basic life support with early defibrillation.[1] A retrospective study in Hampshire of 98 patients who had a cardiac arrest outside hospital showed that the introduction of paramedics resulted in an increase in the number who regained spontaneous cardiac output from 12 to 21 (P=0·01).[2] The number who survived to discharge from hospital, however, did not increase.

In the group treated by paramedics seven of 23 patients who regained spontaneous cardiac output were in asystolic arrest or electromechanical dissociation when first monitored. In the group treated by ambulance technicians only one patient who regained spontaneous cardiac output had such an arrest. The success of initial resuscitation showed a direct but transient benefit of intervention by a paramedic since none of these patients survived to discharge. In both groups three of 23 patients with ventricular fibrillation survived to discharge.

These findings reflect the irreversible pathophysiology and grave prognosis of cardiac arrest when the initial rhythm is not ventricular fibrillation. This is irrespective of where the arrest occurs. Furthermore, the principal therapeutic goal in ventricular fibrillation remains prompt defibrillation.

C J MANN
Registrar in accident and emergency medicine
J R C HEYWORTH
Consultant in accident and emergency medicine

Queen Alexandra Hospital,
Cosham,
Portsmouth PO6 3LY

1 Guly UM, Mitchell RG, Cook R, Steedman DJ, Robertson CE. Paramedics and technicians are equally successful at managing cardiac arrest outside hospital. *BMJ* 1995;310:1091-4. (29 April.)
2 Mann CJ, Heyworth J. Advanced life support skills and out of hospital cardiac arrest: a retrospective evaluation by outcome. *J Accid Emerg Med* (in press).

Studying only admissions is a source of potential bias

EDITOR,—U M Guly and colleagues state that their study, which claims to show that "paramedics and technicians are equally successful at managing cardiac arrest outside hospital," does not "diminish the role of paramedics."[1] Yet the paragraph about their paper in This week in *BMJ* concludes that such patients "are best treated" by technicians and calls into question the requirement of having a paramedic in every emergency ambulance. We do not believe that such a conclusion can be safely drawn from the data presented.

The methodology gives rise to several sources of bias. Information is presented for those patients taken to the emergency department and not for all patients sustaining cardiac arrests in the community. In our series, based on telephone interviews with ambulance staff, 30% of all patients were certified dead at the scene, and for every three cases in which resuscitation was attempted there were two cases in which it was not; paramedics were more likely to start resuscitation.[2] Moreover, if ambulance controllers base their decision to dispatch technicians or paramedics on clinical information, random allocation of crew is unlikely. Thus the two types of crew may not resuscitate patients with the same likelihood of success before the intervention.

Furthermore, a comparison of times spent at the scene and outcome may be distorted by the inclusion of patients attended first by technicians and then by paramedics in the group treated by paramedics. Our data (table) show that these patients spend the longest times at the scene of the arrest. In our community based study of arrests due to all causes, paramedics, who (unlike those in Guly and colleagues' study) were able to give drugs, compared favourably with other crews. Therefore, while we agree that it is most important to provide rapid defibrillation, giving drugs (according to the European Resuscitation Council's guidelines) may be important.

Outcome of cardiorespiratory arrest outside hospital managed by South Glamorgan Ambulance Service (figures are numbers (percentages))

	Technicians with basic life support skills alone	Technicians with basic life support skills and defibrillators	Paramedics	Paramedics providing back up to technicians
Median time at scene (min)	10	13	22	30
Total No of attempts	252	102	517	83
Certified dead	75 (30)	34 (33)	158 (31)	18 (22)
Admitted	31 (12)	10 (10)	86 (17)	9 (11)
Discharged	11 (4)	5 (5)	46 (9)	6 (7)

CLIVE WESTON
Senior lecturer

Department of Cardiology,
Pinderfields Hospital,
Wakefield WF1 4DG

PETER DONNELLY
Senior lecturer

Centre for Applied Public Health Medicine,
University of Wales College of Medicine,
Cardiff CF1 3NW

1 Guly UM, Mitchell RG, Cook R, Steedman DJ, Robertson CE. Paramedics and technicians are equally successful at managing cardiac arrest outside hospital. *BMJ* 1995;310:1091-4. (29 April.)
2 Weston CFM, Burrell CC, Jones SD. Failure of ambulance crew to initiate cardiopulmonary resuscitation. *Resuscitation* 1995; 29:41-6.

