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Refugees: An examination of the Post-Traumatic Stress Disorder NICE guidelines

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ABSTRACT

The aim of this review is to consider whether the NICE guidelines for Post-Traumatic Stress Disorder (PTSD) can appropriately guide professionals in meeting the needs of refugees, through evaluation, assessment and treatment. In particular, the limited consideration for culture within the guidelines is explored. Of key importance is that the NICE guidelines are based on the diagnostic model of PTSD, which may fail to appreciate the broader ways in which refugees may understand their traumatic experiences, and wish to address the impacts. Furthermore, there is a clear gap in literature concerning PTSD treatment for refugees (Lee & Bowles, 2023). Arguably, this brings into question the validity of the treatment recommendations within the NICE guidelines, for refugees. More broadly, within the global context, the application of western-based mental disorders has been disputed based on the cultural, and philosophical differences, varying interpretations of life and different traditions in relation to expressing distress and seeking support (Summerfield, 2013). This paper suggests that the NICE guidelines fail to consider the depth and complexity of the role of culture within trauma and recommend insufficient flexibility with regards to the mode of treatment delivery, including a lack of consideration for native and culturally grounded methods of intervention.

1. Method

An overview is given of the NICE PTSD recommendations. These are then analyzed in the context of the refugee experience drawing on empirical literature exploring trauma interpretation and manifestations, treatment, culture, religion and societal ideologies, which have been reviewed and analyzed in the context of the NICE PTSD recommendations.

2. Introduction

The National Institute for Health and Care Excellence (NICE) guidelines apply quite broadly to all individuals with a diagnosis of Post-Traumatic Stress Disorder (PTSD) or clinically important symptoms of PTSD. The treatment recommendations include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children aged 5 and upwards and adults with a diagnosis of PTSD or clinically important symptoms of PTSD from one month after the traumatic event. From three months after the trauma Eye Movement Desensitisation and Reprocessing (EMDR) therapy is also suggested for adults who have experienced non-combat-related trauma and children from age 7, only if they do not respond effectively to TF-CBT or do not engage. TF-CBT is also suggested in some cases as a prevention method (NICE, 2018a). Arguably, the NICE guidelines recommend CBT and EMDR quite broadly for anyone with a diagnosis of PTSD or clinically important symptoms of PTSD, excluding only combat-related trauma for EMDR. It could be suggested that the broad nature of these guidelines, that can be applied to all individuals who are clinically impacted by trauma, contradicts the notion that trauma is a unique experience influenced by context and culture. Ehlers and Clark (2000) emphasize that trauma will be understood and its meaning concluded based on internal and external influencing factors. Problematically, the PTSD diagnosis focuses purely on reactions to an external event, overlooking the broader social context (Papadopoulos & Hulme, 2002;2018). The NICE guidelines recommend culturally and linguistically appropriate screening, assessment and interventions (NICE, 2018a). However, given the many ethnicities that exist no depth is provided. Potentially the general nature of treatment for all may not align with the cultural background and world view of refugees.

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3. Recommendations for refugees and cultural and linguistic considerations may be insufficient

The proposed treatment of CBT or EMDR, alongside cultural and linguistic considerations (NICE, 2018a) may be insufficient. Rather a contextually sensitive CBT model that considers the cultural group, language spoken and denomination of religion, including attitude towards it, would be more valuable (Hinton & Patel, 2018). Bernal and Jimenez-Chafey define cultural adaptation as "systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that is consistent with the client's cultural patterns, meaning and values" (Bernal & Jimenez-Chafey, 2009, pg. 362). Religious consideration is important since it may influence views of the experience and its impacts, barriers to care or sources of resilience (Hinton & Patel, 2018). In some cultures, trauma symptoms may be associated with bad spirits or relate to low merit, for example; karma, within Buddhism. Within the frame of contextually sensitive CBT clients can be encouraged to elevate spiritual status through meditation (Hinton & Patel, 2018). Hinton and Patel (2018) suggest that engaging community leaders in understanding psychological distress within their community and involving them in promoting engagement to respond to these issues can be productive. Arguably, the cultural and linguistic considerations within the guidelines appear insufficient to properly address the needs of a wide range of ethnicities. Of particular concern is the exclusion of the need for practitioners to have in depth cultural knowledge that can be applied to their practice.

