

## REVIEW ARTICLE

# Improving access to evidence-based interventions for trauma-exposed adults in low- and middle-income countries

Debra Kaminer<sup>1</sup>  | Duane Booysen<sup>2</sup> | Kate Ellis<sup>3</sup>  | Christian Haag Kristensen<sup>4</sup> | Anushka R. Patel<sup>5</sup> | Katy Robjant<sup>6</sup> | Srishti Sardana<sup>7</sup>

<sup>1</sup>Department of Psychology, University of Cape Town, Cape Town, South Africa

<sup>2</sup>Department of Psychology, Rhodes University, Grahamstown, South Africa

<sup>3</sup>Department of Psychology, American University in Cairo, New Cairo, Egypt

<sup>4</sup>School of Health and Life Sciences, Pontifical Catholic University of Rio Grande do Sul, Porto Alegre, Brazil

<sup>5</sup>Department of Epidemiology, Harvard Chan School of Public Health, Boston, Massachusetts, USA

<sup>6</sup>Department of Psychology, University of Konstanz, Konstanz, Germany

<sup>7</sup>Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland, USA

## Correspondence

Debra Kaminer, Psychology Department, University of Cape Town, Cape Town, 7700, South Africa.  
Email: [Debbie.Kaminer@uct.ac.za](mailto:Debbie.Kaminer@uct.ac.za)

## Abstract

In low- and middle-income countries (LMICs), the mental health consequences of trauma exposure pose a substantial personal, societal, and economic burden. Yet, the significant need for evidence-based mental health treatment remains largely unmet. To unlock the potential for mental health care for trauma survivors in lower-resource contexts, it is critical to map treatment barriers and identify strategies to improve access to evidence-based, culturally appropriate, and scalable interventions. This review, based on an International Society for Traumatic Stress (ISTSS) briefing paper, describes the treatment gap facing adults with traumatic stress in LMICs and identifies the barriers that contribute to this gap. We then highlight strategies for enhancing access to effective treatments for these populations, including task-sharing, the use of culturally adapted and multiproblem interventions, and digital tools to scale access to appropriate care. Finally, we offer recommendations for policymakers, researchers, and service providers to guide an agenda for action to close the treatment gap for trauma survivors in LMICs.

Over two thirds of adults living in low- and middle-income countries (LMICs) have experienced at least one traumatic event in their lifetime (Benjet et al., 2016). Among trauma survivors in these settings, mental health difficulties, such as posttraumatic stress disorder (PTSD) and depression, are common. For example, in sub-Saharan African countries, the pooled prevalence of PTSD has been estimated to be 22% (Ng et al., 2020). In countries that have experienced war and conflict, which are predominantly LMICs, the aggregate prevalence rates of PTSD and depression have been estimated at 29% and 24%, respectively (Lim et al., 2022). Moreover, trauma survivors in LMICs often present with forms of trauma-related distress that are not consistent with Western psychiatric diagnoses, including somatic symptoms, impacts on spirituality, and loss of social

status (Kohrt & Hruschka, 2010; Michalopoulos et al., 2020).

According to the World Health Organization (WHO; 2022), mental health is a universal human right. Improving access to effective treatments for trauma-related mental health difficulties is, therefore, a human rights imperative. Moreover, this unmet mental health need carries a substantial economic cost: Through a combination of disability and premature mortality, PTSD and depression in LMICs account for over 2,000 and 40,000 lost healthy life years, respectively (Mathers et al., 2006). Ensuring better treatment access to reduce this burden can yield substantial economic and health benefits in lower-resource countries (Chisholm et al., 2016). In this review, based on an International Society for Traumatic Stress (ISTSS)

briefing paper (Kaminer et al., 2023), we describe the treatment gap facing adults who are experiencing symptoms related to trauma exposure in LMICs, identify the obstacles that drive this gap, and highlight strategies that show promise for enhancing access to effective treatment for this population. We then offer recommendations for policymakers, researchers, and service providers to guide an agenda for action going forward.

## CURRENT ACCESS TO TREATMENT IN LMICs

A growing evidence base supports the effectiveness of psychological interventions to address trauma-related mental health difficulties in lower-resource settings (Morina et al., 2017; Singla et al., 2017). Despite this, treatment access in LMICs lags far behind in comparison to high-income countries (HICs). Although there is some variation across different countries, overall, only 20% of adults living with PTSD in LMICs have had contact with a mental health specialist or general medical provider in the past year compared with 51% in HICs (Stein et al., 2023). Even when considering a broader range of treatment providers (e.g., counselors, spiritual advisors, herbalists, acupuncturists, other healing professionals), treatment access in LMICs is still significantly lower than in HICs for both lifetime (14% vs. 47%) and 12-month PTSD (25% vs. 59%; Thornicroft et al., 2018). Although more severe PTSD symptoms are associated with better treatment access in HICs, this is not the case in LMICs, where even trauma survivors living with severe symptoms often do not receive any form of treatment.

Access to quality evidence-informed interventions is even more scarce. In LMICs, only 5% of adults with PTSD who have had contact with a specialist or general medical provider receive adequate psychotherapy, and only 18% receive any form of effective treatment; in contrast, these figures are 21% and 41%, respectively, in HICs (Stein et al., 2023). Increasing treatment access without improving the quality of available treatments will do little to address the burden of traumatic stress in lower-resource countries. There is limited data on treatment access for trauma survivors with mental health difficulties other than PTSD, but there are likely unmet treatment needs among these survivors as well. Given the extent of the treatment gap for trauma-related mental health concerns, there is an urgent need to identify and address barriers to accessing quality evidence-based trauma treatments in LMIC contexts.