Debriefing after psychological trauma

Inappropriate exporting of Western culture may cause additional harm

EDITOR,—Trauma is a growth industry in the West and thus fertile terrain for fashion. Beverley Raphael and colleagues note that debriefing after psychological trauma, which they call a social movement, is being widely instituted in advance of objective evidence of efficacy.[1] I wish to highlight one aspect with considerable implications: the export of Western psychological practices of this kind to various peoples affected by war worldwide.[2]

Rwanda is a good example. The first flows of destitute Tutsi refugees into Tanzania had scarcely abated when various aid organisations in the West were deciding from afar what was a priority—namely, "counselling." Projects were implemented without prior consultation with the refugees themselves or knowledge of their cultural norms and frameworks for psychological health, which are so different from those in the West. The experience of war is a collective one; processing it is a function of what it means or comes to mean. In the Rwandan case this will be coloured by what previous massacres have come to represent in Tutsi and Hutu social memory and the coping strategies used then. The notion that the complex and evolving impact of such events collapses down in a survivor to a discrete mental entity, the "trauma," that can be addressed by debriefing or similar approaches is risible. Projects should primarily target the impoverished social context of the survivors.

Psychosocial projects in war zones have become attractive for Western donors, driven in part by some expansive claims by professionals. For example, mental health advisers to the World Health Organisation and other agencies state that there are 700 000 people in Bosnia-Herzegovina and Croatia with severe trauma needing urgent treatment and that local professionals can handle less than 1% of these.[3] As a consultant to Oxfam I see these claims as misconceived, reflecting a narrowly pathologising view in which distress is relabelled as psychological disturbance. They also aggrandise the foreign experts who define the disorder and bring the cure. They risk distorting the wider debate about the destructive effects of war, including those on health. These trends can also pose dilemmas for indigenous organisations serving groups affected by war. Workers see that the central problem is the broken social world of these people, including poverty and lack of rights, but tell me that it seems easier to obtain funding from Western donors if they portray it as "trauma," whose antidote is "counselling."

Western psychological ideas are part of Western culture, which is becoming increasingly globalised. It would be ironic if trauma projects unwittingly generated the further disempowerment of non-Western communities weakened by war by presenting Western psychological thought as definitive knowledge and imputing inappropriate sick roles to the communities. The health and humanitarian fields are not exempt from issues of power and ideology.

DEREK SUMMERFIELD
Psychiatrist

Medical Foundation for the Care of Victims of Torture,
London NW5 3EJ

1 Raphael B, Meldrum L, McFarlane A. Does debriefing after psychological trauma work? *BMJ* 1995;310:1479-80. (10 June.)
2 Bracken P, Giller J, Summerfield D. Psychological responses to war and atrocity: the limitations of current concepts. *Soc Sci Med* 1995;40:1073-82.
3 Agger I, Buus Jensen S, Jacobs M. Under war conditions: what defines a psychosocial project? In: Agger I, ed. *Psychosocial projects under war conditions*. Zagreb: European Community Humanitarian Office/Task Force, 1995.

Response to stress is not necessarily pathological

EDITOR,—Beverley Raphael and colleagues' critical examination of the value of debriefing after psychological trauma focuses primarily on treatment after single disasters but could be extended to the wide range of psychological treatments offered to victims of current wars.[1] The failure of the concept of post-traumatic stress disorder to embrace the complexity of the experiences of suffering and loss in these situations has been addressed by other authors,[2] including me.[3] The treatment strategies that follow in its wake are equally problematic. They rest on an assumption of a pathological response to stress that is both universal across different cultures and centred on the individual. They ignore the continuing trauma of flight and resettlement that is experienced by refugees, and of life in regions of continuing conflict. And there is the possibility that they pathologise coping strategies that might be essential to survival. Hypervigilance—the ability to distinguish the sound of an incoming from that of an outgoing mortar, for example—may mean the difference between life and death in Sarajevo. Numbing and denial may allow a person to muster the psychological strength necessary for flight and to endure the miseries of refugee camp life as well as make possible courageous acts of non-violent resistance.

The authors are right to point out that the provision of psychological first aid answers the need of mental health workers to make an immediate response to suffering. I would also suggest that, through its focus on intrapsychic processes, this approach allows the workers to avoid the complexities of political and social causation and maintain that detached objectivity that is the professional ideal. The problem is that while questions such as "Why did this happen?" "Who