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REVIEW

The psychological treatment of Post Traumatic Stress Disorder (PTSD) in adult refugees: A review of the current state of psychological therapies

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Abstract

Background: Large numbers of refugees flee their countries of origin each year. A proportion of these people will have witnessed or experienced traumatic events and may be suffering from psychological distress requiring intervention.

Aims: The article aims to review the literature relating to the psychological treatment of Post Traumatic Stress Disorder (PTSD) in adult refugees. The clinical implications of existing research and specific challenges faced by health services in meeting the mental health needs of non-western individuals are discussed.

Method: A literature search of English language journals was conducted using the Web of Science, Medline and PsycInfo databases.

Findings: There is a dearth of research in this area and the majority of studies conducted have significant methodological limitations. Despite this, the psychotherapeutic studies to date indicate some potentially effective treatments with traumatized refugees and have attempted to employ innovative treatment elements taking into account issues of diversity.

Conclusions: Research and practice in this area is in its infancy and further research is necessary. Culturally sensitive adaptations of CBT seem promising and further research is needed to clarify the value of such specific elements in therapy. The need for greater therapist awareness of issues of diversity raises issues for training and continual professional development.

Keywords: *PTSD, refugee, asylum seeker, psychological treatment, culture.*

Aims

The aim of this paper is to review the literature pertaining to the psychotherapeutic treatment of adult refugees and asylum seekers. It is recognized that research in this area is in its infancy and it is envisaged that by providing a review of this area, clinical practice will be better informed and clinically useful research stimulated.

A literature search of English language journals was conducted using the Web of Science, Medline and PsycInfo databases with the keywords, *refugee, asylum seeker, treatment and post*

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traumatic stress disorder. As the review is focused on the treatment of adult refugees, articles focusing specifically on children have not been included. Some articles discussing the assessment and prevalence of PTSD in refugees are included, where they are relevant to the discussion. However, studies specifically focused on epidemiological factors and the development of assessment measures are outside of the remit of this review. Readers interested in assessment measures are directed to Hollifield et al. (2002) for a review.

Introduction

The extent of the issue

A significant number of the world's population are forced to leave their country of origin each year under threat of their lives, often as a result of catastrophic events such as war or political turmoil. The Office of the United Nations High Commissioner for Refugees (UNHCR, 2002) indicates that worldwide, there are currently 12 million people who can be classified as refugees and 940,800 people who can be classified as asylum seekers. Although the majority of refugees find permanent or temporary residence outside of Europe and North America, the number of asylum applications submitted to Western countries is rising and totaled 614,100 in 2001. According to the United Nations convention (UNHCR, 1951), a refugee is defined as someone who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion;

- is outside the country of his nationality
- is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.

An asylum seeker is a person who has left their country of origin and applied for recognition as a refugee in another country, and is awaiting a decision on their application. Currently, in the UK asylum seekers are entitled to 70% of basic income support rates and free health care, but are unable to work. Some additional support, including aid with accommodation is also provided by the National Asylum Support Service (UNHCR, 2002). Asylum seekers may therefore be experiencing significant ongoing difficulties in terms of their financial and domestic situation, insecurity and fear of forced repatriation. For the purposes of this review the term refugee will be used for both refugees and asylum seekers'.

Mental Health needs of refugees

There may be a variety of pressing health and mental health needs for refugees (Burnett & Peel, 2001). For example, Carey-Wood, Duke, Karn, and Marshall (1995) have reported that two-thirds of refugees in their UK sample had experienced anxiety and depression. It has been commented upon that health problems in general in this population may be related to prior experience of trauma and also to socio-economic deprivation factors (Bardsley & Storkey, 2000) and exile related factors, such as lack of social support and isolation (Gorst-Unsworth & Goldenberg, 1998; Kivling-Bodén & Sundbom, 2002; Söndergaard, Ekblad, & Theorell, 2001; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Weine et al., 1995). Whilst the focus of this review is upon the treatment of such trauma related symptoms, issues of comorbidity need to be kept in mind as they complicate the response to treatment.

Many refugees will have experienced or witnessed events such as rape, torture, war, imprisonment, murder, physical injury and even genocide, prior to fleeing their homes. Such events can clearly be described as *traumatic* and not surprisingly many refugees may experience psychological trauma related distress. The prevalence of specific post trauma type symptoms within refugee populations range, but figures as high as 30% are not atypical in the literature and some studies have found prevalence rates as high as 86% (Thulesius & Hakansson, 1999).