## TREATMENT BARRIERS IN LMICs

According to data from 22 countries in the WHO's World Mental Health Surveys, common treatment barriers for trauma survivors with PTSD include a low perceived need for treatment (e.g., individuals do not think they need help or believe their symptoms are not sufficiently distressing to warrant treatment), a range of other attitudinal barriers (e.g., a belief that the problem will get better on its own, preference to handle the problem by one's self, a lack of confidence in the effectiveness of treatment, concern regarding stigma), and structural barriers related to treatment resources (e.g., the unavailability of mental health specialists and nearby services, a lack of transport to attend distant services, treatment cost) (Thornicroft et al., 2018). In low-income and lower-middle-income countries, the most commonly reported treatment barrier across all levels of PTSD severity is a low perceived need for treatment (i.e., 58% of respondents with severe PTSD and 76% of those with mild/moderate PTSD), followed by other attitudinal barriers (39% and 22%, respectively) and, finally, structural barriers (26% and 8%, respectively). It is notable that even in the most resource-constrained regions of the world, individuals with PTSD more commonly report treatment barriers linked to perceptions and attitudes than structural factors. A crucial first step toward increasing treatment uptake and access for trauma-affected individuals in LMICs is, therefore, improving public awareness and mental health literacy regarding the impact of trauma and addressing stigmatized attitudes about seeking help for trauma-related mental health difficulties.

The second step toward improving access to evidence-based trauma interventions in LMICs is to remove structural treatment barriers to allow trauma survivors to act upon new understandings of their symptoms and find help. Having any form of health insurance is an important predictor of treatment access for adults with PTSD in LMICs (Stein et al., 2023). Although a variety of health insurance schemes have been implemented in LMICs in recent years (Osei Afriyie et al., 2022), two thirds of low-income countries do not include mental health as part of national health insurance (WHO, 2022). Addressing this exclusion is an important step toward closing the treatment gap in LMICs. However, increasing mental health coverage for trauma survivors in lower-resource contexts is not a matter of improved health insurance alone but rather also requires innovative methods of service delivery that can enhance access to acceptable, affordable, and effective trauma treatment.

## IMPROVING ACCESS TO EVIDENCE-BASED TRAUMA INTERVENTIONS IN LMICs

Although empirical evidence supports several interventions for adult PTSD (Bisson et al., 2020), these treatment protocols were largely developed and evaluated in HICs (Singla et al., 2017). However, there is now a growing evidence base demonstrating that these interventions can be effectively adapted for LMICs using a combination of strategies to reduce attitudinal treatment barriers and circumvent structural constraints.

### Task-sharing

Lower-resource countries often have as few as two mental health specialists per 100,000 residents compared with more than 70 specialists per 100,000 people in HICs (WHO, 2017). Training and supervising nonspecialist providers to deliver basic mental health tasks can substantially improve access to, and the dissemination of, mental health treatment (Patel, 2009; WHO, 2022). Within this task-sharing approach, nonspecialist providers can include community health workers selected specifically to deliver only these services or existing primary health care staff, such as nurses (Mutamba & Kumar, 2022).

Task-sharing initiatives have the potential to increase the size of the mental health workforce in LMICs, especially in underserved rural areas, thereby helping to reduce structural barriers to treatment (Hoeft et al., 2018). In addition, enabling trauma-affected individuals to access support from culturally accepted community members rather than specialists in medical settings that tend to be associated with severe mental illness, can help reduce perceived stigma connected to help-seeking (Bolton, 2019). Nonspecialist providers who are cultural insiders can also play a role in psychoeducation initiatives aimed at addressing a low perceived need for treatment and increasing intervention awareness and acceptability within local communities (Kane et al., 2015).

Emerging evidence from randomized controlled trials supports the use of task-shared interventions for trauma survivors in LMICs. For example, among survivors of sexual violence in the Democratic Republic of Congo (DRC), an adaptation of cognitive processing therapy (CPT; Resick et al., 2017) delivered by community health workers was found to be effective in reducing PTSD, combined depression and anxiety symptoms, and functional impairment at posttreatment and 6-month follow-up (Bass et al., 2013). Among survivors of systematic violence in rural areas of Kurdistan, behavioral activation treatment for depression (BATD; Lejuez et al., 2011) was shown to have significant

effects on depression and dysfunction, whereas CPT significantly reduced dysfunction (Bolton, Bass, et al., 2014). In the DRC, an adaptation of narrative exposure therapy (NET; Schauer et al., 2011) delivered to female former child soldiers by community-based lay counselors was effective in treating PTSD, aggression, and depression (Robjant et al., 2019).

There are, however, several challenges to disseminating task-shared trauma interventions at scale in LMICs. For example, staff in primary health care settings already have onerous workloads, and there is high turnover among community health workers due to a lack of accreditation, job security, and adequate pay (Bolton, 2019). In addition, nonspecialist providers need adequate training and supervision to ensure they deliver interventions with adequate skill and fidelity (Petersen et al., 2014). It is not yet clear how the effectiveness of trauma interventions delivered by nonspecialists compares with that of interventions delivered by mental health specialists. Research that directly compares the outcomes of trauma interventions delivered by different cadres of providers in LMICs can inform decisions about the amount and type of support needed to bring nonspecialist providers to optimal competence. Developing local trainers and supervisors can ensure there is a sustainable capacity to grow new cadres of nonspecialist providers in LMICs going forward (Murray et al., 2011). However, in-person supervision by a trained expert still represents a bottleneck in scaling the implementation of interventions due to a shortage of skilled providers in LMICs and sustainability challenges once research funding for projects discontinues (Fairburn & Patel, 2017). Newer models for scaling supervision, such as training nonspecialist providers to peer-deliver supervision through measurement-based models with user-friendly digital platforms, represent an innovative approach to tackle this bottleneck (Singla et al., 2020).