The NICE guidelines do recognise the needs of refugees to a degree, but with little depth and consideration for the complexity of the refugee experience. Routine screening as part of physical and mental health services is advised for refugees and it is suggested that their particular needs are considered (NICE, 2018a). However, the information is vague and generic. Papadopoulos's (2007) adversity-trauma grid is a valuable tool in identifying the broad range of potential impacts of trauma, including resilience and adversity-activated development. Arguably, the refugee experience requires deep conceptualisation and consideration for the interplay between loss of home, potential grief, the various phases of the forced migration journey and resettlement and integration. Alcock (2003) emphasizes the significance of the loss of home and the difficulty of moving emotionally from the past into the present life. Nickerson et al. (2011) emphasizes the significance of grief and how complicated grief strongly impacts the connections between PTSD symptoms, loss and mental health. Recommendations are made for individuals who are unable or unwilling to engage in trauma treatment and target specific symptoms, such as sleep (NICE, 2018a). This may be particularly valuable for refugees who may see their symptoms as more physical or feel unwilling to engage in psychological therapy due to stigma. The guidelines suggest consideration for identifying people who may face challenges identifying the psychological consequences of trauma, due to culture (NICE, 2018a). This is an important consideration, however it also raises the issue that mechanisms for assessing trauma have been developed in western societies (Wells et al., 2015). This suggests an assumption that individuals will all identify trauma inline with the definition within the guidelines. This seems to contradict the notion that trauma will be influenced, understood and manifest through cultural interpretation leading us to consider whether the guidelines appreciate that the presenting consequences of trauma may vary across cultures and not necessarily align with the PTSD diagnosis, within the guidelines.

3.1. Treatment method recommendations may not align with the refugee context

The individual nature of treatment recommendations, by NICE, may not align with the refugee context, trauma experienced, world view and collective approach to the wider community. Eleftheriadou (2010; 2018) suggests that not everyone will feel comfortable addressing their emotions with someone they don't know, away from family or community. For example; many refugees come from communities where grieving is collectively experienced, compared to a more autonomous approach in western societies (Jalonen & Cilia La Corte, 2018). Papadopoulos and Hulme (2002;2018) draw our attention to the practice of Transient Familiar Others (TFO), whereby refugees bring an uninvited person with them to therapy. A practice that perhaps reiterates the unfamiliarity of individual therapy, with an unfamiliar other. The TFO model challenges the typical frame and boundaries within therapy and does not align exactly with the NICE guidance of individual treatment. Psychiatric disorders are typically individually based (Nickerson et al., 2011). However, often trauma may be experienced, by refugees, both individually and collectively and the impacts and symptoms may manifest at the community and family level, highlighting the importance of family mental health, beyond the individual context (Nickerson et al., 2011). Arguably, this may be particularly pertinent to collective societies. The guidelines do place emphasis on involving and supporting family members and consideration for when aspects of treatment, such as psychoeducation, might be provided together when a family has experienced the same trauma. However, systemic therapy is not explicitly recommended. Summerfield (2013) draws our attention to the sociomoral impacts of trauma moving away from the notion that trauma is grounded within the psychological or individual space. This is depicted in the following case study. Debatedly, within the guidelines there does not seem to be substantial consideration for the frame in which individuals may approach services from, but rather a 'one size fits all' approach with vague consideration for culture, including individualistic versus collective societal practices.

Case Study:

Samir is a refugee from Bosnia, who survived war and ethnic cleansing. He attended the psychiatric clinic at the Medical Foundation for the Care of Victims of Torture for a period of three years, following the diagnosis of PTSD. Attempts with antidepressants and a rehabilitation approach were largely ineffective. In therapy, there was repeated reference to the loss of his home. Only when he travelled to visit family and encountered a symbolic reminder of the old Bosnia did he appear less aroused and more neutral. However, these feelings were short-lived. The problem for Samir was not psychiatric but rather moral and social. He was morally outraged at what had happened to this community; with the perpetrators free and the victims without justice. He could not comprehend this world and this impacted his everyday life. The trauma experienced was situated in the social world, not the psychological or individual space. In the psychiatric arena he was not able to accept and move on. Samar's world was shattered and psychiatric treatment was not able to address his sociomoral concerns. The role of his psychiatrist was viewed as one of fellow human offering solidarity and political validation (Summerfield, 2003).