Western psychological health care agencies are increasingly finding themselves concerned with assisting traumatised individuals originating from non-Western cultures. This increased demand has been associated with considerable political, practical and resource issues. Health services have been reported as having difficulty in adapting to this need and deficits in care have been reported in the media. For example, an article in The Guardian (Carvel, 04/06/2002), carried the title ''Mental care denied to refugees: NHS psychologists refuse to treat traumatised asylum seekers''. Indeed, this is a wider issue for the health systems in general and it has been commented upon by the Chairman of the British Medical Association Ethics Committee that there has been little if any planning for the health needs of this group of people in the UK (Wilks, 2001). Clearly, services are struggling to catch up with demand and to modify practices accordingly.

The validity of the PTSD concept for refugees

Both American (DSM IV TR: American Psychological Association, 2000) and European (ICD 10: World Health Organisation, 1992) diagnostic classification systems recognize Post Traumatic Stress Disorder (PTSD) as a condition presenting with typical symptoms which follow the experiencing or witnessing of an event which threatens physical safety, or life. The syndrome is described in terms of three main symptom clusters, intrusive symptoms, avoidance symptoms and symptoms of over arousal. The PTSD concept has been applied effectively in the diagnosis and treatment of individuals exposed to a number of different trauma situations including war, torture, rape, natural disasters and industrial accidents (Friedman & Jaranson, 1994). However, the majority of research studies have been based on populations of Western countries (Roth & Fonagy, 1996). Consequently, some authors have challenged the applicability of the concept to non-Western populations (e.g. Bracken, 2001).

One focus for this challenge refers to the symptoms included within the construct of PTSD. Although similar symptoms may exist in different cultures they do not necessarily have the same value or meaning, for example in some cultures dreams of the dead are perceived as positive and comforting (Zur, 1996). Likewise, cultures vary in their understanding of what constitutes ''normal'' emotional expression. Zur (1996) described post traumatic stress experienced by Quiché Mayan war widows in Guatemala. In this culture experiencing anger or sadness is seen as harmful, and expression of grief is only permitted during a 9 day funeral ritual. Somatization is seen as a ''normal'' or ''adaptive'' response to trauma. Kirmayer (1996) also discusses differences between cultures in how they promote conscious and non-conscious ways of dealing with distress. It is suggested that intrusion and avoidance symptoms may vary in their ''normality'' across cultures. Additional research is necessary to investigate this hypothesis further.

Watters (2001) discuss further criticisms of the use of the PTSD concept in non-Western cultures. It is suggested that the concept minimizes the reality of the refugees story, only that which is clinically significant in terms of diagnosis is attended to and telling the story becomes a therapeutic activity, thus ignoring the cultural and political implications of the story. The focus on the past trauma events as determining the current psychological

difficulties may undermine the importance of the current situation and the ongoing stressors faced by the refugee.

Researchers such as Bracken (2001) and Young (1995) discuss the development of the PTSD concept in relation to changes in Western society and Psychiatry. They propose that PTSD is not a syndrome which has always existed but one that has been socially constructed within society at a time of increased awareness of psychological distress as a reaction to trauma. It has therefore been argued to be a ''disorder of our times'' (Bracken, 2001, p742). Such commentators controversially argue that the PTSD concept is based on Western notions of ''individuality''. Extending such a philosophy to psychological treatment is suggested to result in an emphasis on individual treatment methods, focused on the intra psychic world and utilizing professional–client relationships (Bracken, Giller, & Summerfield, 1995). However, this philosophy is not universal and ''one on one'' exploratory work is reported to be rarely used outside of Western cultures (Kinzie, 2001b). In other cultures relationships with others and the outside world may be perceived differently; interpersonal relationships or spiritual issues may be central. Further, the types of trauma experienced by refugees may not be directed at individuals but at entire ethnic groups through genocide and ethnic cleansing (Weine et al., 1995). Such acts have been argued to be capable of causing ''collective traumatisation'' (Weine et al., 1998), although ultimately symptoms will be experienced at an individual level.