Moving forward, researchers need to focus on evaluating feasible models of scaling up task-shared trauma interventions in routine health and community settings to meaningfully increase the number of people with trauma-related difficulties who can access treatment (Bolton, 2019). Implementation science offers valuable theories and methods to enhance the uptake of task-shared mental health treatments in health and community settings in LMICs (Bauer & Kirschner, 2020; Le et al., 2022) given the contextual needs and conditions (Nilsen & Bernhardsson, 2019).

### Cultural adaptation

Understanding what constitutes trauma, the presentation of posttraumatic reactions, the definition of what

constitutes “abnormal” reactions, and norms about help-seeking all vary immensely across cultural settings (Chentsova-Dutton & Maercker, 2019; Kohrt & Hruschka, 2010). Strategies to improve access to treatment for trauma-related mental health difficulties in LMICs should, therefore, be framed by cultural considerations.

First, culturally appropriate strategies are critical to addressing attitudinal treatment barriers (Na et al., 2016). For example, “low perceived need for treatment” needs to be carefully unpacked in each LMIC, as such perceptions may differ across cultural—and even regional—contexts (Lewis-Fernández & Kirmayer, 2019; Thornicroft et al., 2018). Similarly, the content of stigmatized beliefs and attitudes may have specific local nuances. For example, in postconflict Northern Uganda, ex-combatants with PTSD commonly experience stigmatization due to their previous association with a rebel group (Schneider et al., 2018), whereas stigma and shame associated with sexual trauma are common among women presenting for HIV treatment in South Africa (Watt et al., 2017). Qualitative research that explores trauma survivors’ insider knowledge of barriers to help-seeking in local settings can illuminate such cultural and contextual complexities (Byrow et al., 2020). Findings can then inform the content of public awareness programs to address attitudinal treatment barriers. In addition, social contact strategies, whereby individuals with lived experience of traumatic stress share their experiences with others in their community, have been shown to be an effective and culturally grounded strategy for reducing stigma (Thornicroft et al., 2016; WHO, 2022).

Second, culturally congruent assessment tools are necessary for early and accurate detection of trauma survivors who need treatment referral. Although the use of psychiatric categories outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association, 2022) and *International Statistical Classification of Diseases and Related Health Problems* (11th rev.; *ICD-11*; WHO, 2019) and assessment methods based on these categories have a role to play in LMICs, these could fail to detect culturally based trauma responses, resulting in lost opportunities for treatment (Michalopoulos et al., 2020). The Cambodian Somatic Symptom and Syndrome Inventory (Hinton et al., 2013) and the Egyptian Somatic Symptom and Syndrome Inventory (Jalal et al., 2017) are examples of culturally congruent measures of traumatic stress that can enhance the accurate detection of individuals who need intervention.

Third, cultural adaptations of mental health interventions can enhance treatment acceptability (Padmanathan & De Silva, 2013) and effectiveness (Hall et al., 2016; Smith et al., 2020). These benefits have also been reported for culturally adapted trauma interventions in LMIC settings (Brunnet et al., 2021; Kaysen et al., 2013). For example,

Jalal et al. (2017) developed culturally adapted cognitive behavior therapy for the Egyptian population, incorporating Islamic beliefs and rituals to overcome stigmatizing attitudes and enhance willingness to engage in treatment. Where available, culturally congruent assessment tools should be incorporated as outcome measures when evaluating the effectiveness of culturally adapted interventions for traumatic stress in LMICs.

Finally, cultural considerations can inform the identification of suitable nonspecialist providers within a task-sharing approach. For example, in Zimbabwe, the Friendship Bench project trains grandmothers to deliver evidence-based skills to reduce depression (Chibanda et al., 2015). The research team gathered information systematically in the early stages by using theory-of-change mapping with key local stakeholders. Consequently, this program is a standout model that leverages high-status social resources (i.e., elders) in local communities and partnership communities. Similar approaches could be adopted to identify suitable nonspecialist providers for trauma interventions in specific LMIC settings.

Despite the demonstrated benefits of cultural adaptation, a recent review found a striking gap in studies that systematically document cultural adaptation processes in the development of PTSD interventions (Ennis et al., 2020). There are few studies that go beyond surface-level adaptations (e.g., changes to language and terminology only) to report substantive, deep-level cultural adaptations to the content and delivery of interventions (e.g., modifying explanations to fit with cultural values, adding sessions/techniques, increasing therapist self-disclosure for greater trust) while still preserving the core treatment elements. In addition, none of the reviewed studies included co-design with people with lived experiences of traumatic events and/or distress related to these events. This represents a missed opportunity to enhance treatment engagement and effectiveness.

## Digital interventions

Although there is still a digital divide between HICs and LMICs, the use of mobile phones and smartphone applications (i.e., apps) is rapidly increasing in LMICs and can be leveraged to augment mental health services in several ways (Merchant et al., 2020; WHO, 2022). First, digital technology can be harnessed to address attitudinal treatment barriers. For example, public antistigma campaigns can be delivered on social media to increase reach and impact at the population level (Naslund & Deng, 2021). The effectiveness of such large-scale digital messaging in addressing trauma-related stigma in LMICs should be evaluated. On a more targeted scale, an online intervention

using social contact, psychoeducation, and cognitive reappraisal of negative mental health beliefs was found to reduce self-stigma and increase help-seeking behaviors in a sample of refugee men in Australia (Nickerson et al., 2020). This suggests that similar digital strategies may be effective when directed at specific groups of trauma survivors living in LMIC settings (e.g., women accessing services for gender-based violence, survivors of natural disasters). The anonymity and asynchronicity of many web-based mental health interventions may also help bypass the stigma associated with accessing traditional in-person mental health care and provide a more acceptable modality for treatment engagement (Naslund & Deng, 2021).