3.2. Insufficient guidelines for complex needs and comorbidities

The NICE guidelines specify recommendations for individuals with PTSD and complex needs (NICE, 2018a), which may be valuable for refugees, if the PTSD criteria is met. These provisions include additional time to build trust, in accordance with the individual's needs. Treatment recommendations are six to twelve sessions for children and eight to twelve sessions for adults, for non-complex situations (NICE, 2018a). For both complex and non-complex situations this may not allow sufficient time to build cross-cultural connections, additional time when working with an interpreter or the opportunity for the refugee to understand the therapeutic model and feel confident in its value. Shahnavaz (2023) reflects on the significance of learning from the client about their culture. It is worth considering whether TF-CBT and EMDR allow for such dynamics or role reversal spaces within the timeframe. Further consideration is given to the barriers to engagement (NICE, 2018a). However, these seem to largely focus on PTSD defined symptoms, with no mention of cultural barriers. Recommendations include consideration for safety and stability which may impact engagement and treatment outcomes (NICE, 2018a), but a specific phased approach is not detailed. To support the process of trust, safety and stabilization a phased approach may

be particularly valuable (Herman, 2015) for refugees. This need is echoed within the TFO model, specifically TFO's may enable refugees to take the first step in seeking therapeutic support and facilitate stabilization within therapy until the refugee develops enhanced capacity to process their experiences (Papadopoulos & Hulme, 2002;2018). In the specific context of political asylum such a phased approach may be particularly valuable; "In light of the explicit intent of torture to destroy one's system of beliefs, values, and relationships, the ordering of therapy from safety to reconstruction to reconnection represents an almost exact reversal of the internalized oppression suffered by the victim" (Gorman, 2001, p.449). It could be further suggested that a phased approach aligns well with refugees, whose sense of safety and trust may have been disrupted. Mental health stigma and integration challenges may exist alongside the need to adapt to a new model of recovery, and potentially work with someone who does not understand their cultural heritage.

There may be value in group therapy for refugees. Garland et al. (2002) suggest that often the treatment of choice for refugees is group therapy and that many refugees are traumatized and detached from their culture, impacting their ability to live a normal life often becoming emotionally disconnected with the world around them. Group therapy can serve to challenge these habits, aid a shift to a post-traumatic personality and engage participants safely in the lives of others, in turn encouraging psychological agency (Garland et al., 2002). Groups may also reflect the collective nature of many refugee communities and have the potential to recreate a sense of home (Jalonen & Cilia La Corte, 2018). Though peer support is suggested within the guidelines on the basis that it can be valuable to share experiences and may enable individuals to address their doubts about accessing treatment (NICE, 2018a), this is not therapeutic intervention. Furthermore, group TF-CBT is suggested for children and young people exposed to large scale collective trauma within the past month as a prevention strategy (NICE, 2018a). However, many refugees would not typically fit this criteria due to the long duration of the resettlement process or the time that it takes to reach safety in the UK. Group therapy is not recommended in other age groups or at a later stage (NICE, 2018a). The International Society for Traumatic Stress Studies (ISTSS) do recommend group-CBT for children and adults (ISTSS, 2018). Garland et al. (2002) recommend that therapeutic intervention with refugees requires conceptualisation and should not be addressed routinely. Potentially the generic and narrow options for addressing the impacts of trauma may prevent refugees from engaging or staying in therapy. Although the guidelines promote a person-centered approach, how person-centered can this be when treatment options are so limited? The issue of power dynamics also comes into play when the treatment on offer is grounded in the context of the host country, rather than utilizing traditional means of coping and ultimately the expertise of the person or community seeking support.

