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Treating Posttraumatic Stress Disorder in Diverse Settings: Recent Advances and Challenges for the Future

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Abstract

Racial and ethnic minorities are at high risk for developing posttraumatic stress disorder (PTSD) after experiencing a traumatic event and are less likely to receive evidence-based treatment for their symptoms. There is a growing body of literature showing that culturally appropriate interventions result in greater uptake, symptom reduction, and sustained treatment gains. This article review explores new findings in the cultural understanding of PTSD among racial and ethnic minorities. We first review recent advances in the understanding of PTSD symptomatology. Next, we provide overview of trials demonstrating efficacy and effectiveness of cognitive processing therapy (CPT), prolonged exposure (PE), and trauma-focused cognitive-behavioral therapy (TF-CBT) in diverse communities. Then, we discuss specific implementation strategies common across intervention trials used to increase feasibility, acceptability, adoption, and sustainability. Last, we discuss areas for future research and dissemination efforts.

Keywords

PTSD; Racial/ethnic minorities; Effectiveness; PTSD intervention; Cultural adaptation

Introduction

Posttraumatic stress disorder (PTSD) is an impairing psychiatric disorder characterized by intrusion symptoms (e.g., flashbacks), changes in mood and cognition, hyperarousal, and avoidance of memories and feelings related to the trauma [1]. Individuals diagnosed with PTSD experience significant impairment in interpersonal and work functioning [2], and they are six times more likely than healthy controls to attempt suicide [3]. Symptoms of PTSD

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Compliance with Ethical Standards

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can often persist for up to 20 years if untreated [4], and chronic PTSD is associated with physical health and substance use problems [5–7]. After a traumatic event, racial and ethnic minorities are at higher risk for developing PTSD than their White counterparts [8–10] and may be more likely to terminate treatment early [11]. Given the higher rates of trauma exposure and PTSD in racial and ethnic minorities [12–14], it is important to consider disorder presentation, identification, and treatment from a culturally informed standpoint in order to best address PTSD in the most at-risk patients.

Methodological Considerations

Racial and ethnic groups are heterogeneous, and research findings about one racial/ethnic group may not generalize to other groups of the same race/ethnicity or to all members of that racial/ethnic group. Results from research need to inform our understanding and clinical practice in a way that is nuanced and practical in an effort not to over-generalize and simplify complex phenomena. Throughout this article, we will use the terms *race* and *ethnicity* to refer to shared characteristics of research participants in a given study. Historically, race has referred to a set of physical characteristics that distinguishes individuals, while ethnicity refers to shared language, cultural experiences, and ancestry [15]. Although meaning and understanding of these terms have changed over time, discipline, and academic context, we assume that these definitions apply to the articles in this review.

Cross-Cultural Phenomenology

Previous literature has highlighted current debates in the field on the applicability of DSM-III through DSM-5 criteria for PTSD across cultures (see [16] for a comprehensive review). Several recent studies have expanded our understanding on the phenomenology of trauma among various racial and ethnic groups in the USA. In a study of veterans with PTSD returning from Iraq and Afghanistan, Asian/Pacific Islander (A/PI) women, Latino/Hispanic men, and Black men were more likely to be diagnosed with PTSD than other racial/ethnic groups [17]. It is also important to consider symptom presentation, as certain PTSD symptoms, such as dissociative symptoms, are predictors of PTSD severity [18]. For example, A/PI women are more likely than White women to endorse re-experiencing and emotional numbing symptoms [17], and clinicians working with these racial groups should consider procedures for PTSD symptom screening. Similarly, it is important to consider context when screening for PTSD in clinical settings. Certain PTSD symptoms in communities with ongoing violence may become normative to patients and thus limit disorder identification and provision of services after trauma.

Presentation of PTSD symptoms is also likely culturally influenced. A comprehensive systematic review by Alcántara and colleagues [19] examined sociocultural explanations of PTSD among Latino/as and found that peritraumatic stress reactions and cultural values such as fatalism (the belief that all events are predetermined) and coping strategies predicted PTSD symptoms over and above Latino/a ethnicity. Further, they found mixed support for expressive style (i.e., way of communicating), acculturation, and socioeconomic status as predictors of PTSD over and above Latino/a ethnicity, indicating that further research is

needed in these domains. A more recent article by DiGangi and colleagues [20] found that acculturation was a moderator of the relationship between timing of the trauma (childhood vs. adulthood) and PTSD symptoms in Latino individuals, with less acculturated Latinos/as who experienced childhood trauma endorsing significantly more PTSD symptoms. In another study of Latina women, more negative religious coping (i.e., seeing God as a punishing force) and more masculine sex role (e.g., being “aggressive”) predicted more PTSD symptoms [21]. These studies indicate that considering cultural context for Latinos/as is important for the treatment of PTSD (for an in-depth review of conditional risk of PTSD in Latinos/as, please see [22]).

