



Mary A. Fristad, Ph.D., ABPP, Editor
Associate Editors:
Thomas O'Neil, Ph.D., ABPP
Katherine A. McLeod, Ph.D., ABPP
Managing Editor:
Barbara Kasparik, M.S., CDP



Evidence-Based Practice in Child and Adolescent Mental Health



ISSN: 2379-4925 (Print) 2379-4933 (Online) Journal homepage: www.tandfonline.com/journals/uebh20

“Confident and Effective” – A Mixed-Methods Study on Psychotherapists’ Experiences Implementing TF-CBT with Unaccompanied Young Refugees

Flora Katrin Dietlinger , Barbara Kasparik , Johanna Unterhitzenberger & Rita Rosner

To cite this article: Flora Katrin Dietlinger , Barbara Kasparik , Johanna Unterhitzenberger & Rita Rosner (13 Jul 2026): “Confident and Effective” – A Mixed-Methods Study on Psychotherapists’ Experiences Implementing TF-CBT with Unaccompanied Young Refugees, Evidence-Based Practice in Child and Adolescent Mental Health, DOI: [10.1080/23794925.2026.2701042](https://doi.org/10.1080/23794925.2026.2701042)

To link to this article: <https://doi.org/10.1080/23794925.2026.2701042>



© 2026 The Author(s). Published with license by Taylor & Francis Group, LLC.



[View supplementary material](#)



Published online: 13 Jul 2026.



[Submit your article to this journal](#)



Article views: 149



[View related articles](#)



[View Crossmark data](#)

“Confident and Effective” – A Mixed-Methods Study on Psychotherapists’ Experiences Implementing TF-CBT with Unaccompanied Young Refugees

Flora Katrin Dietlinger^a, Barbara Kasparik^a, Johanna Unterhitzenberger^b, and Rita Rosner^a

^aDepartment of Psychology, Catholic University Eichstätt-Ingolstadt, Eichstätt, Germany; ^bDepartment of Social Sciences, Rosenheim Technical University of Applied Sciences, Rosenheim, Germany

ABSTRACT

Background: Unaccompanied young refugees (UYRs) are a highly vulnerable population, exhibiting elevated rates of posttraumatic stress disorder (PTSD), depression, and anxiety due to trauma exposure and post-migration stressors. Despite the established efficacy of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for PTSD, there is limited research on its implementation and cultural fit for UYRs.

Objective: This study examines psychotherapists’ experiences with implementing TF-CBT in the treatment of UYRs within a randomized controlled dissemination trial in Germany.

Methods: Data were collected as part of the multicenter “BETTER CARE” trial, involving 20 psychotherapists who treated 57 cases of UYRs with TF-CBT. Fidelity was assessed quantitatively through self-reports using the TF-CBT Brief Practice Checklist, while implementation experiences and perceived opportunities were explored through semi-structured interviews. Psychotherapists completed culturally sensitive TF-CBT training and participated in bi-weekly case consultations.

Results: Treatment fidelity was high, with most core components implemented, except in-vivo exposure and caregiver-related modules. Psychotherapists frequently applied flexible, needs-based strategies, such as addressing the “crisis of the week” and adjusting module sequence. Most UYRs (64.9%) were accompanied by interpreters. Components perceived by psychotherapists as particularly helpful included trauma narrative, psychoeducation, and cognitive coping, whereas relaxation and certain stabilization modules were perceived as less essential or challenging to implement. Psychotherapists reported increased confidence in delivering TF-CBT and willingness to continue using TF-CBT.

Conclusions: TF-CBT was perceived by psychotherapists as a feasible and acceptable treatment approach for UYRs in routine care. Flexible, needs-based adaptations were considered to facilitate its application in routine care, while structural constraints, such as limited caregiver involvement, may require additional consideration. These findings support the broader dissemination of TF-CBT in diverse, multilingual refugee settings.

Trial registration: German Clinical Trials Register (<http://www.germanctr.de>; registration number DRKS00017453, registration date: December 11, 2019).

Background

According to the United Nations High Commissioner for Refugees (UNHCR), by October 2024 37.9 million people worldwide were refugees (UNHCR, 2024). In 2023, 41,000 unaccompanied minor refugees applied for asylum in Europe (European Union Agency for Asylum [EUAA], 2024). Unaccompanied young refugees (UYRs) are frequently identified as an especially vulnerable group (Bean et al., 2007; Daniel-Calveras et al., 2022). It has been demonstrated that UYRs display elevated rates of post-traumatic

stress symptoms (PTSS), depression, and anxiety, and that they frequently exhibit more severe symptoms than accompanied minors. Müller et al. (2019) reported that 64% of UYRs score above the cutoff value for PTSS compared to accompanied young refugees (36%). Possible factors besides a higher trauma events exposure (Jensen et al., 2019; Müller et al., 2019), can be post-migration stressors such as an uncertain residence status, and a lack of family contact (Hornfeck et al., 2024). Given the elevated needs and high prevalence of PTSS and comorbid symptoms among UYRs

CONTACT Barbara Kasparik  barbara.kasparik@ku.de  Department of Psychology, Catholic University Eichstätt-Ingolstadt, Eichstätt, Germany
Shared first-authorship.

 Supplemental data for this article can be accessed online at <https://doi.org/10.1080/23794925.2026.2701042>

© 2026 The Author(s). Published with license by Taylor & Francis Group, LLC.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

(Daniel-Calveras et al., 2022), gaining insight into effective treatment approaches is crucial, especially as this population often faces significant barriers to accessing adequate mental health services (Blackmore et al., 2020; Dumke et al., 2024; Oberg & Sharma, 2023).

As recommended by international guidelines, the gold standard for treating post traumatic stress disorder (PTSD) is individual, trauma-focused cognitive behavioral therapy (National Institute for Health and Care Excellence, 2018). Trauma-focused cognitive behavioral therapy (TF-CBT), as developed by Cohen et al. (2006, 2017), is the most extensively studied approach for children and adolescents. It follows a three-phase structure: stabilization, trauma processing, and integration (Cohen & Mannarino, 2015) and typically requires at least eight sessions (Cohen et al., 2017). TF-CBT includes nine components, summarized by the acronym PRACTICE: psychoeducation and parenting skills, relaxation, affective modulation, cognitive coping, trauma narrative, in-vivo exposure, conjoint parent-child sessions, and enhancing safety and development (Cohen et al., 2017). Involving caregivers is considered a key element of the treatment (Brown et al., 2020). So far, 35 randomized controlled trials have confirmed the superiority of TF-CBT over control conditions across different settings (Schreyer et al., 2024). TF-CBT has also been shown to be an effective treatment in reducing symptoms of PTSD, depression and anxiety in samples of UYRs (Chipalo, 2021; Morroni et al., 2025).

