
Diagnosing a culture's distress in foreign words	Turns suffering into a technical problem, displaces the village's own forms	Any people with working rites of their own	People stop using their own rites and wait for the counsellor	Use local words for the trouble, keep the local rites	Summerfield 1999

Red flags

These mean death or permanent damage without what a village cannot give. Each is followed by what to do anyway.

1. **A stated plan to die, with a means and a time.** Do not leave them alone at any hour. Remove rope, blades, poisons, drugs and weapons. Appoint a named watcher for every part of the day and write the rota down. Treat hunger, pain and sleeplessness, often the removable part. Review daily.
2. **Acute psychosis, meaning hallucinations, fixed false beliefs and loss of contact with the shared world.**

Quiet, dark, food, fluids, company, no argument about the beliefs, no chains and no beating. Look for a physical cause first, because fever, dehydration, head injury, alcohol withdrawal and poisoning imitate it. If a salvaged antipsychotic exists, the district decides.

3. **Alcohol or sedative withdrawal with tremor, sweating, confusion or a fit.** This kills. Fluids, sugar, salt, a dark quiet room, constant company, never an abrupt stop if a supply exists.
4. **Catatonia, or refusal of food and fluid for more than two days.** Hand-feed, spoon fluids, watch for dehydration. Most will die if this runs a week.
5. **Violence towards others with loss of self-control.** Protect the others first. Separation, not restraint, wherever possible. Chains and beatings are documented killers (THRIVING library, TR-15 and TR-07).
6. **A child who has stopped speaking, playing or eating after an event.** MI-07 takes this. Keep the child with a calm adult, restore the daily shape of meals and sleep, and do not interrogate.
7. **Persistent severe symptoms at three months that stop the person working or caring for children.** This is the one tenth. Offer the structured course, and if nobody can deliver it, six weekly visits of company, practical problem-solving and an hour of attention, as the Friendship Bench grandmothers did (THRIVING library, TR-16).

Honest comfort when nothing will change the outcome. Say you do not know whether it will pass, then say what you will do regardless: company, food, pain relief as far as the village can give, no abandonment, someone with them at the end. Do not promise a cure. FO-10 gives the script.

The case against

Derek Summerfield is the strongest critic and should be named in the chapter. In his 1999 critique of seven assumptions behind trauma programmes in war-affected areas, written with Bosnia and Rwanda in view, he argued that for most survivors post-traumatic stress disorder is a pseudocondition, that suffering caused by war is recast as a technical problem amenable to short-term fixes like counselling, that Western agencies gain status by defining the problem and supplying the cure, and that there is no evidence affected populations want these imported approaches (Summerfield 1999, abstract and secondary summaries, full text not read). In the BMJ he argued that the diagnosis was invented rather than discovered, a legacy of the American war in Vietnam (Summerfield 2001, secondary summaries). Arieh Shalev replied that clinicians can tell ordinary sorrow from disorder and that nothing is gained by denying that a pervasive and lasting disaster in a person's life is a disorder (Shalev, letter, secondary summary).

Three further criticisms stand. **The trials are weak.** Bisson's Cochrane review rated every comparison very low quality, and Lely and colleagues, pooling 16 narrative exposure therapy trials and 947 people, found large uncontrolled effects, while a separate pooling of 18 trials reported a moderate between-group effect that vanished once publication bias was taken into account (Lely and others 2019, and a second meta-analysis, both search summaries). **The constructs may not travel.** The variation in Steel's 181 surveys is partly a statement about instruments and translation, not only about suffering. **The scaffolding is missing after the Fall.** Section 9 lists it, and the trials prove what supervised programmes in stable camps can do, not what an unsupervised village can do.

The opposite error is live too. The failure of debriefing is read as a reason to do nothing, which the Congolese, Ugandan, Kenyan, Pakistani, Bosnian and Zimbabwean trials refute. Do not impose a session on everyone. Find the ill and treat them.

10-line summary

1. Roughly two of three exposed stay well, one in five is ill and recovers, about one in ten is still ill a year later (Galatzer-Levy 2018). Grade A.
2. Compulsory single-session debriefing does not prevent the disorder, and in two trials the debriefed were worse at 13 months and at 3 years (Rose 2002, Bisson 1997, Mayou 2000). Grade X.