4. Exploring the way in which treatment decisions are recommended, based on the diagnostic model

Treatment decisions are recommended based on the diagnostic model of understanding and treating PTSD. This section of the paper will critically appraise the way in which the NICE guidelines are based on the diagnosis of PTSD and consider factors that have influenced this process. There may be a gap within literature concerning PTSD treatment for refugees that influences these guidelines. Lee and Bowles (2023) conducted a rapid review of the treatment recommendations for PTSD. They found that demographic information, including race and ethnicity, was often unclear or not reported. Furthermore, one study, out of 486, included two studies in refugee camps (Gillies et al., 2012). Lee and Bowles (2023) argue that there is a clear gap in literature concerning PTSD treatment for refugees. Of the NICE guidelines evidence for psychological, psychosocial and other non-pharmacological treatment of PTSD in adults only 5.7 % of studies focus on refugee populations and in the case of children this figure is only 3.3 %, plus none of these studies are situated within the UK (NICE, 2018b). Arguably, the guidelines can therefore not reliably account for the combined context of country of origin and host country. Studies on migrant populations were also present but migration being a broader phenomenon, differentiating legal migration from displaced or exiled refugees was not always possible. Overall, across six evidence reviews in adults and children, only 15 studies included refugees, and none was undertaken in the UK (see Table 1 for the characteristics of these publications and populations. It is worth noting that five studies were conducted in refugee camps in Uganda ($n = 2$) and at the Turkish-Syrian border ($n = 3$), and with a further study in Thailand, these six studies are both low- and middle-income countries and a neighbour country to conflict zones. These studies tended to focus on homogenous communities. All other studies were conducted in western countries, two in Denmark, two in Germany, one in Norway and four in the USA. Studies did not really account for the community aspects and social contexts experienced by the refugees. Furthermore, as the idiom *refugee trauma* was also found several times, it is also important to appreciate the diversity and breadth of both refugee population and traumatic experiences to avoid the essentialisation of refugee traumas as a western construct. Overall this potentially brings into question the validity of the treatment recommendations within the guidelines. Do they really capture the best treatment recommendations across ethnicities, including the refugee cohort? Wells et al. (2015) argues the assumption that such tools are universal is a miscalculation. Of key importance is to understand how mental distress is conveyed and understood in a given culture. Only then can effective interventions be created (Wells et al., 2015). Psychiatric ethnography may clarify the perception of health, daily traditions and coping mechanisms (Wells et al., 2015). CBT research with ethnic minorities is in its early stages concerning whether it is effective across ethnicities, including with refugees. Much research to date has been focused in western populations (Hinton & Patel, 2018). It could be suggested that the lack of diversity within research brings into question the applicability of the NICE guidelines to various ethnicities, including refugees.

4.1. Pathologizing normal responses to abnormal experiences

The NICE guidelines, being grounded within the diagnostic model of understanding and treating trauma, has led to a treatment model that focuses on the psychopathology of trauma. It is interesting to consider why the diagnostic model has become so prominent. Carlat (2010) argues that pharmaceuticals have influenced the growth and expansion of the Diagnostic Statistical Manual (DSM), in turn escalating the role of diagnosis, alongside medication treatments. Debatably, the DSM has become a tool that seeks to pathologize normal responses to abnormal experiences. Frances (2018) argues that the biopsychosocial model has been lost over time, with sectors narrowing in on biological, psychological or social areas creating a division and a loss of consideration for the complexity of human nature and at times there has been competition between these subjects. The strength of the DSM, and PTSD diagnosis within, seem to have dominated recommendations for clinical trauma treatment. There is also concern that there is a tendency to pathologize unnecessarily. Horwitz and Wakefield (2007) draw our attention to ordinary sadness, such as bereavement, being misdiagnosed as depression due to a lack of consideration for causal and contextual factors. Ratnayake further argues that the "theoretical account of CBT struggles to demarcate depression from ordinary life experiences, as it cannot adequately accommodate contextual factors" (Ratnayake, 2022, p.2). It could be suggested that the way in which the guidelines are based on a diagnostic model fails to conceptualize the way in which people understand their trauma. There seems to be an error in the assumption that treatment recommendations will apply universally. The following sections will discuss some of the possible challenges for refugees with this diagnostic pathway to treatment, and consider influencing factors.

Table 1
Studies on refugee populations included in the NICE PTSD evidence.