To the best of our knowledge, a limited number of studies have examined the implementation and outcomes of TF-CBT with children and adolescents from refugee backgrounds in individual settings (Patel et al., 2024; Schottelkorb et al., 2012; Unterhitzenberger et al., 2019). These studies, however, two of them uncontrolled, demonstrated that TF-CBT significantly reduces PTSD symptoms and that these improvements are maintained at follow-up, meanwhile some adaptations to the manual have also been documented. For example, Unterhitzenberger et al. (2015) reported that there was less caregiver involvement than indicated in the manual and the psychoeducational component was augmented with information regarding the asylum procedure, and, where relevant, dissociation. In a pilot study

Unterhitzenberger et al. (2019) described that, in addition to psychoeducation on PTSD and traumatic events, the psychotherapists also offered psychoeducation on psychotherapy, on working with translators and on confidentiality in the psychotherapeutic setting. In their study of unaccompanied migrant children from Central America, Patel et al. (2024) added to the psychoeducation component a distinction between chronic trauma exposure in the country of origin and acute traumatic events to elicit the patient's perspective on stressful and non-stressful events. As Unterhitzenberger et al. (2019) previously described, Patel et al. (2024) also provided information on mental health treatments and their intended recipients, in addition to offering educational material on the US system regarding law and immigration. Furthermore, they explored beliefs concerning roles and relationships (e.g. gender, parenting styles). During the relaxation phase, Patel et al. (2024) made use of the client's existing, culturally relevant strategies for relaxation, whilst also incorporating the spiritual and religious beliefs of the youth. In general, the utilization of culturally pertinent metaphors was observed throughout the treatment. In a qualitative study with psychotherapists on the implementation of TF-CBT with UYRs, Unterhitzenberger et al. (2021) found that additional content to the PRACTICE components mostly focused on the so-called "crisis of the week," resulting in a more extensive discussion on struggles and concerns in daily lives of the UYRs. Only few obstacles during the treatment were reported, and little cultural factors had to be considered. The implementation of the trauma narrative, in conjunction with the agenda provided by the manual, was frequently reported as beneficial (Unterhitzenberger et al., 2021).

However, except for Schottelkorb et al. (2012), all trials with UYRs mentioned above were conducted with study psychotherapists who received specific training and supervision within controlled research settings. Prior studies did not systematically capture the experiences of psychotherapists delivering TF-CBT to young refugees in routine care. As a result, there is a lack of evidence regarding treatment fidelity and the experiences of community-based practitioners. The current study addresses this gap by conducting qualitative interviews within the framework of an effectiveness and implementation trial in routine mental health care,

exploring psychotherapists' perceptions of TF-CBT implementation in real-world clinical settings. Specifically, it investigates treatment fidelity, psychotherapists' experiences with the applicability of TF-CBT, perceived helpful and challenging components, as well as the sustainability and acceptability of the training and intervention in routine care.

Methods

Study context

The data were collected as part of the multicenter, cluster-randomized controlled implementation trial “BETTER CARE” (Rosner et al., 2020). It was conducted in accordance with the International Council for Harmonization Guideline for Good Clinical Practice and received ethical approval from Ulm University (No. 243/19) and the Catholic University of Eichstätt-Ingolstadt (No. 004–19). It was registered on the December 11, 2019 in the German Clinical Trials Register (www.germanctr.de; registration number DRKS00017453). The trial's primary goal is to evaluate a stepped-care approach for UYRs combining the preventive group intervention “My Way” (Pfeiffer & Goldbeck, 2019) and TF-CBT (Cohen et al., 2006, 2017), called BETTER CARE condition, against standard treatment practices. UYRs were recruited through Child Youth Welfare Service (CYWS) facilities. Youth inclusion criteria are the following: age 12–20 years, arrived in Germany as unaccompanied minors, applied for asylum or intend to do so, being cared for by a CYWS facility at screening, written informed consent given by participant and legal guardian (if <16 years at screening), and reported at least one traumatic event in line with the DSM-5 A criterion (Rosner et al., 2020). Each adolescent underwent a mental health screening to identify symptoms of PTSS, depression, and anxiety. Based on the results, treatment recommendations were provided: “My Way” for subclinical PTSS and TF-CBT for clinically significant PTSS. Residential group staff (i.e. social workers or educators) employed in the CYWS facilities acted as professional caregivers in TF-CBT and administered the group intervention “My Way” under supervision.

The BETTER CARE project trained psychotherapists in culturally sensitive TF-CBT. The

trial had the following inclusion criteria for psychotherapists working in routine care: licensed child and adolescent psychotherapists or psychological psychotherapists; willingness and written informed consent to participate and willingness to treat up to three UYRs with PTSS. Training involved the German-language version of TF-CBT Web, an online training platform (<http://tfkvt.ku.de>) supplemented with culturally adapted content. The German TF-CBT Web has previously demonstrated both effectiveness and acceptance (Kasparik et al., 2022). Thereafter, participants attended a two-day live online workshop conducted by a certified TF-CBT trainer. The workshop focused on practical treatment strategies and specific considerations when working with UYRs. Topics included the role of cultural sensitivity in TF-CBT such as adopting a stance of openness and acknowledging cultural oscillation, alongside psychoeducation regarding confidentiality, general aspects of psychotherapy, and the integration of interpreters and professional caregivers as liaisons within the care setting. Psychotherapists treating participants were required to join bi-weekly online case consultations, facilitated by TF-CBT trainers, in groups of two to six psychotherapists. Once they had completed their first case, they became eligible for a follow-up interview. The time between the workshop and the interview averaged 333.94 days ($SD = 170.74$, range: 136–650 days, two missings). To participate in the interview, psychotherapists had to provide additional written consent.

Sample

All in all, psychotherapists in the project treated $N = 57$ patients and completed the fidelity rating for their sessions. The cases treated had a mean age of 16.28 years ($SD = 1.61$), 87.7% participants were male, the majority (75.4%) had an insecure residence status, and 96.5% of the participants were residing in CYWS facilities, while the remaining two were accommodated in supervised independent housing.

Of the 87 psychotherapists who received training within the implementation trial, which included completion of the web-based program TF-CBT Web and participation in a live workshop, a total of $N = 20$ psychotherapists were further

interviewed for the present study. From these $n = 13$ were female and $n = 13$ had prior experience treating UYRs. All participants had been licensed psychotherapists for at least one year ($M = 8.70$ years, $SD = 5.96$, range: 1–23 years). While $n = 18$ psychotherapists were licensed as psychotherapists specialized on working with children and adolescents, two were licensed to work with adults and one of whom also held an additional license to work with children and adolescents (Table 1). In Germany, psychotherapists complete an extensive postgraduate training in psychotherapy after earning a degree in psychology, and specializing in treating adults, youth, or both. Seventeen participants specialized in cognitive-behavioral therapy, and three in psychodynamic psychotherapy. All psychotherapists were working in routine care in their own private practices billing with the statutory health insurance (the most frequent form of psychotherapeutic care in the German healthcare system). At the time of the interview, psychotherapists had treated at least one case within the BETTER CARE project, ($N = 33$, $n = 28$ males, $M = 16.18$ years, $SD = 1.17$). The treatments took place within the context of the German healthcare system in both urban and rural regions. The costs of psychotherapeutic treatment were covered by the statutory health insurance funds, the pertinent youth welfare offices, or, in instances where conventional funding channels were not available, the project itself.

Procedure

Data were derived from the trial mentioned above and comprised participants randomized to the BETTER CARE condition. Furthermore, the data reported here apply only to participants who were referred to psychotherapy (TF-CBT) based on their symptom severity. Each patient underwent a two-step diagnostic process. Following referral due to elevated screening scores, psychotherapists conducted a clinical assessment and established a diagnosis. For every study case, psychotherapists were asked to complete the TF-CBT Brief-Practice Checklist, Revised (Deblinger et al., 2014) after each session as a measure of treatment fidelity.