3. Treating everyone exposed shows no clinically important benefit over usual care, while treating the already symptomatic does (Roberts 2019). Grade B.
4. The first week is safety, food, warmth, sleep, reunion, news, company and not pressing anyone to speak (WHO 2011, Hobfoll 2007). Grade D for the package, B to C for its parts.
5. Lay counsellors with six weeks of training, six sessions and weekly supervision took remission from 37 to 70 per cent in a Ugandan refugee settlement (Neuner 2008). Grade A.
6. Village women trained to deliver group therapy in eastern Congo left 9 per cent of their patients still ill at six months against 42 per cent (Bass 2013). Grade A.
7. Every successful lay-delivered trial had weekly supervision, a competency check and somewhere to refer the suicidal and psychotic. None tested life without them.
8. Benzodiazepines after recent trauma did not help and were associated with more disorder at six months (Gelpin 1996). Grade B against.
9. Semi-starvation alone produces depression, irritability, withdrawal and total preoccupation with food (Keys 1950). Feed the village before diagnosing it.
10. The expected psychiatric collapse of bombed London never arrived, and the hospitals set aside for it went to the army within months (Wessely 2009, Jones 2004).

Open questions

- Can a lay counsellor deliver exposure work safely with no supervisor at all? No trial has tested it, and the near-misses suggest it is the main risk.
- What is the minimum training? Six weeks, eight days plus an internship, and eight days plus weekly supervision all worked. Two weeks alone is untested.
- Do four-week screening questions work where the healer knows everyone and privacy is thin?
- Does written testimony help or endanger, where the attacker still lives nearby?
- Does grief after the mass unnatural death of a collapse follow the 49 per cent figure, or is that an artefact of help-seeking samples?
- Are locally rooted practices as good as imported ones at scale? One trial of 31 children suggests they may be.
- How much of the benefit in lay-delivered trials is structured attention rather than the specific method? Trials comparing methods mostly found no difference.

Sources to read in full

1. **Neuner F and others 2008, Journal of Consulting and Clinical Psychology 76:686-694.** Training, supervision, sessions, exclusions, camp conditions and outcomes.
2. **WHO 2011, Psychological First Aid: Guide for Field Workers.** Short, free, written for non-clinicians, and the source of the don'ts.
3. **Rose S, Bisson J, Churchill R, Wessely S 2002, Cochrane CD000560.** The debriefing verdict and the trials behind it.
4. **Bonanno GA 2004, American Psychologist 59:20-28.** The resilience argument and its epidemiology.
5. **Summerfield D 1999, Social Science and Medicine 48:1449-1462.** The strongest case against the whole enterprise.
6. **Bass J and others 2013, New England Journal of Medicine 368:2182-2191.** What trained village women can do for the severely affected.
7. **Bryant RA and others 2017, PLoS Medicine 14(8):e1002371.** The best-documented account of lay training, competency failure and supervision.

At the bedside after the Fall

Household

- **Minimum.** Keep everyone fed, warm, dry and sleeping. Find out where the missing are and say so out loud, even when the news is bad. Stay with the frightened and say little. Do not ask anyone to describe what happened. Keep meals, chores and bedtimes at their old hours. Say the names of the dead and mark a day for them.
- **Needs.** Food and water. A dark quiet corner. The household's own songs and prayers. A list of names and where people were last seen. One person willing to sit up at night.
- **First failure to expect.** Somebody decides the silent one must be made to talk, and corners them. The second is treating hunger, cold and sleeplessness as sadness.

Village of 300

- **Minimum.** A daily walk of the whole village for the first fortnight by two named people, looking for the four groups the WHO guide names. A name register of the dead, the missing and the found, updated daily and read aloud. A four-week review of everyone exposed, using Protocol 2's five questions, written in a ledger. Two to four trained counsellors offering six sessions from three months on, to the still symptomatic only. A suicide watch rota, with a locked store for poisons, drugs and weapons. Grief rites in the village's own form, on fixed days.
- **Needs.** A ledger and ink. Eight days to six weeks to train the counsellors, and someone able to teach it. Weekly peer supervision even where no supervisor exists. A private room. Village rules on confidentiality, fees and who may hear what [OWNER].
- **First failure to expect.** The counsellors run out of hours because they took on everybody instead of the symptomatic tenth. The second is that the ill do not come forward, and nobody goes to find them.