Of course the issue of cultural relativism is not unique to the concept of PTSD, but applicable to all western diagnostic concepts (a topic outside the remit of this review, for further discussion see Thakker & Ward, 1998). However, despite the universality of PTSD remaining a controversial topic, the majority of authors do recognize that the concept is applicable to refugees, but advocate that wider cultural practices and beliefs should always be explored (Friedman & Jaranson, 1994). Indeed, we have been impressed by Friedman and Jaranson (1994) conclusion that the PTSD concept is useful but requires broadening to incorporate ''ethnocultural differences'' in the expression of traumatic stress. A key point has been made by Zur (1996), that rather than seeking to prove the universality of the PTSD concept, it is important to look at how people make sense of their own worlds through cultural concepts. Many of the treatment studies described below have implicitly expressed this view and have attempted to address some of the other issues described above.

Psychological treatment studies

Only ten reports were identified in the literature that specifically described and evaluated the treatment of PTSD in refugees. These studies have been separated into those focused on individual psychological approaches and those focused on group psychological approaches.

Individual based treatment approaches

Many of the individually based psychological treatment approaches described in the literature are anecdotal qualitative case studies. Only one randomized controlled study has been completed to date (Pauvonic & Ost, 2001).

Kinzie and Fleck (1987) describe four cases of treatment with antidepressant medication and supportive psychotherapy. The interventions are described as having some success at alleviating symptoms. However, outcome measures are not reported, which makes drawing conclusions about the efficacy of the intervention difficult. Kinzie (2001b) describes a further three case studies examining a combination of medication and supportive psychotherapy, with the addition of strategies aimed at reducing isolation. Again the article

states that the treatment approach reduced symptoms of PTSD. The importance of the therapeutic relationship and clients perceptions of safety is stressed. It is suggested that while confronting the trauma story may lead to increased ''intellectual mastery and integration'' for some clients, for others acceptance and avoidance may be the most adaptive approach (Kinzie, 2001b, p272).

Schreiber (1995) describes the case of an Ethiopian woman, whose baby had been killed in traumatic circumstances. The assessment via an interpreter identified what appeared to be delusions and hallucinations and the woman was initially diagnosed as suffering from a psychotic episode and treated with anti-psychotic medication. She was admitted to hospital where it became evident that she was experiencing trauma related dissociation. Further, what had been misidentified as delusions were instead found to be descriptions of cultural specific beliefs and consequently she was re-diagnosed as suffering with PTSD.

Following the diagnosis of PTSD psychotherapy was offered, which involved encouraging her to talk about her memories of her baby's death. Anthropological consultation identified specific traditions and rituals which were necessary for purification following contact with a corpse. The therapy attempted to facilitate the expression of these and a significant reduction in anxiety, the cessation of flashbacks, and an improvement in psychosocial functioning was reported. Treatment gains were reported as being maintained following a 30 month follow up period. This outcome suggests that for this patient, the adaptation of therapy to allow the completion of culturally sanctioned rituals, may have been instrumental in the treatment's efficacy. The importance of grief rituals to successful adjustment in bereavement is recognized as being important across cultures and times, and may well be a universal phenomenon. Indeed, Castle and Phillips (2003), have recently conducted a study which reports on the value of rituals in adjusting to bereavement in a sample of American participants, many of whom did not hold strong religious beliefs.

Kinzie and Fleck (1987), Kinzie (2001b) and Schreiber's (1995) approaches have not been empirically tested and the conclusions drawn are based on qualitative and anecdotal clinical reports, preventing generalization of the findings to other refugee populations. However, they do highlight important issues. Firstly, a failure to adequately consider linguistic and cultural factors is shown to lead to incorrect diagnosis and unhelpful treatment. Secondly, the value of considering cultural traditions/beliefs and cultural isolation is demonstrated.

Brune, Haasen, Krausz, Yagdiran, Bustos, and Eisenman (2002) report retrospectively on the treatment of 141 refugees, 77% of whom were diagnosed with PTSD (DSM-IV criteria, APA, 2000), over a 9 year period between 1990 and 1999. This study is primarily concerned with exploring the value of belief systems in predicting therapy outcome, and details of the precise therapeutic approach used are limited. The therapies used were described as employing a range of psychosocial and medical interventions, with treatment length varying between 3 months and 6 years. A reduction in distress was shown on two psychometric measures and no differences were found between therapies. Competency in language, level of education, and additional psychopharmacological treatment, were not related to outcome. Having a firm belief system (either politically or religiously orientated) was the only factor significantly related to reduction of distress. This study has a number of limitations, the most obvious ones being its reliance on retrospective data and its simple pre-post test analysis of limited measures. Lack of specific information regarding specific treatment approaches also reduces the generalizability of the findings. However, it does suggest that traditional western therapies can be useful and highlights the need to consider cultural and personal beliefs. The importance of religious and spiritual beliefs has been discussed by other authors (James & Wells, 2002; Calhoun et al., 2000), but is generally an area which is neglected by Western therapies.