The interviews took place between September 2021 and February 2024. Participants did not receive compensation. The interviews lasted between 22 and 54 minutes and were recorded, audio files were subsequently transcribed. To maintain anonymity, any information in the transcripts that could lead to the identification of individuals was removed. The individual recorded interviews were conducted by BK and FD via the video platform ZOOM, utilizing end-to-end encryption. Both interviewers held master's degrees in clinical psychology and worked as research assistants on the project. They were responsible for recruiting psychotherapists and coordinating training and case consultations but did not serve as trainers or supervisors.

Table 1. Interviewed psychotherapists' characteristics ($N = 20$).

ID	Gender	Theoretical background	Educational background	Experiences since licensure (years)	No of UYRs treated in the project		
					dropout	completed	ongoing
T1	M	CBT	Psychology, Social Pedagogy	8	2	0	0
T2	F	PP	Social Pedagogy	23	1	1	0
T3	F	CBT	Pedagogy	5	1	1	0
T4	M	PP	Social Work, Social Pedagogy	8	0	3	0
T5	F	CBT	Psychology	20	1	0	0
T6	M	CBT	Social Pedagogy	8	2	1	0
T7	M	CBT	Education	6	0	2	0
T8	F	CBT	Social Work	6	0	1	1
T9	F	CBT	Social Work	6	0	1	0
T10	F	PP	Social Pedagogy, Social Work	18	0	1	1
T11	M	CBT	Pedagogy	6	1	0	0
T12	F	CBT	Social Pedagogy	7	1	0	1
T13	F	CBT	Social Work	4	1	0	0
T14	F	CBT	Pedagogy	5	0	1	0
T15	F	CBT	Social Pedagogy	1	0	1	0
T16	F	CBT	Social Work	9	0	2	0
T17	M	CBT	Psychology	4	1	1	0
T18	F	CBT	Psychology	11	1	0	0
T19	F	CBT	Psychology	16	1	0	0
T20	M	CBT	Pedagogy	3	1	0	0

Note. M = male, F = female, CBT: Cognitive Behavior Therapy; PP: Psychodynamic Psychotherapy.

Measures

The Brief Practice Checklist, Revised (BPC-R; Deblinger et al., 2014) was completed following each treatment session by each of the psychotherapists. It is a structured assessment tool designed to evaluate psychotherapists' adherence to the core components and fidelity of TF-CBT sessions, as well as the extent of caregiver involvement. The checklist records the session date, participants (patient, caregiver, interpreter), and includes a 0–100 visual analog scale to assess the implementation of each TF-CBT component, followed by a single-choice selection of the component addressed today and an open-ended response field for additional comments on the session. The checklist was translated into German by project staff. A study by Cohen et al. (2011) reported high inter-rater reliability (.92) between psychotherapists' self-ratings of TF-CBT fidelity and expert ratings of the corresponding audiotaped sessions.

Interview

The interviews were conducted using a semi-structured format guided by an interview guideline specifically developed for this study (see Additional file 1). The initial interview guide underwent a review process involving team members, all of whom were licensed psychotherapists with expertise in treating UYRs, TF-CBT and qualitative research. Feedback from this review led to adjustments in the guide. The final version was piloted in a test interview with one psychotherapist and included questions about prior experiences in treating traumatized children, youth, and UYRs. Besides exploring the experiences with the TF-CBT and its components, it also explored experiences facilitators and challenges in the implementation. The results of the latter have been published in another publication (Dietlinger et al., 2025). All interviews were conducted in German.

Statistical and qualitative analysis

All statistical analyses were conducted with IBM SPSS Statistics for Windows version 29.0.1.0 and descriptive statistics were used. For the qualitative

analysis, all interviews were transcribed using the software “amberscript” (Amberscript, 2026) and team members proofread and corrected the transcripts. The analysis followed the focused interview analysis approach by Kuckartz and Rädiker (2024). The coding aimed to capture key themes related to participants' experiences regarding the applicability of TF-CBT with UYRs, including perceptions of specific PRACTICE components, experiences with the intervention, and the sustainability of the TF-CBT training. The final code system is presented in Additional File 2. Following an initial review of the transcript content, the coding process employed a combination of inductive and deductive methods. BK and LS created a preliminary codebook based on four interviews, which was iteratively refined through further analysis with input from FD. Consensus on codes was reached after review, achieving an inter-rater reliability of $k = .78$. Discrepancies in coding were resolved through discussion, resulting in a finalized code list analyzed using MAXQDA 24. Codes mentioned only once were grouped under the category “other” and illustrated with two examples each. Code frequencies were calculated using the “Code Frequencies – Valid Percent” function in MAXQDA 24, examining the occurrence of specific codes relative to the total number of valid codes, excluding interviews that did not address the relevant topics.

Results

Quantitative results: treatment fidelity

The reported data refer to therapists' session-wise ratings of TF-CBT component implementation derived from the BPC-R. Among the $N = 57$ UYRs receiving TF-CBT, $n = 19$ (33.3%) terminated the treatment prematurely, defined as discontinuation prior to completion of the trauma narrative (for details see additional file 2, ADD.-Table 5). The average number of treatment sessions (50 minutes) was 20.74 ($SD = 14.74$, range: 1 – 59). Double sessions (two 50-minute sessions) occurred in $n = 26$ cases (45.6%) on average 1.72 times ($SD = 3.64$, range 1 – 19) during treatment.

Caregiver participation varied across therapies, with the highest involvement observed in parenting

skills sessions ($M = 1.94$, $SD = 1.67$), and considerably lower involvement in cognitive coping sessions ($M = 0.39$, $SD = 0.78$). A total of 37 participants (64.9%) were accompanied by interpreters, who were regularly present, especially during affective modulation ($M = 2.23$, $SD = 3.27$) and trauma narrative sessions ($M = 5.00$, $SD = 5.78$). Table 2 provides an overview of the implemented TF-CBT modules, including the number of sessions dedicated to each component, as well as the extent of caregiver and interpreter involvement.

Overall, fidelity to the TF-CBT manual was high, with the majority of psychotherapists implementing the core components of the intervention. The clinical assessment and psychoeducation were implemented by nearly all psychotherapists (100% and 96.5%, respectively), as were the trauma

narrative (97.6%) and the enhancement of safety and development (97.1%). High implementation rates were also observed for relaxation (92.5%), affective modulation (92.2%), and cognitive coping (93.6%). In contrast, certain components were applied less frequently, including parenting skills (58.5%) and conjoint caregiver-youth sessions (70.6%), while in-vivo exposure was not implemented by any psychotherapist. In-vivo exposure was rarely implemented, primarily due to the absence of clinical indication – specifically, the lack of avoidance behavior toward anxiety-provoking stimuli in daily life following the trauma narrative. Psychotherapists did not report specific barriers to in-vivo exposure during interviews. The number of sessions per module varied substantially (e.g., $M = 2.16$, $SD = 1.72$ for parenting skills; $M = 4.28$, $SD =$

Table 2. Implementation of TF-CBT components.