An emerging body of literature has focused on posttrauma stress reactions as cultural concepts of distress. *Ataques de nervios* among Latinos [23] and *khyâl attacks* among Cambodians [23–25] have received the most attention in terms of symptom presentation and diagnosis. A recent investigation by Hinton and colleagues [26] examined dream experiences of Cambodian refugees who had lived through the Khmer Rouge and Vietnamese invasion. Cambodian refugees interviewed believe that dreams with images of deceased loved ones occur when the loved one has a wandering soul and has not yet been reincarnated. Hinton and colleagues reported that almost all of the refugees studied found the dreams deeply upsetting and performed rituals upon waking. It is important to understand cultural norms and practices such as these in order to better develop and implement culturally sensitive interventions for posttrauma reactions. Several researchers have argued that having a deeper understanding of cultural concepts of posttrauma reactions aids in producing better clinical outcomes and making predictions about health status [23, 24, 27].

As our understanding of PTSD phenomenology in diverse communities continues to evolve, determining the best way to identify and measure PTSD symptoms becomes increasingly important. Recent literature on PTSD measurement in diverse communities has focused on literacy and clarification of concepts (see Table 1) of adapted PTSD measures (e.g. Clinician-Administered PTSD Scale [34]). Yet, there is a dearth of research examining the psychometric properties of culturally adapted measures for PTSD, and doing so is crucial for disease identification and should be pursued as future research.

Evidence-Based Treatments for PTSD: Beyond the Academic Medical Center

Various evidence-based interventions to treat PTSD have been implemented domestically and abroad in racially and ethnically diverse communities, including cognitive processing therapy (CPT; [35]), prolonged exposure (PE; [36]), and trauma-focused cognitive-behavioral therapy (TF-CBT; [37]). CPT is a cognitive-behavioral therapy that was first developed to treat trauma symptoms in female survivors of sexual violence. Most recently, CPT has been implemented in Iraq [38–40], the Democratic Republic of Congo (DRC); [41•, 42], and an urban community health center outside Boston [43, 44]. One of the first global randomized controlled trials of CPT occurred in the DRC for survivors of sexual violence [41•]. This study added a significant contribution to our understanding of the

treatment of ongoing trauma: namely, that individuals living in high-violence areas or who are experiencing chronic trauma can achieve significant reduction in PTSD symptoms by receiving CPT, compared to individual supportive therapy, similar to previous trials conducted in low-conflict regions. Additionally, a randomized controlled trial of adapted CPT was performed in Iraq with Kurdish survivors of torture [38]. CPT was effective at reducing depression, dysfunction, anxiety, PTSD symptoms, and traumatic grief, providing support for the finding that CPT (compared to the wait-list control) is not only effective at reducing PTSD symptoms alone, but has secondary effects at reducing other psychopathology symptoms.

PE is a behavioral intervention that focuses on approaching reminders of the trauma and reducing avoidance. PE contains two treatment components: (1) imaginal exposure, in which the patient is asked to revisit the trauma memory imaginably by recounting details about the trauma in session, describing thoughts, feelings, and behaviors associated with the trauma, and then listens to a recording of this recounting of the trauma memory for homework, and (2) in vivo exposure, in which the patient is asked to approach reminders (i.e., triggers) of the trauma, such as places or objects, that the patient typically avoids because of the trauma. PE has been used both with racial/ethnic minority patients in the USA [45, 46, 47••] and in international settings [48, 49]. A recent study by Jeffreys and colleagues [47••] documented that African-Americans responded significantly better to PE than other racial groups and that there were no differences in treatment response between Hispanic and non-Hispanic Whites. Yet, it is worth noting that other studies have not found race/ethnicity to be a predictor of outcome [11, 50]. Further, in a randomized controlled trial of patients with comorbid PTSD and psychotic disorders in the Netherlands, de Bont and colleagues [42] found that those who received PE experienced fewer depressive symptoms posttreatment and after a 6-month follow-up period compared to those who received eye movement desensitization and reprocessing (EMDR) or were in the wait-list control condition. Compared to the wait-list control, those in the PE condition also experienced fewer psychotic symptoms and were more likely to experience schizophrenia remission at the 6-month follow-up. Additionally, in a small pilot study of 12 female clients [51], researchers tested the feasibility of implementing PE with bachelor-level social workers in a methadone clinic in Israel. Most clients experienced a significant reduction in symptoms that was maintained up to 12 months after treatment termination, and the women in this study did not exhibit an increase in substance use during treatment. These studies speak to the robustness of PE as an evidence-based treatment (EBT) that can be implemented in a variety of treatment settings.