Evidence Reviews	Publication	Country	Type of trauma (verbatim from NICE evidence reviews)	Characteristics of refugees (includes verbatim from NICE evidence reviews)
A	No included studies on refugee populations			
B	Schottelkorb et al. (2012)	United States	Witnessing war as a civilian (Childhood Refugee Trauma)	Age range (mean): 6–13 (9.2) Gender (% female): 45
	Ruf et al. (2010)	Germany	Witnessing war as a civilian - Violent attacks against their parents or other family members at home (73 %) were the most common trauma type reported. These assaults were mainly conducted by soldiers or other organized militant groups (58 %). Other traumatic experiences included witnessing physical attacks against non-family members outside of the house (50 %), accidents (46 %), violence against the child at home (35 %, most of these were by militant forces, 27 %), assaults against the child outside of the home (35 %), living in a place of war (35 %), seeing dead bodies (35 %), painful or scary medical treatments (27 %), hearing about the violent death of a beloved person (27 %), earthquakes (19 %), other natural disasters (12 %), and sexual abuse (8 %)	Age range (mean): 7- 16(11.4) Gender (% female): 46
C	Bolton et al. (2014)	Thailand	Witnessing war as a civilian (Burmese survivors of imprisonment, torture, and related traumas)	Age range: 18–85 Gender (% female): 63 63 % ethnically Burman
D	Buhmann et al. (2016)	Denmark	Mixed (Trauma history: 39 % torture; 22 % refugee camp; 57 % Danish asylum centre; 27 % ex-combatant)	Age range (mean): NR (45) Gender (% female): 41
	Hijazi et al. (2014)	United States	Witnessing war as a civilian - Iraqi refugees: Racial/religious oppression (92 %); exposure to combat situation (92 %); witnessing murder (68 %); murder/violent death of family/friends (65 %); kidnapping of family/ friends (59 %); witnessing torture (41 %); physically harmed (38 %); imprisoned arbitrarily (29 %); witnessing mass execution of civilians (27 %); kidnapped (27 %); tortured (25 %); taken hostage (18 %); sexually abused/raped (6 %). Most participants experienced multiple events (mean 19.8; SD=6.4)	Age range (mean): NR (48.2) Gender (% female): 56 Majority Chaldean, a Christian minority in Iraq.
	Hinton et al. (2005)	United States	Witnessing war as a civilian - Participants had passed through the Cambodian genocide (1975–1979) where they may have been subjected to slave labour, physical and sexual violence, threat of death by illness, starvation or execution	Age range (mean): NR (51.8) Gender (% female): 60
	Hinton et al. (2009)	United States	Witnessing war as a civilian - Participants were exposed to the Cambodian genocide (1975–1979)	Age range (mean): NR (49.5) Gender (% female): 60
	Neuner (2004)	Uganda - refugee settlement	Witnessing war as a civilian - Most refugees had experienced multiple traumatic events in the Sudanese civil war before they fled to Uganda. However, northern Uganda was not a safe exile for the refugees as the settlements were threatened and attacked by Sudanese and Ugandan rebel armies. The majority of participants (52 %) reported the witnessing of people badly injured or killed as worst event type (which included the killing of relatives as well as massacres and mutilations); further worst event types were threats with weapons and kidnappings (17 %), physical attacks (12 %), torture (7 %), combat experiences (7 %), sexual assaults (5 %) and natural disasters (2 %)	Age range (mean): NR (33.2) Gender (% female): 60
	Neuner et al. (2008)	Uganda - refugee settlement	Witnessing war as a civilian - Rwandan and Somalian refugees settled in a refugee camp in Uganda	Age range (mean): NR (35) Gender (% female): 51
	Neuner et al. (2010)	Germany	Witnessing war as a civilian - Asylum-seekers with a history of victimization by organized violence. The most common traumatic event types reported by the patients were witnessing a violent assault on a familiar person (91 %), torture (88 %), being in a war zone (72 %), and experiencing a violent assault by a stranger (62 %). Origin: Turkey (78 %); Balkans (13 %); Africa (9 %)	Age range (mean): NR (31.4) Gender (% female): 31
	Stenmark et al. (2013)	Norway	Witnessing war as a civilian - Refugees and asylum seekers. Region of origin: Afghanistan (15 %); Iraq (27 %); Middle East (remaining countries; 16 %); Africa (26 %); Other (15 %)	Gender (% female): 31
	Acarturk et al. (2015)	Kilis Refugee Camp, Turkish–Syrian border	Witnessing war as a civilian (Syrian refugees)	Age range (mean): 19–63 (36.6) Gender (% female): 76
	Acarturk et al. (2016)	Kilis Refugee Camp, Turkish–Syrian border	Witnessing war as a civilian (Syrian refugees. Traumatic events included: death of family members; threatened death to self or others; serious injury to self or loved ones; husband being at war; arrested family members; not being able to bury significant others who have died in Syria; lack of shelter)	Age range (mean): 17–64 Gender (% female): 74
	Ter Heide et al. (2016)	The Netherlands	Witnessing war as a civilian - Refugee sample, with most frequently reported traumatic events being close to death (83 %), murder of family or friend (75 %) and threatened with torture (72 %)	Age range (mean): NR (41.5) Gender (% female): 28
	Yurtsever et al. (2018)	Kilis Refugee Camp, Turkish–Syrian border	Witnessing war as a civilian: Syrian refugees residing in a refugee camp in southeast Turkey on the Syrian border	Age range (mean): NR (37.5) Gender (% female): 77
E	No included studies on refugee populations			
F	Buhmann et al. (2016)	Denmark	Mixed (Trauma history: 39 % torture; 22 % refugee camp; 57 % Danish asylum centre; 27 % ex-combatant)	Age range (mean): NR (45) Gender (% female): 41