Implemented Modules	<i>M(SD)</i>	Cases in treatment	Cases completing module (% of eligible)
Assessment		57	57 (100%)
Number of sessions,	4.09 (3.24)		
Number of sessions with caregiver	1.33 (.95)		
Number of sessions with interpreter	1.91 (2.59)		
Psychoeducation		57	55 (96.49%)
Number of sessions	3.73 (2.48)		
Number of sessions with caregiver	1.20 (1.25)		
Number of sessions with interpreter	1.89 (2.31)		
Parenting Skills		53	31 (58.49%)
Number of sessions	2.16 (1.72)		
Number of sessions with caregiver	1.94 (1.67)		
Number of sessions with interpreter	.81 (1.52)		
Relaxation		53	49 (92.45%)
Number of sessions	2.33 (1.59)		
Number of sessions with caregiver	.51 (.98)		
Number of sessions with interpreter	1.37 (1.60)		
Affective Modulation		51	47 (92.16%)
Number of sessions	4.28 (3.51)		
Number of sessions with caregiver	.62 (1.28)		
Number of sessions with interpreter	2.23 (3.27)		
Cognitive Coping		47	44 (93.62%)
Number of sessions	2.55 (1.68)		
Number of sessions with caregiver	.39 (.78)		
Number of sessions with interpreter	1.41 (1.59)		
Trauma Narrative		41	40 (97.56%)
Number of sessions	8.28 (6.10)		
Number of sessions with caregiver	.90 (1.88)		
Number of sessions with interpreter	5.00 (5.78)		
In Vivo Exposure	0	34	0
Number of sessions			
Number of sessions with caregiver			
Number of sessions with interpreter			
Conjoint Caregiver-Youth Session		34	24 (70.59%)
Number of sessions	1.75 (1.65)		
Number of sessions with caregiver	1.21 (.98)		
Number of sessions with interpreter	.75 (1.15)		
Enhancing Safety and Development		34	33 (97.06%)
Number of sessions	2.70 (2.2)		
Number of sessions with caregiver	.30 (.59)		
Number of sessions with interpreter	1.36 (1.50)		

Note: Due to attrition during the treatment, *n* varies throughout the modules; % refers to the proportion of cases still being in treatment that actually received the module.

3.51 for affective modulation). On average, the trauma narrative required most sessions ($M = 8.28$, $SD = 6.10$).

Qualitative results: implementation and treatment deviations

The reported implementations and treatment deviations of TF-CBT with UYRs are summarized in Table 3 (see also Additional file 2).

In total, four psychotherapists reported adhering strictly to the TF-CBT manual. The majority of reported experiences related to the “crisis of the week” (COW), described as follows: “That they don’t just come with their traumatic experiences but also have to live with them in everyday life, and sometimes everyday problems take priority.” (T04). Three participants reported difficulties in reacting to those COWs because of “[...] the question of how much you can focus on other things and at what points, because normally in therapy, I tend to orient myself a bit around the daily events, which isn’t really what the manual suggests.” (T07). Two psychotherapists each reported the following strategies in dealing with COWs. The first strategy involved dedicating single treatment sessions exclusively to addressing COWs, with subsequent sessions returning to the structured PRACTICE components: “There were occasional crises, which I responded to. But I still continued as usual in the next session. So more like brief lapses.” (T03). The second strategy consisted of allocating a defined period of time at the beginning of each

session to address COWs: “Actually, we were clear about it during the day, and when small crises came up [...] we discussed it in the first ten minutes and then continued with the context.” (T14). The third strategy involved establishing a direct link to the TF-CBT: “Yes, if something else came up, I would somehow relate it to the trauma symptoms, like sleep issues or something, and then emphasize the importance of the narrative, in that way.” (T17). Lastly, other strategies were reported by two psychotherapists such as for example to “[...] make cautious attempts to redirect. And if I notice it’s pointless because it keeps coming back, then I leave it at that. [...]” (T09).

Another important observation made by the psychotherapists was the importance of the flexible use of the manual’s components, which was mentioned by ten psychotherapists. This was for example necessary.

When the caregivers told me they were worried [patient prename] might fall into the wrong circles, I decided to bring up what usually comes at the end, namely, how to secure her future and how to live safely in Germany, earlier. I discussed with her that there are older women who tend to approach young refugee women and that she should be cautious about that. So, I did switch things around in this case, but at the end, I came back to it, [...] (T14).

This is consistent with the notion of adapting components to meet the specific needs of patients, which was mentioned five times, as illustrated in this quote: [...] I [...] definitely say that I keep the structure of the manual in mind when implementing TF-CBT, um,

Table 3. Implementations and treatment deviations of TF-CBT with UYRs.

Code	Frequency
No modifications described	4 (20.0%)
“Crisis of the Week” (COW)	4 (20.0%)
Difficulties in reacting to COWs	3 (15.0%)
Some sessions dedicated only to COWs	2 (10.0%)
Dedicated period of time to COWs in the beginning of the treatment session	2 (10.0%)
Establish a reference to TF-CBT	2 (10.0%)
Other ways to react to COWs	2 (10.0%)
Flexible use of manual components	10 (50.0%)
Adapting components flexible to patients needs	5 (25.0%)
Broader psychoeducation	2 (10.0%)
Integration of other materials	4 (20.0%)
Stuck point list	2 (10.0%)
Structural modifications	
Not sharing trauma narrative with caregiver	4 (20.0%)
No regular (conjoint) caregiver sessions	3 (15.0%)
More time needed	3 (15.0%)
No double sessions	2 (10.0%)
Other	6 (30.0%)

Note. Interviews with code $n = 20$.

but I adjust it individually to the patient.” (T06). Two psychotherapists reported the need to provide a more extensive psychoeducation, as “[...] we took a step back. We repeated and explained psychotherapy again, what psychotherapy is. We also went back to psychoeducation and revisited the accompanying symptoms like anger, dissatisfaction, and then we went into reorientation a second time. [...] that was the adjustment.” (T18).

Four psychotherapists also included other materials, that were not originally part of the manual, two participants used a stuck point list, a technique that has been employed in the context of Cognitive Processing Therapy (Resick et al., 2017), which they used as follows:

In the narrative, there was [...] a stuck points list, and I borrowed that whole part a bit. So, first of all, what are stuck points, and what kind of thoughts and beliefs are involved in the dysfunctional thoughts about the trauma? [...] And I find that very helpful. (T03)

Finally, some psychotherapists made structural modifications. Four psychotherapists reported that their patients did not share the trauma narrative with a caregiver within the therapeutic setting, because the patients “[...] didn’t want to share it with the caregiver.” (T16). Three participants indicated that they were unable to conduct regular conjoint caregiver sessions. This was because “[...] the facility couldn’t provide that, and also because the adolescents didn’t want it. They didn’t want the caregivers involved with these issues.” (T14). Additionally, three participants reported that the allocated number of treatment sessions was not sufficient, and two noted that they were unable to conduct double sessions. Participants described these challenges as follows: “[...] double session is out of the question for me, that’s something that’s almost actually not possible.” (T07) and,

Well, it naturally takes different amounts of time than one might have initially thought. It definitely took more time ... If I now think about the fact that I would have only had half the time, it definitely required much more time. (T03)

Six psychotherapists reported additional themes, including for example “[...] a lot of it was about rebuilding the therapeutic relationship,

establishing commitment, and ensuring compliance.” (T06).

Helpful and challenging TF-CBT components

Several *helpful TF-CBT components* were identified (for details see Table 4 as well as Additional file 2, ADD.-Table 2).

Eight psychotherapists mentioned the trauma narrative and processing component as a helpful component, as it “[...] actually worked out the best and most smoothly.” (T07). Four psychotherapists felt security through the structured manual, as “[...] there were already a few options provided as possibilities.” (T14). Using a life line, a visual timeline exercise used in therapy to map key positive and negative life events across the lifespan and identify major stressors and resources as a preparation for the trauma narrative was seen as helpful by three participants, as it helped “[...] to see where the peaks of experiences and burdens are [...]” (T15). Finally, two pointed out the method of “[...] writing down stories. I think that’s very helpful.” (T18).