District of 3,000

- **Minimum.** One supervisor for the village counsellors, meeting them weekly or fortnightly, who sees patients only rarely. A competency check before any counsellor works alone, and the willingness to stand someone down. A referral place for the suicidal, the psychotic and the violent, meaning beds, watchers and food, not a cell. A district register of the dead and the displaced. Agreed rules for funerals during an epidemic, from HY-07. A working relationship with the district's traditional and faith healers, on the COSIMPO pattern (THRIVING library, TR-07 and TR-16).
- **Needs.** One person with real training or the longest experience. Ten beds. Authority to stop a harmful rite and to stand down a counsellor [OWNER]. A second copy of the registers.
- **First failure to expect.** The supervisor becomes a therapist and stops supervising, and within a year nobody knows which counsellors are competent.

Protocols

Protocol 1. The first two weeks after a catastrophe

- ☐ **Hour 0 to 24.** Stop the danger. Count the people. Write the names of the dead, the missing and the found in one book. Give water, then food, then shelter and dry clothing, in that order.
- ☐ Reunite children with family or known caregivers immediately, and never let an unaccompanied child be taken by an unknown adult. Register the child's name, age, village and the adult holding them.
- ☐ Read the name register at a fixed time and place daily. Say what is known and plainly what is not.
- ☐ **Walk the village twice daily for 14 days**, two named people, looking for the four urgent groups: the badly injured, those who cannot care for themselves or their children, those who may hurt themselves, those who

may hurt others. Act the same day.
- ☐ Give every household a dark quiet sleeping place, aiming for 7 to 8 hours. Treat pain, because pain stops sleep.
- ☐ Give people useful work within the first week, matched to strength, no more than 8 hours.
- ☐ Sit with the distressed at a normal distance. Allow silence. Offer water or food rather than questions.
- ☐ **Do not run a meeting at which people are asked to describe what happened and how they felt.** A gathering is for news, decisions, naming the dead and shared work, not recounting.
- ☐ Do not give alcohol or sedatives to calm the distressed.
- ☐ If someone chooses to tell, listen without interrupting or pressing for more, and do not repeat what you hear.

Protocol 2. The four-week review

Ask every exposed adult, in private, in your own language, at 28 days plus or minus 5. Write the answers in the ledger with the date.

- ☐ 1. Over the past week, have pictures or memories of what happened come back when you did not want them, including in dreams? (yes or no, and how many days of the seven)
- ☐ 2. Over the past week, have you kept away from places, people or talk that remind you of it? (yes or no)
- ☐ 3. Over the past week, have you been jumpy, watchful, or unable to sleep? (yes or no, and hours of sleep on a usual night)
- ☐ 4. Over the past week, have you been unable to do your usual work or care for your household? (yes or no, and how many days)
- ☐ 5. Have you thought you would be better off dead, or thought of harming yourself? (yes or no, and if yes, ask about a plan and a means today)

Scoring. Any yes to question 5 goes to Protocol 5 the same hour. Three or more yes answers among questions 1 to 4, or a yes to question 4 on four or more days, marks the person for review at 3 months. Review everyone at 3 months regardless, because people hide it and delayed onset is real in about 5 to 10 per cent.

Protocol 3. The three-month offer

- ☐ Offer, do not impose. The person may decline and may come back later.
- ☐ Before starting, check the five exclusions: current danger, acute psychosis, intoxication or withdrawal, active suicidal plan, inability to understand and consent. Any one means no exposure work.
- ☐ Check that the person has eaten in the last day and slept in the last two nights. If not, fix that first and start in a week.
- ☐ **Six sessions, one or two each week, 60 to 120 minutes each.** Never more than two sessions in a week. Never one session alone, because an opened account must be closed.
- ☐ Session 1 is explanation and agreement only: the symptoms are a known response, most people get better, this is what the sessions involve, and you may stop at any time.
- ☐ Sessions 2 to 5 follow the agreed method. Where it is a life account, keep to the order of the whole life and not the worst event alone, write it down as they speak, and read it back at the start of the next session.
- ☐ End every session in the present. Ask the date, the place and who else is in the house. Spend the last 10 minutes on today and tomorrow, not on the past.
- ☐ Session 6 gives the person the written account in their own language, if they want it, and agrees who keeps it. If keeping it is dangerous, burn it together.
- ☐ Re-ask the five questions of Protocol 2 at the end, at 3 months and at 6 months after the last session, and write the answers down.
- ☐ **Counsellors meet weekly, every week without exception**, each naming their cases, what went wrong and what they did. Where a supervisor exists, this is their meeting.