TF-CBT was developed to treat children with a wide variety of mental health problems who have a history of trauma exposure [52]. TF-CBT focuses on correcting maladaptive beliefs about the traumatic event, reducing negative emotional reactions to the trauma, and providing caregivers with the tools needed to manage their child's stress and their own stress. TF-CBT has been used in diverse health settings in the USA [53, 54•, 55] and around the world [56–59, 60••, 61–63]. In one study that included a significant cultural adaptation of TF-CBT, O'Callaghan and colleagues [60••] conducted a randomized controlled trial (RCT) of TF-CBT, the first of its kind to test an intervention specifically for female adolescent victims of sexual violence in a non-Western population, namely, among adolescent Congolese girls who had either witnessed or experienced rape or sexual abuse.

Results indicated that those girls assigned to the TF-CBT treatment group experienced significant reductions in trauma symptoms, depression symptoms, and conduct problems and had an increase in pro-social behavior compared to the waitlist control group, all gains that were maintained or improved at the 3-month follow-up. This study provides evidence that treating PTSD with TF-CBT provides secondary benefits to PTSD symptom reduction.

In addition to the aforementioned interventions, there are three interventions for which more efficacy and effectiveness evidence is needed. First, culturally adapted CBT (CA-CBT) has demonstrated preliminary evidence of being an EBT for PTSD and panic disorder [64, 65]. Hinton and colleagues [25] argue that CA-CBT offers several benefits over other EBTs for PTSD, namely, that patients learn emotion regulation skills prior to starting exposure, patients make new associations with the trauma memory (in line with contemporary theories of fear extinction [66]), and the treatment incorporates exposures to somatic complaints, which are common in refugee populations. Second, EMDR has been used in diverse health settings to treat traumatic stress symptoms. A small pilot study of EMDR in the DRC showed preliminary evidence that group EMDR can significantly reduce trauma symptoms and subjective units of distress (SUDs; [67]). Third, narrative exposure therapy (NET) has been used extensively outside of the USA [68–71]. Most recently, NET was compared to Emotional Freedom Techniques (EFT) among 60 students with PTSD in Iraq [72]. Results showed that NET was effective at significantly reducing PTSD symptoms overall. These three interventions offer promise in treating PTSD in diverse communities, but more evidence is needed before considering them to be EBTs.

Lessons Learned: Developing an Implementation Toolkit

How and when to adapt and implement an EBT are ongoing debates in the field. Both implementation scientists and cultural adaptation researchers alike seek to understand how EBTs can be implemented in diverse settings without diluting their effectiveness [73]. Across the PTSD literature, several core aspects of successful implementation processes have emerged. One useful tool has been utilizing qualitative data from providers, patients, and community stakeholders throughout treatment implementation [74]. Additionally, researchers have worked with providers to make formal adaptations to treatments themselves to establish a better fit for the patient population and have worked to modify treatment delivery processes to increase uptake. Further, research groups have made significant advances in understanding methods to increase sustainability in communities. These four areas are important to consider for any researcher or clinician working with diverse communities in order to produce the best treatment outcomes. An overview of intervention studies utilizing these strategies is found in Table 2.