Besides the trauma narrative, psychoeducation and cognitive coping were seen as the most helpful components. Four psychotherapists emphasized the particular importance of psychoeducation: “[...] when working with refugees, who often have even less of an understanding of psychotherapy [...]” (T15). Two psychotherapists pointed out that metaphors were very helpful, as “[...] many of them have headaches and all those symptoms. And the metaphor of the disorganized closet, I was able

Table 4. Helpful TF-CBT components.

Code	Frequency
All components	2 (11.1%)
Diagnosing	2 (11.1%)
Psychoeducation	4 (22.2%)
Metaphors	2 (11.1%)
Relaxation	1 (5.6%)
Affect Modulation	2 (11.1%)
Cognitive Coping	4 (22.2%)
All Stabilizing Components	2 (11.1%)
Trauma Narrative and Processing	8 (44.4%)
Security through a structured manual	4 (22.2%)
Life line	3 (16.7%)
Exposition/Confrontation	2 (11.1%)
Written Form	2 (11.1%)
In-vivo Mastery	/
Conjoint Sessions	2 (11.1%)
Enhancing Safety & Future Development	/

Note. Interviews with code $n = 18$.

to work well with that [...]” (T02). Cognitive Coping was mentioned by four psychotherapists, as “cognitive restructuring worked incredibly well, and seeing that was just amazing!” (T03). Finally, affect modulation was seen as beneficial by two participants as,

[...] it helped them start to understand a bit better what therapy is actually about. Before that, you can talk a lot and explain, but with this, I felt like it sort of clicked. Like, ‘Aha, this is about how I feel about something, how something affects me, how I can reduce the strain and lower my stress level. (T10)

Relaxation was reported by only one psychotherapist, who described that “all those relaxation techniques, [...] were really helpful as well.” (T10). Two participants highlighted that all stabilizing components (psychoeducation, relaxation, affect modulation, cognitive coping) were helpful and that they learned that it is not necessary to prolong stabilization even for patients exhibiting high levels of PTSD. One psychotherapist concluded: “What I also liked, which was often a bit different in previous trauma training, was that the stabilization phase wasn’t given as much weight. I mean, yes, stabilization should happen, of course, but it doesn’t dominate as much.” (T03).

Two psychotherapists cited conjoint sessions as a beneficial practice, despite initially expressing resistance to it. They subsequently expressed their experience of the effect of these sessions as follows:

I think if it hadn’t been for the manual, I wouldn’t have done it. [...] But to see the effect it had on the caregiver and also on the young refugee, what that deeper relief really meant I was really glad I went along with it. (T09)

Two psychotherapists found all components helpful as “[...] it works within the process, in the sequence. I wouldn’t be able to highlight any one of them.” (T12).

Challenging TF-CBT components were also reported (for details see Table 5 as well as Additional file 2, ADD.-Table 3).

Challenging TF-CBT Components

Relaxation was the component most frequently identified as challenging. Two psychotherapists indicated that relaxation represents the least essential component of the entire manual: “[...] it wasn’t

Table 5. Challenging TF-CBT components.

Code	Frequency
None	6 (35.3%)
Psychoeducation	
Metaphors	1 (5.9%)
Relaxation	2 (11.8%)
Not applied by adolescents	3 (17.6%)
Affect Modulation	1 (5.9%)
Cognitive Coping	/
All Stabilizing Components	2 (11.8%)
Trauma Narrative and Processing	1 (5.9%)
In-vivo Mastery	/
Conjoint Sessions	1 (5.9%)
Enhancing Safety & Future Development	/
Manual Restrictiveness	3 (17.6%)
More sessions necessary	2 (11.8%)
Other	5 (29.4%)

Note. Interviews with code $n = 18$.

necessarily something I needed, but on the other hand, it doesn’t take up a huge part anyway.” (T11). Specifically, two psychotherapists noted that adolescents often do not actively engage with this component: “For example, the relaxation module – I did it with him, and he dutifully told me, yes, I’m practicing it, but I’m a thousand percent sure he didn’t actually do it.” (T17). One participant found psychoeducation with the use of metaphors to be less helpful: “The closet metaphor just doesn’t work for me.” (T18). And one participant mentioned difficulties in following the manual regarding the affect modulation component, as,

[...] the feelings module, we also dutifully collected them [...]. But I think, if I had done it now, I might have said, [...] we can delve much deeper into when and where he feels a certain way and try to get closer to understanding that, so to speak. [...]” (T14). Two psychotherapists noted overall that the “[...] stabilizing measures aren’t really well received by the adolescents.” (T16). One participant found that the conjoint sessions were challenging as, “[...] it turned out to be difficult, and it posed challenges for me.” (T06). Overall, the manualized procedure was difficult to handle for three psychotherapists, as it “[...] was very counterproductive, um, because it certainly hindered me from building a good relationship with the patient at first.” (T20). And two psychotherapists mentioned that the estimated number of sessions, is not sufficient and “[...] the manual suggested in many places that it would go faster than it actually did in real life.” (T07). Five participants mentioned other challenges such as offering the treatment in double sessions, which was not possible for one

participant: “I couldn’t do the last session as a double session anymore, it just wasn’t possible.” (T08). Experiences with interpreters were rarely reported. One participant described the use of an interpreter during trauma narrative work as challenging due to the time-intensive nature of translation and the disruption of therapeutic flow, this was also the only challenging point being mentioned about the trauma narrative module.

Sustainability/acceptability of the TF-CBT training

Ten participants mentioned that they are now offering more trauma treatment and eight of them also use TF-CBT more than before participating in the project (for details see Additional file 2 (ADD.-Table 4). In total many participants would use TF-CBT further to treat UYRs ($n = 18$) and to treat traumatized youth in general ($n = 17$). Furthermore, nine psychotherapists reported that they gained self-confidence as “[...] this project ... especially this treatment manual, has contributed to me feeling more confident.” (T03) and two want to share the knowledge with their colleagues: “And I also try to incorporate it into my work at the clinic, motivating people to at least take this online course, and try to support them a bit on that basis.” (T11).

Discussion

This paper evaluated the implementation of TF-CBT with UYRs within an implementation trial in routine healthcare and analyzed how psychotherapists experienced the treatment process. Summed up, treatment fidelity was satisfying, and psychotherapists’ experiences were mostly positive. Overall, psychotherapists viewed TF-CBT as an acceptable and empowering approach, enhancing their confidence and capacity to deliver trauma-focused care for UYRs.

With regards to the *fidelity* of TF-CBT, the drop-out rate of 33.3% was lower than the one described by Patel et al. (2024), who offered TF-CBT to unaccompanied children in the USA and higher than average drop-out rates reported in a meta-analysis with adult trauma patients (Lewis et al., 2020) and with refugees (Semmlinger & Ehring, 2022). On average, participants received 20.74

sessions, which is comparable to previous TF-CBT studies with UYRs delivered in double sessions (~90–100 minutes; 8–15 sessions; Patel et al., 2024; Unterhitzenberger et al., 2019), but above average compared to a meta-analysis ($M = 20.74$ vs $M = 16.66$) that also included a vast population such as refugees, foster children etc (Thielemann et al., 2022). It is possible that for many psychotherapists working in routine outpatient care, double sessions were difficult to implement, as they usually have 50 minutes-slots for each patient. In total, double sessions were conducted in only 45.6% of the cases, with a mean of 1.72 double sessions. Additional contributing factors may include the high percentage of interpreter involvement, limited mental health literacy, and different expectations toward psychotherapy (e.g. Asfaw et al., 2020) as well as the fact that all psychotherapists in this study were treating UYRs with TF-CBT for the first time and seven had never worked with UYRs before. This may have contributed both to an increased number of psychoeducation sessions (3.73) and to a higher mean number of treatment sessions overall. This finding highlights the idea, that aspects of psychoeducation and expectation management could already be addressed in advance by staff at CYWS facilities for example through low-threshold, psychoeducational interventions, such as the “Tea Garden” program (Mewes et al., 2021) or the “Tell Your Story” program (Nickerson et al., 2020).