Weine et al. (1998) report a study of ''Testimony Psychotherapy'', with twenty Bosnian refugees meeting DSM-IV criteria for PTSD. The sample consisted of volunteers identified through outreach work conducted by the authors. Testimony Psychotherapy is described as a brief individual psychotherapeutic method of working with survivors of state sponsored violence. The treatment involves refugees telling their trauma story in detail in their own language. A record is made of the account, one copy of which is given to the refugee and a copy is kept as part of a project, the aim of which is to make the atrocities known to others. Immediately post intervention 75% of the sample still met DSM-IV criteria, this decreased to 70%, 2 months on and 53%, 6 months later. Measures of PTSD, depression and global functioning, showed significant improvements relative to pre-intervention scores. Participants also anecdotally reported appreciating the opportunity to share their experiences with someone who respected them.

The authors discuss the relationship of Testimony Psychotherapy to traditional CBT. Factors suggested to account for the efficacy of the treatment include the therapist-client relationship and the integrative nature of the work, giving the participants the opportunity to reassemble dissociated fragments of the memory and affective states and look at past and current attitudes. These factors all appear very similar to those involved in standard CBT. Other factors suggested to account for improvement are the ''ritual'' nature of the treatment, which is proposed to fit within the traditions of the refugees' home culture, and the social context of the work. Testimony Psychotherapy is based on the concept that ''collective traumatization is at least as significant as individual traumatization''. The approach gives the opportunity to explore the trauma in a way that can encourage ''new collective understandings of history and communal identity''. It is suggested that for Bosnian refugees the trauma is a collective as well as an individual experience, as ethnic cleansing targets not only the individual but the collective way of life.

Weine et al.'s findings are limited due to the sample size and recruitment source. It is also impossible to conclude which aspects of the intervention were responsible for any effects. Further, due to a lack of control group, conclusions cannot be drawn as to whether treatment effects occurred due to spontaneous recovery over time. The authors state that the approach is not suitable for all refugees, it is not clear which populations the therapy is recommended for. The context of Testimony Psychotherapy is very different to traditional CBT carried out in clinical settings and clearly also has a political element to it. This will have implications for the application of such therapeutic techniques within routine clinical practice.

Paunovic and Ost (2001) have conducted the only randomized control trial of psychotherapeutic treatment for PTSD for refugees. They describe an intervention comparing the efficacy of exposure treatment alone ($n = 9$) in comparison to Cognitive Behaviour Therapy ($n = 7$), including both exposure and cognitive restructuring, for treating refugees meeting DSM-IV PTSD criteria. There was no waiting list control as this was considered unethical due to the severity of the trauma. The two interventions are fully described within the article and do not include any specific ''cultural adaptations''. Post treatment and at 6 month follow up significant improvements were found on both assessor and patient completed measures of PTSD symptom severity, anxiety, depression, cognitive schemas and quality of life. No significant differences were found between treatment groups, although it is probable that the study did not have sufficient power to detect any group effects.

This study provides evidence for the efficacy of both exposure and cognitive interventions for a severely traumatized group of refugees diagnosed with PTSD. However, due to strict inclusion criteria, the study focuses on a specific sub-sample of refugees in a stable situation

(all had residency status and were fluent speakers of the host country language). Five participants were also excluded from the study due to high levels of distress in initial interviews. The group of refugees in this study are therefore likely to represent only a small proportion of the ''typical'' refugee population. Very little mention is made of culture within the article and the native countries of the refugees were not stated.

Group based treatment approaches

As with the individual approaches described above, several innovative interventions have been reported in the literature. However, although some have been evaluated, none have been subjected to rigorous randomized control conditions.

Drozdek (1997) reports on the treatment of one hundred and twenty male concentration camp survivors from Bosnia-Herzegovina who had recently arrived in the Netherlands. Participants were assessed for PTSD and allocated into groups according to whether or not they met DSM-III-R diagnostic criteria for PTSD (American Psychiatric Association, 1987) and whether they wanted treatment. Forty-four per cent of the sample met the criteria for PTSD, of these, 20% refused treatment. Those who met PTSD criteria and accepted treatment were allocated into one of three groups; group psychotherapy, group psychotherapy and drug treatment, and drug treatment alone. Allocation to groups was not random but based on therapists and patient preference and the number of participants in each group was not stated.