Beyond addressing attitudinal treatment barriers, digital interventions can play a significant role in addressing structural challenges. For example, nonspecialist providers in remote or rural areas can be trained and supervised using digital technologies, increasing treatment access for trauma survivors who live far from formal mental health services (Naslund et al., 2019). Moreover, digital mental health interventions may be far less costly to disseminate at scale than traditional in-person treatment and, even when data costs are considered, less costly to access for individuals without health insurance (Muñoz, 2022).

Digital interventions for traumatic stress within LMIC settings are only beginning to be evaluated, but early findings are promising. In Egypt, a culturally adapted, online version of PTSD Coach (Possemato et al., 2016) was found to reduce the stigma of treatment-seeking (Ellis et al., 2022) and demonstrated reductions in PTSD symptoms at 3-month follow-up, although the effects were small in magnitude (Miller-Graff et al., 2021). A counselor-supported version of the PTSD Coach mobile app was found to have a high level of acceptability and was effective in reducing PTSD and stress symptoms in a South African sample (Bröcker et al., 2024). Although these preliminary studies are encouraging, building on this limited evidence base should be an important focus of future research. Including individuals with lived experience of traumatic stress in the development and design of digital interventions for specific LMIC settings can enhance both treatment acceptability and effectiveness (Ellis & Miller-Graff, 2021).

## FLEXIBLE, MULTIPROBLEM APPROACHES

As discussed, there is evidence that treatments targeting PTSD symptoms can be effective in LMIC contexts. However, many trauma survivors in LMICs present with a broad array of comorbid disorders or distress symptoms beyond PTSD, including depression (Hoppen & Morina, 2019) and substance use disorders (Kaysen

et al., 2023). Such survivors may struggle to engage in and complete trauma-focused treatment when comorbid difficulties are not addressed (Gutner & Pressau, 2019). Other survivors have subclinical symptoms that do not meet the threshold for PTSD treatment but may still cause distress and impair functioning (McLaughlin et al., 2015). Consequently, transdiagnostic interventions that target multiple outcomes across a spectrum of severity may offer added efficiency and effectiveness to mental health service provision (Gutner et al., 2016).

There is growing evidence that transdiagnostic approaches are effective in trauma-affected populations in LMICs. For example, the “common elements treatment approach” (CETA; Murray et al., 2014), which combines evidence-based treatment components in a flexible manner, has been found to lead to significant reductions in multiple mental health outcomes in trauma-exposed LMIC populations when delivered by community health workers (Bolton, Lee, et al., 2014; Bonilla-Escobar et al., 2018; Weiss et al., 2015). Problem Management Plus (PM+; Dawson et al., 2015) and Self-Help Plus (SH+; Karyotaki et al., 2021), developed by the WHO as transdiagnostic, scalable mental health interventions that can be delivered by nonspecialist providers, have both been found to effectively address a range of outcomes, including distress, depression, anxiety, and PTSD symptoms, in individuals living in LMIC contexts that include conflict, violence, and adversity (Bryant et al., 2017; Karyotaki et al., 2023; Rahman et al., 2016; Schäfer et al., 2023).

Addressing a range of mental health difficulties within a single intervention can save time in busy, underresourced public health settings and reduce the likelihood of repeat visits for untreated comorbidities. In addition, transdiagnostic approaches allow for the simplified, cost-efficient training of nonspecialist providers compared with developing competencies in several diagnosis-specific protocols; offer flexibility in treatment delivery; and can be readily adapted across contexts (Gutner & Pressau, 2019). Transdiagnostic approaches, therefore, have the potential for greater reach and sustainability in contexts with limited financial and human resources for the delivery of trauma interventions.

Some transdiagnostic interventions also aim to reduce the risk for other public health issues that commonly affect trauma-exposed populations in LMICs. For example, NETfacts (Robjant et al., 2022), an adaptation of NET, was found to reduce mental health symptoms, violence perpetration, and stigma towards sexual violence in the DRC. CETA has been found to reduce interpersonal partner violence among Zambian adults living with HIV (Murray et al., 2020), and its effectiveness in improving HIV treatment outcomes is currently being trialed with women experiencing intimate partner violence in

South Africa (Pascoe et al., 2022). By addressing a multiplicity of outcomes within a single, brief intervention, treatment access for trauma survivors with comorbid mental and behavioral health difficulties can be scaled up considerably within lower-resource settings. Although multiproblem approaches show promise in LMICs, further research is needed to evaluate their effectiveness compared to diagnosis-specific treatments and assess their long-term sustainability, particularly when delivered by nonspecialist providers (Guttner & Pressau, 2019).

## RECOMMENDATIONS

The scale of untreated mental health needs among adult trauma survivors in LMICs and the economic burden that this poses to already resource-constrained settings necessitate urgent collaborative action from policymakers, researchers, and service providers. Based on the evidence reviewed in this paper, we offer the following recommendations.