In total the findings indicate that the majority of psychotherapists adhered closely to the TF-CBT protocol, with high implementation rates of the core components. The number of sessions dedicated to each component was largely in line with the manual’s recommendations, with the trauma narrative being the most emphasized element. The lacking implementation of in-vivo exposure may reflect the specific challenges of applying this component with UYRs, whose trauma-related triggers are often located in their countries of origin or along their flight routes and thus cannot be easily or safely reexperienced in the current setting (Nickerson et al., 2021). Further deviations primarily concerned the slightly reduced use of conjoint caregiver sessions (70.6%), and of parenting skills (58.5%). This may point to structural barriers within the

youth welfare system, where consistent involvement of caregivers can be challenging among others due to limited staff availability and instable support networks (Dietlinger et al., 2025; McGuire et al., 2024).

The findings regarding the *applicability* of the TF-CBT manual are largely positive and align well with expectations. Psychotherapists frequently reported flexible use of core components and minor adaptations, such as responding to the “crisis of the week” (COW), to meet the specific needs of UYRs. These flexible, needs-based strategies are anticipated in the manual itself, which explicitly encourages adjusting the sequence, emphasis, and timing of components based on the individual case (Cohen et al., 2017). Furthermore, these adaptations have already been reported in previous studies (e.g. Unterhitzenberger et al., 2021), underscoring the practical utility and feasibility of TF-CBT in routine clinical care. Overall, the findings indicate that flexible implementation, including refugee-specific applications, is both beneficial and actively employed by psychotherapists. Given the diverse post-migration stressors UYRs are facing (e.g. Höhne et al., 2022), psychotherapists should be encouraged to implement enhanced problem management throughout the treatment for this population. In contrast, structural modifications, such as not sharing the trauma narrative with caregivers, the absence of regular conjoint caregiver – youth sessions, the need for more time, and the inability to conduct double sessions were the only notable deviations. These challenges align with the fidelity analysis and largely reflect the structural and organizational constraints of youth welfare settings, rather than limitations of the manual or psychotherapist competence. Overall, the results suggest that TF-CBT can be successfully applied with UYRs, but effective implementation requires flexibility (Atiyeh & Gray, 2022).

In terms of *psychotherapists’ experiences*, TF-CBT was perceived as an acceptable and empowering framework for addressing the complex mental health needs of UYRs. The trauma narrative was identified as the most helpful component, aligning with existing research that identifies narrative trauma exposure and working on maladaptive posttraumatic cognitions as key change mechanisms in trauma treatment (e.g. Kangaslampi & Peltonen, 2019). Psychoeducation is also considered a critical component, particularly

given the variability in mental health literacy across different cultural backgrounds, as noted above. Most psychotherapists did not report substantial difficulties with TF-CBT, indicating that the manual and its training approach are feasible and well-suited for implementation in treating trauma among UYRs in routine care. However, some clinicians rated manual restrictiveness and the limited applicability of relaxation techniques for adolescents challenging. These results are consistent with previous findings (Unterhitzenberger et al., 2021). Thus, the relaxation component might need further applications to fit the needs of adolescent and young adult refugees. Patel et al. (2024) suggest the assessing and incorporation of existing culturally relevant relaxation strategies. Encouraging psychotherapists to explore and utilize existing personal resources and relaxation techniques of young refugees could therefore be helpful. Overall, findings on either helpful or challenging TF-CBT components align with those from a previous TF-CBT pilot study with psychotherapists treating UYRs (Unterhitzenberger et al., 2021). This is particularly interesting because the present study is an implementation and effectiveness study, whereas Unterhitzenberger et al. (2021) pilot trial was primarily an efficacy trial.

With regard to *sustainability*, the psychotherapists participating in this implementation trial have indicated that they now use TF-CBT more often. Furthermore, due to the support provided, they were able to increase their self-confidence with regard to the use of trauma-focused methods. The findings indicate that the successful implementation of evidence-based treatment approaches, even among marginalized groups such as UYRs, is achievable through active training. Active training has been demonstrated to result in increased knowledge among psychotherapists, as well as heightened satisfaction with the training (Valenstein-Mah et al., 2020). In this context, ongoing support is a critical factor, as training is more likely to result in improved manual adherence and treatment fidelity when psychotherapists receive post-training consultation (Dietlinger et al., 2025; Frank et al., 2020).

The present study has several strengths, including the qualitative and quantitative investigation of an implementation approach of TF-CBT with a difficult to reach sample. In addition, interviews were conducted with 20 psychotherapists from

a variety of backgrounds, experiences with UYRs, and regions across Germany. Besides these strengths, several limitations warrant acknowledgment. First, the sample size of psychotherapists is relatively small, and the sample might be somewhat selective as it only included psychotherapists interested in treating UYRs and applying trauma-focused treatment. Second, the project funded treatment, as some UYRs did not yet have health insurance to cover the costs due to the ongoing asylum process. All psychotherapists had free access to German TF-CBT web training and were compensated for documentation and their participation in case consultations. This arrangement may have led to socially desirable responses in the interviews. Third, applications of the TF-CBT manual, as reported in previous work (e.g., Unterhitzenger et al., 2021), may have influenced the supervision in this study; this may have influenced the psychotherapists' reporting of the modifications they made to the manual. Fourth, there is no information on the actual, longer-term use of TF-CBT in the practice of the psychotherapists surveyed. The information on the sustainability of the TF-CBT training refers to statements made immediately after completion of the study.

It is recommended that future research includes the perspectives not only of psychotherapists, but also of patients and caregivers. It would be beneficial to gain further insight into how they perceive the TF-CBT methods and what is helpful to them, or in what type of application they may benefit most from cognitive-behavioral techniques. This may include, for example, the form of psychoeducation or the form of relaxation training. Given the high rate of treatment dropout, the reasons for premature termination of treatment should be explored in more detail and measures derived to prevent such premature termination. With regard to future dissemination and implementation of TF-CBT, further efforts are needed to ensure that as many young patients with PTSD as possible receive trauma-focused treatment.

Clinical implications

The present findings provide empirical support for the implementation of TF-CBT for UYRs in routine outpatient mental health care. The observed

high level of treatment fidelity, together with favorable psychotherapist evaluations, indicates that TF-CBT can be implemented with a high degree of adherence and acceptability in this population when therapists receive structured training and ongoing clinical supervision. However, these findings should be interpreted in light of the study context, which included specialized training, ongoing case consultation, and project-specific support, all of which may have facilitated successful treatment delivery.

The results indicate that TF-CBT is a feasible and acceptable treatment approach for UYRs in routine clinical care and may be generalized to accompanied refugee youth and other mental health services working with refugee populations. Furthermore, the core principles and intervention components of TF-CBT are likely applicable to migrant children and adolescents with PTSD who have not experienced forced displacement. Nevertheless, context-specific adaptations may be necessary to ensure optimal implementation and effectiveness across different service settings, depending on available resources, support structures, and patient characteristics. In particular, post-migration stressors, the need for interpreter-mediated treatment, and caregiver availability or involvement may substantially influence treatment process and implementation outcomes.