The description given of the group psychotherapy is somewhat unclear. It is described as being ''reality and psychodynamically orientated''. The treatment included phases focusing on support, identifying triggers for re-experiencing traumatic events, working out individual trauma histories in order to integrate traumatic memories and affect, and looking at changes in core beliefs and aspects of migration and exile. As such, the description given seems very similar to standard CBT approaches. The group intervention was fairly lengthy (forty-eight sessions). Participants allocated to the drug treatment were given either anxiolytics or tricyclic antidepressants based on their individual symptoms. A randomly chosen sample of fifty refugees, taken from the treatment groups, those who refused treatment and clients without PTSD symptoms, were re-assessed at the end of treatment and 3 years later. The results show a decrease in the rate of PTSD diagnosis post treatment with 73% no longer diagnosed 6 months on in the treatment group compared to only 10% in the treatment refusal group. Three years on 83% of the treatment group and 60% of the treatment refusal group no longer met DSM-IV PTSD criteria. No statistical differences were found between treatment types, it is not stated whether differences between treatment and treatment refusal groups were significant.

This study suggests the treatment to have had a significant impact on the level of PTSD diagnosis but the following factors need to be taken into account. Firstly, the study sample is a specific population of concentration camp survivors who may differ greatly to other refugee populations. The characteristics of the participants who refused treatment were not stated, this prevents generalizations being made and questions the validity of comparing treatment with treatment refusal groups. Participants were not randomly allocated to groups and only ten participants per group were followed up, this obviously has implications for the ability to identify treatment effects and the reliability of the findings. Further, as only brief descriptions of treatment were given which were not referenced to any established treatment type it is impossible to replicate the study or to make firm recommendations about efficacy of different treatment types in the refugee population.

Snodgrass et al. (1993) describe a group based intervention with Vietnamese refugee students using a coping skills model originally based on Stress Inoculation Training designed for sexual assault victims. The treatment, a course on ''Coping with Stressful Experiences'', was offered to fifty Vietnamese University students. Of these, eleven volunteered to take part, eight of whom completed the course of six 3 h weekly training sessions. Treatment included sessions on deep breathing, thought stopping and cognitive restructuring. Post treatment a significant decrease in scores was found in the treatment but not in the control group which was made up of relatives of the participants.

The researchers acknowledge the limitations of this ''pilot'' study. Specifically the sample was a very small self-selected group taken from a University and thus represents a younger and highly educated group, which makes generalizing difficult. Although the study showed PTSD symptoms declined, standardized measures were not used and it cannot be presumed that the participants would have been diagnosed as suffering PTSD prior to intervention. The investigators were also unable to ascertain whether participants in the comparison group had experienced similar traumatic experiences.

Bowen, Carscadded, Beighle, and Fleming (1992) describe a group community orientated intervention. The paper reports on thirty-one women living in a displaced community within El-Salvador, 87% of whom reported having experienced three or more traumatic incidents and 41% fulfilled DSM-III-R diagnostic criteria for PTSD. The treatment was adapted to consider cultural issues and participants were encouraged to talk about what had happened to them and to help others, using art, play, music and massage therapy. The overall aim was to rebuild a sense of community through working towards communal goals and assisting each other. Unfortunately, no evaluation of effectiveness was completed.

Discussion

The literature relating to the treatment of PTSD in refugees has been described and has been shown to be limited by methodological difficulties, including non random allocation to treatment, lack of controls, non blind outcome assessments. A range of psychotherapeutic methods have been employed and the existing studies have typically involved small group sizes and have focused on specific refugee populations, thus limiting generalizability of findings. In addition they have also often failed to define the specific sample and it is often unclear whether participants had additional socio-economic needs which needed addressing. However, the majority of studies are promising in that they have reported generally positive results and suggested some innovative methods for considering culturally specific issues.