### Public health and policy

1. In LMICs that currently have or are planning to implement national health insurance schemes, treatment coverage for PTSD and other trauma-related disorders should be included.
2. Mental health literacy and stigma reduction programs should be implemented to address attitudinal barriers to seeking help for traumatic stress. These programs should be tailored to address context-specific attitudes, beliefs, and norms that hinder help-seeking, drawing on research with local populations of trauma survivors. Individuals with lived experience of traumatic stress should be involved in the delivery of these programs using social contact strategies.
3. LMICs should invest in the development of a cadre of adequately compensated community health workers to provide psychoeducation programs and trauma interventions. This can substantially reduce the treatment gap, especially in rural and remote areas. Capacitating community health workers to engage in peer-delivered supervision using digital platforms can ensure the ongoing growth of this mental health workforce. In the long term, this investment will be offset by a reduction in the economic and health burden posed by traumatic stress in LMICs.
4. Funding agencies should include task-shared, culture-specific trauma interventions as a priority for health and programming budgeting. Targeted programming efforts should be developed for marginalized and vul-

nerable groups in LMICs that are at higher risk of trauma exposure and/or traumatic stress (e.g., persecuted religious minorities, people living with HIV/AIDS, survivors of intimate partner violence).

## Researchers

1. Research on improving access to evidence-based trauma interventions in LMICs should be led or co-led by researchers in LMICs to ensure contextually and culturally relevant research approaches and findings.
2. Treatment barriers in specific LMIC contexts should be explored using qualitative research approaches that can capture the nuance and complexity of local experiences. These can then inform large-scale quantitative studies documenting the prevalence and correlates of contextually relevant treatment barriers.
3. There is a need for the development of evidence-based screening and detection tools that include culturally congruent expressions of trauma-related distress alongside more universal aspects of traumatic stress, such as PTSD.
4. Head-to-head comparisons between trauma interventions delivered by specialist versus nonspecialist providers in LMIC settings should be conducted to inform decisions about the amount of training and supervision needed to bring nonspecialist providers up to optimal competence.
5. Research in LMICs should extend beyond evaluating the effectiveness of task-shared trauma interventions at the level of clinical trials to focus on implementation processes for disseminating these interventions in community settings and existing health systems.
6. Cultural adaptations of evidence-based trauma interventions should be developed and evaluated in specific LMIC settings, with the involvement of local experts and community navigators. Adaptations should include both surface-level (e.g., language) and deep-level components (e.g., modifying explanations to fit with cultural values, or integrating local religious or cultural rituals). Involving people with lived experience of trauma and/or traumatic stress is crucial in all stages of intervention development, including piloting phases, wherein their feedback can be actioned for greater acceptability by the target beneficiaries.
7. Culturally congruent outcome measures should be used alongside measures of *DSM*- or *ICD*-based trauma-related mental disorders to evaluate the effectiveness of culturally adapted evidence-based trauma interventions in LMICs.
8. Additional research in LMIC settings is needed to evaluate the feasibility and effectiveness of digital

platforms for the (a) training of nonspecialist providers, (b) delivery of large-scale psychoeducation and anti-stigma programs, and (c) dissemination of trauma intervention programs. Given connectivity and data constraints in many LMICs, research should focus on developing and evaluating digital strategies that have low requirements for internet connectivity and mobile data usage. For example, the PTSD Coach mobile app requires no postdownload data usage.

9. Researchers should compare the feasibility and effectiveness of PTSD-focused interventions versus multiproblem transdiagnostic interventions for different populations of trauma survivors in LMICs to establish what works best for whom.

## Trauma practitioners and service providers in LMICs

1. When delivering mental health interventions to trauma survivors in LMICs, culturally congruent, evidence-based assessment tools should be used to inform treatment decisions and monitor treatment progress. Validated trauma symptom measures that include key local idioms related to distress and measure treatment targets deemed important to the local population should be used where available.
2. There are evidence-based diagnosis-specific and multiproblem interventions for traumatic stress in LMICs. When selecting among these interventions, those that have been culturally adapted for the specific LMIC settings in which practitioners are based are likely to be most acceptable and effective for recipients.

## CONCLUSION

In LMICs, critically low access to trauma interventions for adults is the result of a range of demand- and supply-side barriers at different stages in the help-seeking process. However, there is promising empirical evidence that task-sharing, cultural adaptation, digital interventions, and flexible, multiproblem approaches can contribute to addressing these barriers. None of these is a standalone solution, but they are well-suited to working in tandem to synergistically increase quality treatment access in lower-resource contexts. Moving forward, it is important to build on the existing evidence base, identifying both strategies that can be applied across LMICs and those that are relevant to specific local contexts. Moreover, addressing challenges to implementation will be vital for increasing the

population reach of evidence-based trauma interventions. We have offered recommendations for action that policy-makers, researchers, and trauma service providers can take as they work together toward closing the treatment gap for adult trauma survivors in LMICs.

## ACKNOWLEDGEMENT

The authors gratefully acknowledge valuable input from Rachel Hiller, Debra Kaysen, Diane Borbon, Judith Bass, Jamie Gradus, Angela Nickerson, Elena Newman, and Kathryn Magruder of the ISTSS Public Health and Policy Committee.