4.2. Do refugees relate to the symptoms and diagnosis of PTSD and treatment recommendations?

In some cultures people may not identify with the elements defined within the PTSD diagnosis or they may wish to address their traumatic experiences through non-psychological means. Some people might wish for the opportunity to collectively share experiences, understand their past and explore ways to manage current challenges. Such work does not necessarily require clinical intervention, but instead community based support, promoting connection, problem solving and validation of coping remedies (Hassan et al., 2016). In Afghanistan it was found that no word for PTSD existed within the local language. Afghan's also felt that they did not relate to the combination of symptoms within the PTSD diagnosis but connected with depression and had existing idioms for it (Ventevogel & Faiz, 2018). Jefee-Bahloul et al. (2014) note that Syrian refugees may choose alternative means of coping that they relate more strongly to such as connecting with God, speaking with close family and friends and validating their response to trauma as being understandable and normal. Costa (2010; 2018) found that among Croatian women coming together to knit, drink coffee and talk reflected a self-healing tradition that had been practiced for centuries during former wars. In contrast, middle-class women from cities, where psychotherapy was normalized, may not have opted for such a model of recovery. This highlights the diversity within communities and the complexity of applying a cultural lens to supporting refugees, arguably such complexity is not appreciated within the NICE guidelines. Potentially individuals from certain cultures may not meet the diagnostic threshold and the provision of individual CBT and EMDR may not align with refugees traditional methods of trauma recovery, meaning that support is not necessarily accessed. Hinton et al. (2011) suggest identifying psychological dimensions beyond the PTSD diagnosis within a group, including somatic symptoms, catastrophic cognitions and pathological worry. It is worth considering whether prior appreciation for the importance of diversity within studies could have influenced the trajectory of treatment and subsequent recommendations. For example; might broader treatment options have been suggested if a wider range of ethnicities had been included in the research?

Somatic experiencing is common among refugees impacted by trauma, but it is not detailed within the PTSD diagnosis. Brewin (2003)) critiques the PTSD diagnosis for its siloed focus on the individual mental impacts of trauma. Notably in collectivist cultures, trauma often manifests as a physical health complaint impacting functioning (Engelbrecht & Jobson, 2016). For example; Cambodians often associate anxiety symptoms to 'heart weakness' and 'wind attack', named *khyal* (Hinton & Patel, 2018). Weiss et al. (2001) explored psychiatric stigma across cultures looking specifically at Bangalore and London. They found that the participants from Bangalore affirmed somatic experiences, while the London participants emphasized psychological aspects related to the meaning and experiences of their ailments. Furthermore, some patients did not disclose all aspects of the symptoms and suffering due to stigma and fear of the consequences of disclosure. Individuals who experience the impacts of trauma as somatic often expect treatment to concern their physical health and tend not to disclose details about their memories and experiences (Weiss et al., 2001). This suggests that some cultures are more likely to experience somatic symptoms, which seem to carry less stigma. The NICE guidelines do suggest that the presence of unexplained physical symptoms should initiate inquiry into traumatic experiences (NICE, 2018a). However, the absence of somatic symptoms within the PTSD diagnosis may be problematic with regards to identifying psychological trauma and access to subsequent treatment and support. Hinton and Patel (2018) suggest that framing treatment within the context of the individual's key concerns is likely to make treatment more accessible and help to understand their frame of reference. However, it could be suggested that such an approach may require a more person-centered model as opposed to TF-CBT or EMDR. Overall, the siloed focus on the diagnostic model, within the guidelines, appears to fail to capture the physical ways in which trauma manifests across cultures. Utilizing the diagnostic criteria means that individuals must fit these standards to access treatment.