Addressing current stressors through a flexible and responsive approach to emerging “crises of the week” and integrating structured problem-management strategies may help promote treatment engagement and reduce the risk of premature dropout among refugee youth. In settings where patients possess adequate proficiency in the treatment language, treatment may be delivered without the involvement of interpreters. Likewise, caregiver involvement may be facilitated through close collaboration with CYWS facilities or, where available, through the inclusion of biological caregivers. Tailoring treatment delivery to these contextual factors may improve both engagement and intervention effectiveness while preserving adherence to the core principles of TF-CBT.

Conclusion

This study demonstrates that TF-CBT is a feasible, acceptable, and empowering treatment approach

for UYRs within routine healthcare settings. The high fidelity to core treatment components, the flexible but structured implementation, and the overall positive experiences reported by psychotherapists suggest that TF-CBT can be effectively adapted to the specific needs and challenges of this vulnerable population. While certain structural constraints, such as limited opportunities for caregiver involvement, interpreter reliance, and the inability to conduct double sessions posed challenges, which were primarily systemic in nature rather than limitations of the TF-CBT model itself.

Acknowledgments

RR conceived the study. BK and JU conceived the trial. FD, BK and JU were involved in the analysis. FD and BK drafted the manuscript. All authors read and approved the final manuscript.

Author contributions

CRedit: **Flora Katrin Dietlinger**: Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing; **Barbara Kasparik**: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing; **Johanna Unterhitzberger**: Methodology, Supervision, Writing – original draft, Writing – review & editing; **Rita Rosner**: Conceptualization, Funding acquisition, Supervision, Writing – original draft, Writing – review & editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the German Federal Ministry of Education and Research [01EF1802A, 01EF1802B, 01EF1802C].

Abbreviations

(TF-CBT): Trauma-Focused Cognitive Behavioral Therapy
(UYRs): unaccompanied young refugees
(PTSS): post-traumatic stress symptoms
(PTSD): post traumatic stress disorder
(COW): crisis of the week

Data availability statement

The datasets used and analyzed during the current study are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

The studies involving human participants were reviewed and approved by ethics committees at Ulm University (No. 243/19) and at the Catholic University of Eichstätt-Ingolstadt (No. 004–19). Written informed consent to participate in this study was provided by the participants and their legal guardians if necessary.

References

- Amberscript, B. V. (2026). *Amberscript* (2024 version) [Transcription software]. <https://www.amberscript.com/de/>
- Asfaw, B. B., Beiersmann, C., Keck, V., Nikendei, C., Benson-Martin, J., Schütt, I., & Lohmann, J. (2020). Experiences of psychotherapists working with refugees in Germany: A qualitative study. *BMC Psychiatry*, 20(1), 588. <https://doi.org/10.1186/s12888-020-02996-0>
- Atiyeh, S., & Gray, G. (2022). Counsellors' competency to counsel refugees: A constructivist grounded theory study. *Counselling and Psychotherapy Research*, 22(1), 32–42. <https://doi.org/10.1002/capr.12477>
- Bean, T., Eurelings-Bontekoe, E., & Spinhoven, P. (2007). Course and predictors of mental health of unaccompanied refugee minors in the Netherlands: One year follow-up. *Social Science and Medicine*, 64(6), 1204–1215. <https://doi.org/10.1016/j.socscimed.2006.11.010>
- Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Medicine*, 17(9), e1003337. <https://doi.org/10.1371/journal.pmed.1003337>
- Brown, E. J., Cohen, J. A., & Mannarino, A. P. (2020). Trauma-focused cognitive-behavioral therapy: The role of caregivers. *Journal of Affective Disorders*, 277, 39–45. <https://doi.org/10.1016/j.jad.2020.07.123>
- Chipalo, E. (2021). Is trauma focused-cognitive behavioral therapy (TF-CBT) effective in reducing trauma symptoms among traumatized refugee children? a systematic review. *Journal of Child & Adolescent Trauma*, 14(4), 545–558. <https://doi.org/10.1007/s40653-021-00370-0>
- Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics of North America*, 24(3), 557–570. <https://doi.org/10.1016/j.chc.2015.02.005>

- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Press.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). The Guilford Press.
- Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: A randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*, 165(1), 16–21. <https://doi.org/10.1001/archpediatrics.2010.247>
- Daniel-Calveras, A., Baldaquí, N., & Baeza, I. (2022). Mental health of unaccompanied refugee minors in Europe: A systematic review. *Child Abuse and Neglect*, 133, 105865. <https://doi.org/10.1016/j.chiabu.2022.105865>
- Deblinger, E., Cohen, J. A., Mannarino, A. P., Murray, L. K., & Epstein, C. (2014). *Brief practice checklist revised (BPC-R)*. Unpublished checklist.
- Dietlinger, F. K., Kasparik, B., Unterhitzberger, J., Saupe, L. B., & Rosner, R. (2025). Challenges and facilitators in treating unaccompanied young refugees with post-traumatic stress disorder in a dissemination trial: A qualitative study with psychotherapists. *Child and Adolescent Psychiatry and Mental Health*, 19(1). <https://doi.org/10.1186/s13034-025-00873-w>
- Dumke, L., Schmidt, T., Wittmann, J., Neldner, S., Weitkämper, A., Catani, C., Neuner, F., & Wilker, S. (2024). Low access and inadequate treatment in mental health care for asylum seekers and refugees in Germany: A prospective follow-up study over 12 months and a nationwide cross-sectional study. *Applied Psychology, Health and Well-Being*, 16(3), 1141–1158. <https://doi.org/10.1111/aphw.12523>
- European Union Agency for Asylum. (2024). *Asylum report 2024*. <https://www.euaa.europa.eu/asylum-report-2024>
- Frank, H. E., Becker-Haimes, E. M., & Kendall, P. C. (2020). Therapist training in evidence-based interventions for mental health: A systematic review of training approaches and outcomes. *Clinical Psychology: Science and Practice*, 27(3), e12330. <https://doi.org/10.1111/cpsp.12330>
- Höhne, E., van der Meer, A. S., Kamp-Becker, I., & Christiansen, H. (2022). A systematic review of risk and protective factors of mental health in unaccompanied minor refugees. *European Child & Adolescent Psychiatry*, 31(8), 1–15. <https://doi.org/10.1007/s00787-020-01678-2>
- Hornfeck, F., Garbade, M., Kappler, S., Rosner, R., Pfeiffer, E., Sachser, C., & Kindler, H. (2024). Trajectories of mental health problems in unaccompanied young refugees in Germany and the impact of post-migration factors - a longitudinal study. *European Child & Adolescent Psychiatry*. Advance online publication. 34(3), 1051–1062. <https://doi.org/10.1007/s00787-024-02535-2>
- Jensen, T. K., Skar, A. M. S., Andersson, E. S., & Birkeland, M. S. (2019). Long-term mental health in unaccompanied refugee minors: Pre- and post-flight predictors. *European Child & Adolescent Psychiatry*, 28(12), 1671–1682. <https://doi.org/10.1007/s00787-019-01340-6>
- Kangaslampi, S., & Peltonen, K. (2019). Mechanisms of change in psychological interventions for posttraumatic stress symptoms: A systematic review with recommendations. *Current Psychology*, 41(1), 258–275. <https://doi.org/10.1007/s12144-019-00478-5>
- Kasparik, B., Saupe, L. B., Mäkitalo, S., & Rosner, R. (2022). Online training for evidence-based child trauma treatment: Evaluation of the German language TF-CBT-Web. *European Journal of Psychotraumatology*, 13(1), 2055890. <https://doi.org/10.1080/20008198.2022.2055890>
- Kuckartz, U., & Rädiker, S. (2024). *Focused interview analysis with MAXQDA: Step by step* (2nd ed.). Springer VS.
- Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological therapies for post-traumatic stress disorder in adults: Systematic review and meta-analysis. *European Journal of Psychotraumatology*, 11(1), 1729633. <https://doi.org/10.1080/20008198.2020.1729633>
- McGuire, R., Meiser-Stedman, R., Smith, P., Schmidt, D., Bjornstad, G., Bosworth, R., Clarke, T., Coombes, J., Simpson, E. G., Hudson, K., Oliveira, P., Macleod, J., McGovern, R., Stallard, P., Wood, K., & Hiller, R. M. (2024). Access to best-evidenced mental health support for care-experienced young people: Learnings from the implementation of cognitive therapy for PTSD. *British Journal of Clinical Psychology*, 64(1), 63–85. <https://doi.org/10.1111/bjc.12471>
- Mewes, R., Giesebrecht, J., Weise, C., & Grupp, F. (2021). Description of a Culture-Sensitive, Low-Threshold Psychoeducation Intervention for Asylum Seekers (Tea Garden). *Clinical Psychology in Europe*, 3(Spec Issue), e4577. <https://doi.org/10.32872/cpe.4577>
- Morroni, D., Konstantinou, P., Gkleka, C., Kassianos, A. P., & Karekla, M. (2025). Examining cognitive behavioral therapy interventions for unaccompanied minors: A systematic review and qualitative research synthesis. *European Child & Adolescent Psychiatry*, 34(2), 465–481. <https://doi.org/10.1007/s00787-024-02500-z>
- Müller, L. R. F., Büter, K. P., Rosner, R., & Unterhitzberger, J. (2019). Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: A cross-sectional study. *Child and Adolescent Psychiatry and Mental Health*, 13(1), 8. <https://doi.org/10.1186/s13034-019-0268-1>
- National Institute for Health and Care Excellence. (2018). *Post-traumatic stress disorder: NICE guideline*. <https://www.nice.org.uk/guidance/ng116>
- Nickerson, A., Byrow, Y., Pajak, R., McMahon, T., Bryant, R. A., Christensen, H., & Liddell, B. J. (2020). ‘Tell your story’: A randomized controlled trial of an online intervention to reduce mental health stigma and increase help-seeking in refugee men with posttraumatic stress. *Psychological Medicine*, 50(5), 781–792. <https://doi.org/10.1017/S0033291719000606>