## AUTHOR NOTE

This manuscript is based on the following International Society for Traumatic Stress Studies (ISTSS) briefing paper: Kaminer, D., Booyesen, D. D., Kristensen, C. H., Ellis, K., Patel, A. R., Robjant, K., & Sardana, S. (2023). *Improving access to evidence-based interventions for trauma-exposed adults in low- and middle-income countries: An International Society for Traumatic Stress Studies (ISTSS) briefing paper*. <https://istss.org/public-resources/istss-briefing-papers/briefing-paper-improving-access-lmics>

## ORCID

Debra Kaminer  <https://orcid.org/0000-0002-6097-6211>

Kate Ellis  <https://orcid.org/0000-0002-4228-8263>

## REFERENCES

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
- Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., Wachter, K., Murray, L. K., & Bolton, P. A. (2013). Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine*, 368(23), 2182–2191. <https://doi.org/10.1056/NEJMoa1211853>
- Bauer, M. S., & Kirchner, J. A. (2020). Implementation science: What is it and why should I care? *Psychiatry Research*, 283, Article 112376. <https://doi.org/10.1016/j.psychres.2019.04.025>
- Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., ... Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine*, 46(2), 327–43. <https://doi.org/10.1017/S0033291715001981>
- Bisson, J. I., Berliner, L., Cloitre, M., Forbes, D., Jensen, T., Lewis, C., Monson, C. M., Olf, M., Pilling, S., Riggs, D. S., Roberts, N. P., & Shapiro, F. (2020). ISTSS PTSD prevention and treatment guidelines: Recommendations. In D. Forbes, J. I. Bisson, C. M. Monson, & L. Berliner (Eds.), *Effective treatments for PTSD. Practice guidelines from the International Society for Traumatic Stress Studies* (3rd ed., pp. 109–114). Guilford Press.

- Bolton, P. (2019). Global mental health and psychotherapy: Importance of task-shifting and a systematic approach to adaptation. In D. J. Stein, J. K. Bass, & Stefan, G. (Eds.) *Global mental health and psychotherapy* (pp. 11–24). Academic Press.
- Bolton, P., Bass, J. K., Zangana, G. A., Kamal, T., Murray, S. M., Kaysen, D., Lejuez, C. W., Lindgren, K., Pagoto, S., Murray, L. K., Van Wyk, S. S., Ahmed, A. M., Amin, N. M., & Rosenblum, M. (2014). A randomized controlled trial of mental health interventions for survivors of systematic violence in Kurdistan, Northern Iraq. *BMC Psychiatry*, *14*, 360. <https://doi.org/10.1186/s12888-014-0360-2>
- Bolton, P., Lee, C., Haroz, E. E., Murray, L., Dorsey, S., Robinson, C., Ugueto, A. M., & Bass, J. (2014). A transdiagnostic community-based mental health treatment for comorbid disorders: Development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. *PLoS Medicine*, *11*(11), Article e1001757. <https://doi.org/10.1371/journal.pmed.1001757>
- Bonilla-Escobar, F. J., Fandiño-Losada, A., Martínez-Buitrago, D. M., Santaella-Tenorio, J., Tobón-García, D., Muñoz-Morales, E. J., Escobar-Roldán, I. D., Babcock, L., Duarte-Davidson, E., Bass, J. K., Murray, L. K., Dorsey, S., Gutierrez-Martinez, M. I., & Bolton, P. (2018). A randomized controlled trial of a transdiagnostic cognitive-behavioral intervention for Afro-descendants' survivors of systemic violence in Colombia. *PLoS One*, *13*(12), Article e0208483. <https://doi.org/10.1371/journal.pone.0208483>
- Bröcker, E., Olf, M., Suliman, S., Kidd, M., Greyvenstein, L., & Seedat, S. (2024). A counsellor-supported 'PTSD Coach' intervention versus enhanced treatment-as-usual in a resource-constrained setting: A randomised controlled trial. *Cambridge Prisms: Global Mental Health*, *11*, Article e7. <https://doi.org/10.1017/gmh.2023.92>
- Brunnet, A. E., Bolaséll, L. T., Bujak, M. K., Rigoli, M. M., & Kristensen, C. H. (2021). Protocolos de terapia cognitivo-comportamental culturalmente adaptados para tratamento de TEPT: Uma revisão sistemática da literatura [Cognitive-behavioral therapy protocols culturally adapted for PTSD Treatment: A systematic review of the literature]. *Geraios: Revista Interinstitucional de Psicologia*, *14*(1), 1–19. <https://doi.org/10.36298/geraios202114e15516>