Qualitative Data: Building a Foundation for Implementation with Diverse Clientele

A cornerstone of dissemination implementation practices is information gathering in the form of qualitative interviews with providers, patients, and other stakeholders [74]. Performing qualitative interviews offers several advantages prior to treatment implementation. First, they are important for understanding cultural beliefs and norms that

are unique to the patient population [39, 43]. In one qualitative examination of clients' maladaptive beliefs after trauma (i.e., "stuck points" [43]), little difference was found between Latino and non-Latino clients in terms of number of stuck points produced or domain of stuck point (i.e., safety, trust, power/control, esteem, intimacy). However, the manner in which Latino clients arrived at their stuck points focused more heavily on family environment, religious beliefs, and repeated exposure to violence. These findings have implications for the way in which clinicians go about identifying and challenging stuck points in similar contexts. For example, clinicians might need to know more about the patient's particular cultural beliefs such as believing in life after death, in order to sensitively challenge the stuck points around such beliefs.

Second, qualitative interviews are important for selecting an intervention prior to implementation. In a study of CPT in Iraq, Kaysen and colleagues [39] conducted qualitative interviews with 63 torture or chemical burn survivors, who identified problems consistent with PTSD as their main concern. As such, the research team decided to use CPT as their method of treatment. This example emphasizes the importance of involving community stakeholders, providers, and patients in the decision of which intervention to use as a way to increase buy-in and adoption of proposed treatments [77].

Last, qualitative interviews aid researchers in making preliminary adaptations prior to treatment implementation [78]. In a study of TF-CBT with Haitian children who have fallen victim to indentured servitude, providers were first interviewed in order to make preimplementation recommendations to the protocol [63]. Further, several studies have utilized an iterative approach to modification, which allows for treatment elements to be changed as needed throughout treatment [39, 41••]. For example, in the study of CPT in the DRC [41••], interviews with providers throughout the implementation process highlighted the need to change treatment formatting, homework, and training methods. Qualitative interviews are an important component of treatment implementation and should be utilized at all stages of treatment in order to assure treatment fit and provider adoption.

Manual Modification: Increasing Acceptability

Modifications to the treatment manual or protocol itself are the most common in recent literature on treating PTSD in diverse communities. In conjunction with qualitative data, manual modifications can be made in an iterative manner throughout treatment. Some studies have made systematic changes to the treatment manuals based on qualitative data [41••], while others have allowed providers to make changes to the protocol on an as-needed basis [75]. An important consideration for researchers or clinicians working in a diverse community is understanding therapist literacy level. Usually, therapist materials are written for providers with at least a bachelor-level education. However, when working outside usual care settings, it is best to have therapist materials that are easy to understand for providers with all educational backgrounds. Similarly, client materials should be adapted for illiterate or low-literacy clientele. For example, some studies have utilized worksheets that contain picture cues [41••] to ensure homework understanding and completion.

Another important component of manual modification is the use of bicultural translators to translate therapist manuals and client materials. In one study of TF-CBT with Haitian youth, researchers utilized native Haitian speakers to translate the protocol into native Creole [63]. Another study of TF-CBT with Jordanian children used an accredited Arabic translator, but then relied on critiques and suggestions from 10 Jordanian psychotherapists prior to intervention implementation [56]. The use of bicultural translators are useful in assuring that language is culturally appropriate and that abstract concepts (e.g., “self-esteem”) are translated in a way that conveys correct meaning.

Lastly, treatment elements may need to be modified to better fit treatment settings or client needs. For example, in the abovementioned study of Jordanian youth, TF-CBT was shortened from 12 to 10 sessions, and parents were offered parenting classes outside of TF-CBT at the recommendation of the adaptation reviewers consulted in the study. Further, in a study of refugees in Germany [62], intervention components were modified and delivered using examples, songs, and games stemming from local culture to illustrate treatment concepts. Adding or modifying treatment elements is important to increasing acceptability.

Treatment Delivery: Increasing Adoption

Several recent advances have been documented in delivery mechanisms that increase uptake. First, several studies have modified individual interventions for PTSD to be completed in group formats. In one study of TF-CBT in Tanzania [61], two focus groups conducted with local stakeholders and local adolescents indicated that TF-CBT, if conducted in groups, should ensure homogeneity of the age and sex of children in the groups. To adapt the TF-CBT for childhood traumatic grief protocol to a group format, the researchers added three individual visits for the child and guardian to complete the narrative creation portion of treatment. This study highlights the importance of working with community stakeholders and patients to determine the best treatment delivery format.