- Nickerson, A., Byrow, Y., Rasmussen, A., O'Donnell, M., Bryant, R. A., Murphy, S., Mau, V., McMahon, T., Benson, G., & Liddell, B. J. (2021). Profiles of exposure to potentially traumatic events in refugees living in Australia. *Epidemiology and Psychiatric Sciences*, 30, e18. <https://doi.org/10.1017/S2045796021000068>
- Oberg, C., & Sharma, H. (2023). Post-traumatic stress disorder in unaccompanied refugee minors: Prevalence, contributing and protective factors, and effective interventions: A scoping review. *Children (Basel, Switzerland)*, 10(6), 941. <https://doi.org/10.3390/children10060941>
- Patel, Z. S., Casline, E. P., Vera, C., Ramirez, V., & Jensen-Doss, A. (2024). Unaccompanied migrant children in the United States: Implementation and effectiveness of trauma-focused cognitive behavioral therapy. *Psychological Trauma: Theory, Research, Practice and Policy*, 16(2), 389–399. <https://doi.org/10.1037/tra0001361>
- Pfeiffer, E., & Goldbeck, L. (2019). *Traumafokussierte pädagogische Gruppenintervention für junge Flüchtlinge: Das Programm "Mein Weg"* (1. Aufl.). Therapeutische Praxis. Hogrefe.
- Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. Guilford Press.
- Rosner, R., Sachser, C., Hornfeck, F., Kilian, R., Kindler, H., Muche, R., Müller, L. R. F., Thielemann, J., Waldmann, T., Ziegenhain, U., Unterhitzenberger, J., & Pfeiffer, E. (2020). Improving mental health care for unaccompanied young refugees through a stepped-care approach versus usual care +: Study protocol of a cluster randomized controlled hybrid effectiveness implementation trial. *Trials*, 21(1), 1013. <https://doi.org/10.1186/s13063-020-04922-x>
- Schottelkorb, A. A., Doumas, D. M., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy*, 21(2), 57–73. <https://doi.org/10.1037/a0027430>
- Schreyer, B., Thielemann, J. F. B., Kasparik, B., & Rosner, R. (2024). Differences of TF-CBT treatment effects using various outcome measures: A meta-analysis. *European Journal of Psychotraumatology*, 15(1), 2406136. <https://doi.org/10.1080/2008066.2024.2406136>
- Semmlinger, V., & Ehring, T. (2022). Predicting and preventing dropout in research, assessment and treatment with refugees. *Clinical Psychology and Psychotherapy*, 29(3), 767–782. <https://doi.org/10.1002/cpp.2672>
- Thielemann, J. F. B., Kasparik, B., König, J., Unterhitzenberger, J., & Rosner, R. (2022). A systematic review and meta-analysis of trauma-focused cognitive behavioral therapy for children and adolescents. *Child Abuse and Neglect*, 134, 105899. <https://doi.org/10.1016/j.chiabu.2022.105899>
- UNHCR. (2024). *Mid-year trends 2024*. <https://www.uno-fluechtlingshilfe.de/fileadmin/redaktion/PDF/UNHCR/mid-year-trends-report-2024.pdf>
- Unterhitzenberger, J., Eberle-Sejari, R., Rassenhofer, M., Sukale, T., Rosner, R., & Goldbeck, L. (2015). Trauma-focused cognitive behavioral therapy with unaccompanied refugee minors: A case series. *BMC Psychiatry*, 15(1), 260. <https://doi.org/10.1186/s12888-015-0645-0>
- Unterhitzenberger, J., Haberstumpf, S., Rosner, R., & Pfeiffer, E. (2021). "Same same or adapted?" psychotherapists' feedback on the implementation of trauma-focused cognitive behavioral therapy with unaccompanied young refugees. *Clinical Psychology in Europe*, 3(Special Issue), e5431. <https://doi.org/10.32872/cpe.5431>
- Unterhitzenberger, J., Wintersohl, S., Lang, M., König, J., & Rosner, R. (2019). Providing manualized individual trauma-focused CBT to unaccompanied refugee minors with uncertain residence status: A pilot study. *Child and Adolescent Psychiatry and Mental Health*, 13(1), 22. <https://doi.org/10.1186/s13034-019-0282-3>
- Valenstein-Mah, H., Greer, N., McKenzie, L., Hansen, L., Strom, T. Q., Stirman, S. W., Wilt, T. J., & Kehle-Forbes, S. M. (2020). Effectiveness of training methods for delivery of evidence-based psychotherapies: A systematic review. *Implementation Science*, 15(1), 40. <https://doi.org/10.1186/s13012-020-00998-w>