Unfortunately the studies do not clarify which of these innovative methods actively contribute to positive treatment outcome. Many of the studies report the use of exposure like techniques or methods, which are reported to be a key ingredient of treatment with Western PTSD populations (Roth & Fonagy, 1996). However, Kinzie (2001a, b) stresses the need to handle exposure work with refugees sensitively and the importance of the therapeutic relationship and therapist skill, to prevent an increase in feelings of being out of control. Further research is necessary to identify whether some refugee populations and/or some types of extreme traumas warrant any special consideration in the use of exposure.

Clearly treating traumatized individuals from different cultural backgrounds raises numerous practical, theoretical and ethical issues for which psychological therapists will need to be aware, and can be summarized as follows:

1. The presentation (and to some extent the validity of the construct) of PTSD in non-Western cultures may be open to debate. As such, it is likely that cultural and linguistic issues will affect clinical presentations, in a way that will have both practical and conceptual implications.
2. The nature of trauma experienced by refugees may differ from typical occurring Western traumas and as such may be novel for clinicians. Multiple, extremely severe and prolonged traumatic incidents may be common and require complex treatment approaches.
3. The use of standard assessment measures can be criticized as lacking in reliability and validity with this population.
4. Efficacious PTSD psychotherapeutic treatment approaches, have been developed and evaluated within Western countries, and as such the findings of these will not necessarily generalize to other cultures. There is also the question of whether clinic based interventions form the best context in which to delivery care?
5. The use of an interpreter removes the traditional therapeutic dyad and may slow down the pace of therapy (Paunovic & Ost, 2001). Further, listening to trauma stories and the distress of clients is potentially overwhelming and may impact on both therapists and interpreters (Kinzie & Fleck, 1987; Kinzie, 2001a, 2001b). Such work therefore requires careful consideration and training for both the interpreter and clinician.
6. Refugees are often undergoing additional life-stresses (poverty, loss of status, uncertainty of residence, discrimination and prejudice), which raises the question of when or even whether to address psychological issues, in the presence of pressing fundamental needs.
7. Clinicians will be faced with exploring cultural and religious practices that are likely to be different from their own and may stimulate strong countertransference feelings and possibly underlying prejudices.

Clearly, there are many practical problems involved in working with refugee populations. The therapeutic relationship may be hampered by language problems, clients withholding information out of respect, lack of trust, shame, numbing or lack of emotional expression, the stigma of mental illness, difficulties communicating with therapists from a different culture and therapists bias in accepting or understanding cultural idioms or suggesting culture specific treatments (Kinzie & Fleck, 1987; Kinzie et al., 1990; Schreiber, 1995; Ton-That, 1998; Marsella, Bornemann, Ekbland, & Orley, 1994).

The majority of existing studies have included some social aspect to the intervention used, and often taken a more holistic approach encompassing elements of the social, medical and psychological. This may be crucial in any work with refugees and mental health services may need to carefully consider social and political elements of individuals' presentations (Prilleltensky, 2002). Indeed, given the pressures on new arrivals in terms of dealing with the immigration system and meeting their basic needs some authors have suggested that the most appropriate interventions should be supportive or crisis interventions (Brune et al., 2002; Veer Van der, 1998). Watters (2001) has suggested that given the choice refugees would request social and economic help rather than psychological. However, this review did not find any studies specifically addressing this suggestion. In conjunction with other authors we would argue for holistic treatment that seeks to address both practical and mental health issues (Summerfield, 2001). Such approaches are arguably best delivered by multidisciplinary teams of professionals with a range of skills.

There does seem to be a role for existing CBT principles of treatment, across cultures. However, further research is vital to ascertain what types of treatments work for which groups of refugees and at what time. Further, there is a need to clarify what alterations are required to traditional therapeutic approaches in order to make them culturally sensitive. Studies are also needed to explore the impact of involving an interpreter and the impact of work with traumatized refugees on therapists. Finally it is vital that research starts to address the opinions and needs of refugees themselves.

In conclusion, this review has considered the current state of the evidence of the effectiveness of psychological treatments for PTSD and suggested several important factors to be considered when working with this population. Care must be taken not to over-generalize the findings from the limited research studies reported here. However, a key conclusion appears to be a reminder that it is particularly important for the therapist to appreciate and explore individual clients' cultural beliefs (this would include religious, spiritual and ritualistic practices) as well as the individual personal beliefs/appraisals (usually assessed for in Western therapies). Stemming from this is a need for greater therapist awareness and ability to work with issues of diversity and a willingness to facilitate access to appropriate practical support. This raises issues for training and continual professional development for health care professionals.

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