Second, in recent years, our understanding of the use of paraprofessionals for the delivery of mental health interventions has dramatically increased [41••, 61]. In the study of CPT in the DRC, Bass and colleagues [41••] trained local community members with an average of an eighth-grade education to deliver CPT, and they saw treatment effects equivalent to previously conducted randomized controlled trials in the USA [79, 80]. Lay community health workers offer a way for individuals from low-middle-income countries who experience barriers to care (such as stigma and lack of access to mental health centers) to receive treatments they need [81].

Lastly, web-based interventions may offer advantages for disseminating PTSD interventions. One recent comparative effectiveness trial examined a web-based TF-CBT intervention (W) compared to a web-based TF-CBT intervention plus live dissemination (W+L) for adjudicated teens [54•]. Results showed that teens who received both web-based intervention and live intervention experienced significant reduction in PTSD symptoms when compared to the web-only group. Additionally, the teens in the W+L condition were more likely to complete TF-CBT. These results are important to consider when disseminating web-based

interventions and suggest that perhaps adding a live treatment component to these interventions could significantly improve symptoms in the most at-risk patients.

Building a Network of Providers: Treatment Sustainability

One of the most influential and important findings for intervention sustainability is the use of a train-the-trainer model [82]. In both studies of CPT globally [39, 41••] and in one study of TF-CBT [59], research teams have worked to find local supervisors who provide consultation to therapists. These community supervisors receive supervision from the research team via in-person or Skype consultation. This model of supervision is important to implement in diverse treatment settings because it ensures that therapists can receive supervision after the research team has left and that new therapists can be trained in the intervention. Yet, no study has investigated the long-term effect of the train-the-trainer model for treating PTSD in diverse communities. Although the model was developed to ensure sustainability, no empirical data is available at this time.

Conclusions

Recent studies of interventions for PTSD in diverse communities have highlighted the ways in which interventions have capitalized on community-based approaches to implementation. Specifically, the use of qualitative data at all phases has proven essential to identifying appropriate interventions, making preliminary adaptations, and implementing iterative modifications throughout treatment. Further, ensuring treatment fit by modifying intervention elements is crucial for increasing uptake. Researchers have modified treatment elements by matching patient and provider literacy levels, their cultural beliefs, and demands of the treatment setting. Additionally, many studies have modified the method by which the intervention is delivered, either by utilizing paraprofessionals, using a group format, or capitalizing on mobile technology. Lastly, several studies have used the train-the-trainer model for ensuring sustainability of intervention after the research team has left. However, no long-term follow-up data on sustainability of the train-the-trainer model for treating PTSD is available at this time. All studies included in this review have demonstrated that EBTs developed in academic medical centers can be translated into a wide array of diverse health settings by relying on community-based participatory practices [83]. Despite these recent advances in the field, there are several areas in need of more research.

Moving forward, it is important for future research to examine potential moderators of treatment efficacy in diverse populations in order to increase dissemination and implementation. In a recent comparison of CPT and PE in a racially and ethnically diverse patient sample from a Veteran's Health Administration specialty clinic [47••], PE reduced PTSD symptoms significantly more than CPT. However, there are several explanations to this finding that warrant further investigation, including selection bias, assignment completion, and adjunctive therapies, which could all be influenced by culture. Additionally, a recent review [84] compared the theoretical bases and components of NET and PE and argued that NET may be a better "fit" for refugee populations. Differences in treatment components could be better fits for some diverse communities over others; as such, more comparative effectiveness trials are needed that examine moderators of treatment outcome.

It is also important to identify barriers to access to evidence-based care among racial and ethnic minorities. Many common barriers to treatment include work and school schedules, transportation, financial concerns, negative perceptions of therapy, and patient beliefs that treatment will exacerbate the traumatic experience [44, 85]. Interestingly, a greater proportion of TF-CBT completer caregivers had their own history of trauma exposure. Studies like these highlight the need to identify hard-to-reach populations and integrate facilitators to treatment in care settings.

Lastly, it is increasingly important to understand how provider modifications to EBTs for PTSD are made and how these modifications affect treatment outcome. In other words, how much can a community provider alter an EBT before it ceases being an EBT? An emerging body of literature has focused on developing coding frameworks for cognitive-behavioral interventions [86], and preliminary descriptive studies have examined what types of modifications providers have made to interventions [87]. However, these studies have not been done with a trauma-focused intervention. Knowing that providers do, in fact, modify the treatments they deliver, an understanding of the relationship among fidelity, latitude, and treatment outcomes for trauma-focused interventions in diverse populations is warranted.