4.3. The role of religion and narrative coping mechanisms

Considerations for interventions that incorporate community, native coping mechanisms, resilience and religion may be valuable, but are not included within the NICE guidelines. Jefee-Bahloul (2015) argues that services for refugees typically focus on acute mental health needs and referral systems, but such provision should be expanded to include community-based and culturally sensitive programming that focuses on building coping and functioning strategies. Wells et al. (2015) suggests that interventions that incorporate systems that strengthen native coping mechanisms may aid a process of stronger validity in conceptualizing community distress. Bernal and Saez-Santiago (2006) highlight that the aspect of spirituality has not really been incorporated into treatment approaches for PTSD. Yet religious participation, religiosity and spirituality have been found to contribute significantly to resilience and post traumatic growth (Shaw et al., 2005). In a case report, Işık and Toprak (2024) demonstrate the value of religious adapted CBT for a survivor of rape. It is likely that the incorporation of religion enabled patience, trust and optimism, while harmonising feelings of anger and guilt. Specifically, the connections made in therapy between sinful beliefs and her guilt created understanding and trust. Additionally, exploration of the perpetrator being punished in the afterlife reduced her anger and enhanced her relationships (Işık &Toprak, 2024). Furthermore, family solidarity, culture, honour and hope were factors that supported the resilience of Afghan families (Eggerman, 2010). Rehberg (2015) proposes a shift from vulnerability approaches to a resilience and recovery model, in turn validating individual agency. Arguably, resilience and recovery sit in direct opposition to the diagnostic model. It is important to acknowledge that the ISTSS incorporates non-psychological recommendations, for adults, within their guidance on PTSD. This includes recognition of emerging evidence supporting non-psychological treatment including acupuncture, somatic experiencing and yoga (ISTSS, 2018) (see Table 2 for the contrasts between the NICE guidelines, ISTSS guidelines and the Therapeutic Frame of Orientation approach). Once again this raises the issue that although the guidelines recommend a person-centred approach, it appears that the diagnostic foundations of the model ultimately do not allow for choice within treatment that meet individual needs, within their frame of reference.

4.4. Evidence-based frameworks

There is evidence that therapeutic interventions that are contextually and culturally aligned may be effective in refugee populations. Community-based sociotherapy is a promising model; in Rwanda such a programme, called mvura-nkuvure (you heal me, I heal you), was effectively implemented with Congolese refugees (Sewimfura et al., 2023) . It is grounded in a belief that individual oriented therapy is less effective than sociotherapy groups which provide opportunities to reconnect with everyday life and offer transitional spaces where members can 'experience the value of listening, sympathising with others, speaking with others about problems, making decisions together, and empowering each other' (Sewimfura et al., 2023,) pg. 60). Since the traumatic exposure of mass-violence experienced by this cohort was inter-personal, a key task was to remedy the shattered social environment, which required a collective approach (Sewimfura et al., 2023). This reiterates the social impacts of trauma and provides an example of an effective remedial approach. The ethnopsychoanalytic approach at the Avicenne hospital, in France, is based on the practitioners first understanding both the cultural context and current situation of the individual in order to understand and support them. The model involves a group of culturally diverse therapists and the client and often their

Table 2
Comparative table of psychological treatment recommendations.

	NICE Guidelines - treatment recommendation	ISTSS Guidelines - treatment recommendation	Therapeutic Frame of Orientation
Assumptions about etiology	Utilises the DSM-5 and ICD-11 as a foundational diagnostic framework.	Utilises the DSM-5 and ICD-11 as a foundational diagnostic framework.	Adversity grid: PTSD, distressful psychological reaction, ordinary human suffering, resilience, adversity-activated development across four levels; individual, family, community, society/culture.
Therapeutic modality - children	Individual TFCBT, EMDR.	Strong recommendation: CBT (caregiver & child), CBT (child), EMDR. Emerging evidence: Group-CBT, psychoeducation, Parent/child relationship enhancement.	Synergic therapeutic model. Holistic, person-centred, non-pathologizing and context-conscious therapeutic approach. Utilises psychodynamic, systemic, spiritual, cultural, socio-political elements.
Therapeutic modality - adults	Individual TFCBT; cognitive processing, narrative exposure therapy, prolonged exposure therapy. EMDR. Online CBT.	Strong recommendation: Individual CBT, group TFCBT, online TFCBT, narrative exposure therapy, present centred therapy. Emerging evidence: Couple TFCBT, Individual TFCBT, reconsolidation of traumatic memories, single session CBT, written exposure therapy, virtual reality therapy. Acupuncture, neurofeedback, saikokeishikankyoto, somatic experiencing, transcranial magnetic stimulation, yoga.	Synergic therapeutic model. Holistic, person-centred, non-pathologizing and context-conscious therapeutic approach. Utilises psychodynamic, systemic, spiritual, cultural, socio-political elements.
Cultural responsiveness	Basic, generalised guidance on cultural considerations.	Provides guidance on cultural considerations.	Emphasis on the importance of understanding the cultural context at the individual and community level.
Treatment structure	Typically 6–12 sessions (children), 8–12 sessions (adults) for PTSD, longer for complex PTSD. No recommendations for people with complex needs or living with comorbidities, aside from extending the number of sessions.	Treatment length is based on individual needs and progress.	Adaptable structure in line with clients evolving circumstances and needs.