Protocol 4. Stopping a session that is going wrong

- ☐ Stop the account at once if the person loses contact with the room, panics, or talks of harming themselves.
- ☐ Say their name, where they are and what day it is. Ask them to name five things they can see, then four sounds, then to feel the chair or the ground.
- ☐ Give water. Open the door. Walk outside together if they can.
- ☐ Do not return to the account in that session, even if they ask.
- ☐ Hand them to a family member or friend who will stay with them tonight, saying only that they need company.
- ☐ Record it, and raise it at the next counsellors' meeting before the next session is booked.
- ☐ **Stop the exposure work entirely if** sleep has worsened across three consecutive sessions, the account has looped twice with no new detail, drinking has increased, self-harm talk has started, or the person has begun to avoid you. Keep supportive visits and practical help, and tell them plainly that stopping is not a failure.

Protocol 5. The person who speaks of dying

- ☐ Ask directly. Have you thought of killing yourself? Do you have a plan? Do you have the means? When?
- ☐ Do not leave them alone from this moment until the watch is arranged.
- ☐ Remove rope, blades, firearms, poisons, pesticides, salvaged drugs and alcohol and lock them elsewhere.
- ☐ Write a rota naming a watcher for every hour of the next 72 hours, and give the household a copy.
- ☐ Feed them, warm them, treat pain, and aim for sleep. Hunger, pain and sleeplessness are often the removable part.
- ☐ Visit daily for 14 days, then weekly for 6 weeks, and write each visit in the ledger.
- ☐ Do not start exposure work, and do not debate whether life is worth living. Ask what would have to change for the next week to be bearable, and change one of those things.
- ☐ Tell them you will come back, name the day, and come.

Protocol 6. The village grief rite

- ☐ Keep the village's own form. Do not import one. TR-16 holds the evidence.
- ☐ Fix a day. Say the names aloud. Have food. Have the children present unless the family says otherwise.
- ☐ Repeat it at burial, at a month, at a year, and on a yearly day for all the dead of the Fall.
- ☐ Where there is no body, the rite still happens, with something of the person's in its place.
- ☐ In an epidemic, keep the rite and change the method: the family stands at a distance and sings, and trained people handle the body (THRIVING library, HY-07 and TR-16).
- ☐ Offer Protocol 3 to the bereaved still unable to work or eat at 6 months.
- ☐ No rite involves fasting, purging, prolonged heat or a night-long vigil for a child, a pregnant woman, a malnourished or sick person, or the old.

Numbers to carry

1. **Two in three recover without help.** Resilient 65.7 per cent, recovering 20.8 per cent, chronic 10.6 per cent (Galatzer-Levy 2018).
2. **One in ten is still ill at a year.** That tenth is where the village spends its hours.
3. **Four weeks is the gate, three months is the offer.** Symptoms before four weeks are expected. Symptoms at three months are treated.
4. **Debriefing everybody harms.** PTSD at 13 months 26 against 9 per cent after burns, worse at three years after road accidents (Bisson 1997, Mayou 2000).
5. **Six sessions, one to two hours, twice a week** took remission from 37 to 70 per cent with six-week-trained lay counsellors (Neuner 2008).

6. **9 against 42 per cent still ill at six months** after twelve group sessions by village women in eastern Congo (Bass 2013).
7. **Supervision is weekly, forever.** Two hours a week in Nairobi, where 3 of 23 trained workers failed the competency check.
8. **Never for exposure work:** current danger, acute psychosis, intoxication, an active suicide plan, inability to consent.
9. **Grief after unnatural death is different.** 9.8 per cent prolonged grief after natural loss, pooled 49 per cent after unnatural (Lundorff 2017, 2020).
10. **Feed them first.** Six months at about 1,570 kilocalories a day produced depression, irritability, withdrawal and preoccupation with food in healthy young men (Keys 1950).

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