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Table 1

Published measures

Authors	Year	Type of measure	Name of measure	Population	Adaptations
Boyes, Cluver, and Gardner [28]	2012	Self-report	Child PTSD Checklist	South African children and adolescents	Translated and back-translated
Caraballo, Pérez-Pedrogo, and Albizu-García [29]	2013	Self-report	Davidson Trauma Scale—Spanish (DTS-S)	Latino prison population	Experienced interviewers used a computer-assisted personal interview modality to aid in administration of the scale.
Diehle, de Roos, Boer, and Lindauer [30]	2013	Clinician-administered	Dutch Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA)	Dutch children between 8 and 18	Translated and back translated.
Dokkedah, Oboke, Ovuga, and Elklit [31]	2015	Self-report	UNICEF War Trauma Screening Scale ICD-11 Trauma Questionnaires The Mini International Neuropsychiatric Review (MINI)	Former abducted children in northern Uganda	Validated: internal consistency, inter-rater reliability, convergent validity, divergent validity, and concurrent validity
Z. Liu, Y. Liu, Zhang, Chen, and Hannak [32]	2014	Self-report	Chinese PTSD Inventory (CPI)	Chinese earthquake victims in Sichuan	Translated and back translated
Rasmussen, Verkuilen, Ho, and Fan [33]	2015	Self-report	Harvard Trauma Questionnaire	Refugees that were survivors of torture and other human rights abuses from 81 different countries of origin in 11 different global regions	Qualitative analysis conducted to create scale, then implemented to determine validity and reliability
Rendón [34]	2015	Clinician-administered	Culturally adapted Clinician Administered PTSD Scale for DSM-5 for Spanish Speakers with Limited English Proficiency	Latinos with limited English proficiency (LEP)	Translated
					Translated, revised by bicultural community stakeholders, and back translated

Table 2
Implementation strategies of PTSD intervention trials for diverse populations: 2013 to present

Authors	Year	Intervention	Population/location	Type of study	Adaptations made? (Y/N)	Qualitative data	Manual modification	Treatment delivery	Sustainability
Weiss et al. [40]	2015	CPT	Southern Iraq	RCT	Y	X	X		X
Bolton et al. [38]	2014	CPT	Kurdistan, Iraq	RCT	Y	X	X		X
Kaysen et al. [39]	2013	CPT	Kurdistan, Iraq	Cultural adaptation	Y	X	X		X
Hall et al. [42]	2014	CPT	DRC	RCT	Y	X	X	X	X
Bass et al. [41••]	2013	CPT	DRC	RCT	Y	X	X	X	X
Schiff et al. [51]	2015	PE	Methadone Clinic, Israel	Feasibility	N				
Williams et al. [75]	2014	PE	African Americans in the US	Cultural adaptation	Y	X	X		
Jeffreys et al. [47••]	2014	PE	VA Specialty Clinic	Effectiveness	N				
Aderka, Gillihan, McLean, and Foa [76]	2013	PE	Black and White Women in the USA	Comparative effectiveness	Y		X		
De Bont et al. [42]	2016	PE	Patients with psychosis in the Netherlands	RCT	N				
Wang et al. [63]	2016	TF-CBT	Haiti	Cultural adaptation/ effectiveness	Y	X	X	X	
Cohen et al. [54•]	2016	TF-CBT	Adjudicated youth	Comparative effectiveness	Y		X	X	
Kameoka et al. [57]	2015	TF-CBT	Japan	Feasibility	N				
Unterhitzberger et al. [62]	2015	TF-CBT	Unaccompanied refugees in Germany	Case series	Y		X		
Konanur et al. [58]	2015	TF-CBT	Canada	Effectiveness	N				
O'Donnell et al. [61]	2014	TF-CBT	Tanzania	Feasibility	Y	X	X	X	
Damra, Nassar, and Ghabri [56]	2014	TF-CBT	Jordan	Feasibility	Y	X	X		
Murray et al. [59]	2014	TF-CBT	Zambia	Feasibility	Y	X		X	X
O'Callaghan et al. [60••]	2013	TF-CBT	DRC	RCT	Y	X	X	X	