- Bryant, R. A., Schafer, A., Dawson, K. S., Anjuri, D., Mulili, C., Ndogoni, L., Koyiet, P., Sijbrandij, M., Ulate, J., Harper Shehadeh, M., Hadzi-Pavlovic, D., & van Ommeren, M. (2017). Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial. *PLoS Medicine*, *14*(8), Article e1002371. <https://doi.org/10.1371/journal.pmed.1002371>
- Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, Article 101812. <https://doi.org/10.1016/j.cpr.2019.101812>
- Chentsova-Dutton, Y., & Maercker, A. (2019). Cultural scripts of traumatic stress: Outline, illustrations, and research opportunities. *Frontiers in Psychology*, *10*, Article 2528. <https://doi.org/10.3389/fpsyg.2019.02528>
- Chibanda, D., Bowers, T., Verhey, R., Rusakaniko, S., Abas, M., Weiss, H. A., & Araya, R. (2015). The Friendship Bench programme: A cluster randomised controlled trial of a brief psychological intervention for common mental disorders delivered by lay health workers in Zimbabwe. *International Journal of Mental Health Systems*, *9*, 21. <https://doi.org/10.1186/s13033-015-0013-y>
- Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., & Saxena, S. (2016). Scaling-up treatment of depression and anxiety: A global return on investment analysis. *The Lancet Psychiatry*, *3*(5), 415–424. [http://doi.org/10.1016/S2215-0366\(16\)30024-4](http://doi.org/10.1016/S2215-0366(16)30024-4)
- Dawson, K. S., Bryant, R. A., Harper, M., Kuowei Tay, A., Rahman, A., Schafer, A., & van Ommeren, M. (2015). Problem Management Plus (PM+): A WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry*, *14*(3), 354–357. <https://doi.org/10.1002/wps.20255>
- Ellis, K., & Miller-Graff, L. E. (2021). Lessons learned in adapting an online intervention program for posttraumatic stress for use in Egypt. *Transcultural Psychiatry*, *58*(1), 63–75. <https://doi.org/10.1177/1363461520970748>
- Ellis, K., Miller-Graff, L. E., & Hosny, N. (2022). User experiences of a culturally adapted web-based intervention for post-traumatic stress disorder in Egypt: A qualitative study. *Psychotherapy*, *59*(1), 13–25. <https://doi.org/10.1037/psr0000429>
- Ennis, N., Shorer, S., Shoval-Zuckerman, Y., Freedman, S., Monson, C. M., & Dekel, R. (2020). Treating posttraumatic stress disorder across cultures: A systematic review of cultural adaptations of trauma-focused cognitive behavioral therapies. *Journal of Clinical Psychology*, *76*(4), 587–611. <https://doi.org/10.1002/jclp.22909>
- Fairburn, C. G., & Patel, V. (2017). The impact of digital technology on psychological treatments and their dissemination. *Behaviour Research and Therapy*, *88*, 19–25. <https://doi.org/10.1016/j.brat.2016.08.012>
- Gutner, C. A., Galovski, T., Bovin, M. J., & Schnurr, P. P. (2016). Emergence of transdiagnostic treatments for PTSD and posttraumatic distress. *Current Psychiatry Reports*, *18*(10), 95. <https://doi.org/10.1007/s11920-016-0734-x>
- Gutner, C. A., & Pesseau, C. (2019). Dealing with complexity and comorbidity: Opportunity for transdiagnostic treatment for PTSD. *Current Treatment Options in Psychiatry*, *6*(2), 119–131. <https://doi.org/10.1007/s40501-019-00170-2>
- Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993–1014. <https://doi.org/10.1016/j.beth.2016.09.005>
- Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E., & Hofmann, S. G. (2013). The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI). *Transcultural Psychiatry*, *50*(3), 347–370. <https://doi.org/10.1177/1363461513481187>
- Hoelt, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2018). Task-sharing approaches to improve mental health care in rural and other low-resource settings: A systematic review. *The Journal of Rural Health*, *34*(1), 48–62. <https://doi.org/10.1111/jrh.12229>
- Hoppen, T. H., & Morina, N. (2019). The prevalence of PTSD and major depression in the global population of adult war survivors: A meta-analytically informed estimate in absolute numbers. *European Journal of Psychotraumatology*, *10*(1), Article 1578637. <https://doi.org/10.1080/20008198.2019.1578637>
- Jalal, B., Samir, S. W., & Hinton, D. E. (2017). Adaptation of CBT for traumatized Egyptians: Examples from culturally adapted CBT