family. In this model, cultural depictions can support the understanding of one's suffering and these representations can also be explored and questioned within the therapeutic space (Sturm et al., 2008). Arguably, this model is in opposition to the NICE guidelines which fail to include a focus on the individual's culture and context within its foundations. Another evidenced based model is Narrative Exposure Therapy (NET), which is grounded in a testimonial method as opposed to a clinical approach, effectively acknowledging the role of human rights violations (Wright et al., 2020), which arguably may be more appealing to communities where mental health concerns are stigmatised. It is further interesting to consider whether, for those who have experienced human rights violations, this offers empowerment and advocacy opportunities. The element of storytelling within NET, may align with traditional customs; 'the oral tradition is a common element among many cultures; thus narrative approaches seem ideally suited to cross-cultural applications' (Neuner et al., 2004, pg. 580). Gwozdziewycz and Mehl-Madrona (2013) highlight the overall potential of NET with the refugee cohort and demonstrate scope for its delivery by locally trained counsellors. Arguably this leads us to ask whether NET, and potentially other interventions, could be situated within community-based settings, outside of the clinical realm.

5. Discussion and conclusion

For the NICE guidelines to be beneficial for refugees they need to first fit the diagnostic criteria of PTSD or clinically important symptoms of PTSD, which arguably they may not do due to the diversity of ways in which trauma is understood and manifests in people across cultures. Typically they must then agree to an individual form of treatment, which may not align with their world view or traditional means of coping. Limited sessions will be provided, with potential for additional sessions if complex needs are present. Within the allocated time the refugee needs to understand the TF-CBT or EMDR model of recovery, potentially connect across cultures with the practitioner and engage in a treatment programme that is designed for all people clinically impacted by trauma; effectively a one size fits all treatment model, that fails to appreciate the role of religion, community and resilience in recovery. Rather a contextually sensitive CBT model that considers the cultural group, language spoken and denomination of religion, including attitude towards it (Hinton & Patel, 2018), would be more valuable, although this poses some financial and practical challenges. It could be suggested that the NICE guidelines fail to consider the depth and complexity of the role of culture within trauma and consequently recommend insufficient flexibility with regards to the mode of treatment delivery. This may relate to the foundations of the NICE guidelines being based on a diagnostic model, which seems to contradict the notion that trauma will be influenced, understood and manifest through cultural interpretation and that its impacts will go beyond the psychological context. Overall, it seems probable that refugees may not meet the NICE guidelines criteria to obtain support and feel comfortable engaging in a western model of recovery that fails to appreciate traditional modes of healing.

In conclusion, given that refugees will continue to come to the UK to seek safety, as a result of conflict and human rights abuses, it is recommended that the NICE PTSD guidelines are updated to incorporate greater depth of cultural consideration. Recognition that the basis of the NICE guidelines fails to incorporate sufficient literature concerning PTSD treatment for refugees is an important aspect of this. An update of the NICE PTSD guidelines should include an overhaul of the literature contributing to the guidelines, an appreciation that the PTSD diagnosis pathologizes' trauma and in doing so fails to incorporate a broader spectrum of experiences and manifestations leading to treatment recommendations that do not cater for all. Consideration should be given to whether the focus on purely adults and children is too narrow and whether key populations be incorporated into the evidence review process. An annex within the guidelines focused specifically on supporting refugee populations would add depth thereby supporting professionals. In addition, mandatory cultural formulation training for clinicians treating trauma should be recommended. There may be some valuable learning from the ISTSS Guidance, which acknowledges emerging evidence supporting non-psychological treatment including acupuncture, somatic experiencing and yoga (ISTSS, 2018). The commissioning of comparative trials between NICE guidelines and culturally adapted interventions for PTSD is also recommended. Overall

a deeper analysis of how trauma presents and what treatments are effective across cultures is needed. The fact that refugees may benefit from treatment that aligns with their culture, tradition, religion and native coping mechanisms should be considered.

CRediT authorship contribution statement

Hannah Sansom: Writing – original draft, Conceptualization.

Declaration of competing interest

The author declares that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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