- (CA-CBT). *Cognitive and Behavioral Practice*, 24(1), 58–71. <https://doi.org/10.1016/j.cbpra.2016.03.001>
- Kaminer, D., Booysen, D. D., Kristensen, C. H., Ellis, K., Patel, A. R., Robjant, K., & Sardana, S. (2023). *Improving access to evidence-based interventions for trauma-exposed adults in low- and middle-income countries: An International Society for Traumatic Stress Studies (ISTSS) briefing paper*. <https://istss.org/public-resources/istss-briefing-papers/briefing-paper-improving-access-lmics>
- Kane, J. C., Adaku, A., Nakku, J., Odokonyero, R., Okello, J., Musisi, S., Augustinavicius, J., Greene, M. C., Alderman, S., & Tol, W. A. (2015). Challenges for the implementation of World Health Organization guidelines for acute stress, PTSD, and bereavement: A qualitative study in Uganda. *Implementation Science*, 11(1), 1–15. <https://doi.org/10.1186/s13012-016-0400-z>
- Karyotaki, E., Sijbrandij, M., Purgato, M., Acarturk, C., Lakin, D., Bailey, D., Peckham, E., Uygun, E., Tedeschi, F., Wancata, J., Augustinavicius, J., Carswell, K., Välimäki, M., van Ommeren, M., Koesters, M., Popa, M., Leku, M. R., Anttila, M., Churchill, R., ... Barbui, C. (2021). Self-help plus for refugees and asylum seekers: Study protocol for a series of individual participant data meta-analyses. *European Journal of Psychotraumatology*, 12(1), Article 1930690. <https://doi.org/10.1080/20008198.2021.1930690>
- Karyotaki, E., Sijbrandij, M., Purgato, M., Acarturk, C., Lakin, D., Bailey, D., Peckham, E., Uygun, E., Tedeschi, F., Wancata, J., Augustinavicius, J., Carswell, K., Välimäki, M., van Ommeren, M., Koesters, M., Popa, M., Leku, M. R., Anttila, M., Churchill, R., ... Barbui, C. (2023). Self-Help Plus for refugees and asylum seekers: An individual participant data meta-analysis. *BMJ Mental Health*, 26(1), Article e300672. <https://doi.org/10.1136/bmjment-2023-300672>
- Kaysen, D., Lindgren, K., Zangana, G. A. S., Murray, L., Bass, J., & Bolton, P. (2013). Adaptation of cognitive processing therapy for treatment of torture victims: Experience in Kurdistan, Iraq. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(2), 184–192. <https://doi.org/10.1037/a0026053>
- Kaysen, D. L., van Stolk-Cooke, K., Kaminer, D., Greene, M. C., López-Castro, T., & Kane, J. C. (2023). Comorbid posttraumatic stress disorder and alcohol use disorder in low- and middle-income countries: A narrative review. *Cambridge Prisms: Global Mental Health*, 10, Article e5. <https://doi.org/10.1017/gmh.2022.63>
- Kohrt, B. A., & Hruschka, D. J. (2010). Nepali concepts of psychological trauma: The role of idioms of distress, ethnopsychology, and ethnophysiology in alleviating suffering and preventing stigma. *Culture, Medicine, and Psychiatry*, 34(2), 322–352. <https://doi.org/10.1007/s11013-010-9170-2>
- Le, P. D., Eschliman, E. L., Grivel, M. M., Tang, J., Cho, Y. G., Yang, X., Tay, C., Li, T., Bass, J., & Yang, L. H. (2022). Barriers and facilitators to implementation of evidence-based task-sharing mental health interventions in low-and middle-income countries: A systematic review using implementation science frameworks. *Implementation Science*, 17(1), 1–25. <https://doi.org/10.1186/s13012-021-01179-z>
- Lejuez, C. W., Hopko, D. R., Acierno, R., Daughters, S. B., & Pagoto, S. L. (2011). Ten-year revision of the brief behavioral activation treatment for depression: Revised treatment manual. *Behavior Modification*, 35(2), 111–161. <https://doi.org/10.1177/0145445510390929>
- Lewis-Fernández, R., & Kirmayer, L. J. (2019). Cultural concepts of distress and psychiatric disorders: Understanding symptom experience and expression in context. *Transcultural Psychiatry*, 56(4), 786–803. <https://doi.org/10.1177/1363461519861795>
- Lim, I. C. Z., Tam, W. W., Chudzicka-Czupala, A., McIntyre, R. S., Teopiz, K. M., Ho, R. C., & Ho, C. S. (2022). Prevalence of depression, anxiety and post-traumatic stress in war-and conflict-afflicted areas: A meta-analysis. *Frontiers in Psychiatry*, 13, Article 978703. <https://doi.org/10.3389/fpsy.2022.978703>
- Mathers, C. D., Lopez, A. D., & Murray, C. J. L. (2006) The burden of disease and mortality by condition: Data, methods, and results for 2001. In A. D. Lopez, C. D. Mathers, M. Ezzati, D. T. Jamison, & C. J. L. Murray (Eds.), *Global burden of disease and risk factors* (pp. 45–240). Oxford University Press.
- McLaughlin, K. A., Koenen, K. C., Friedman, M. J., Ruscio, A. M., Karam, E. G., Shahly, V., Stein, D. J., Hill, E. D., Petukhova, M., Alonso, J., Andrade, L. H., Angermeyer, M. C., Borges, G., de Girolamo, G., de Graaf, R., Demyttenaere, K., Florescu, S. E., Mladenova, M., Posada-Villa, J., ... Kessler, R. C. (2015). Subthreshold posttraumatic stress disorder in the World Health Organization world mental health surveys. *Biological Psychiatry*, 77(4), 375–384. <https://doi.org/10.1016/j.biopsych.2014.03.028>
- Merchant, R., Torous, J., Rodriguez-Villa, E., & Naslund, J. A. (2020). Digital technology for management of severe mental disorders in low-and middle-income countries. *Current Opinion in Psychiatry*, 33(5), 501–507. <https://doi.org/10.1097/YCO.0000000000000626>
- Michalopoulos, L. M., Meinhart, M., Yung, J., Barton, S. M., Wang, X., Chakrabarti, U., Ritchey, M., Haroz, E., Joseph, N., Bass, J., & Bolton, P. (2020). Global posttrauma symptoms: A systematic review of qualitative literature. *Trauma, Violence, & Abuse*, 21(2), 406–420. <https://doi.org/10.1177/1524838018772293>
- Miller-Graff, L. E., Ellis, K., & Hosny, N. (2021). PTSD Coach Online-Arabic: A randomized controlled pilot trial to examine feasibility, acceptability, and preliminary effectiveness. *Journal of Traumatic Stress*, 34(1), 23–34. <https://doi.org/10.1002/jts.22621>
- Morina, N., Malek, M., Nickerson, A., & Bryant, R. A. (2017). Meta-analysis of interventions for posttraumatic stress disorder and depression in adult survivors of mass violence in low-and middle-income countries. *Depression and Anxiety*, 34(8), 679–691. <https://doi.org/10.1002/da.22618>
- Muñoz, R. F. (2022). Harnessing psychology and technology to contribute to making health care a universal human right. *Cognitive and Behavioral Practice*, 29(1), 4–14. <https://doi.org/10.1016/j.cbpra.2019.07.003>
- Murray, L. K., Dorsey, S., Bolton, P., Jordans, M. J., Rahman, A., Bass, J., & Verdelli, H. (2011). Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers. *International Journal of Mental Health Systems*, 5, 30. <https://doi.org/10.1186/1752-4458-5-30>
- Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., Weiss, W. M., & Bolton, P. (2014). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice*, 21(2), 111–123. <https://doi.org/10.1016/j.cbpra.2013.06.005>
- Murray, L. K., Kane, J. C., Glass, N., Skavenski van Wyk, S., Melendez, F., Paul, R., Kmett Danielson, C., Murray, S. M., Mayeya, J., Simenda, F., & Bolton, P. (2020). Effectiveness of the common elements treatment approach (CETA) in reducing intimate partner violence and hazardous alcohol use in Zambia (VATU): A randomized controlled trial. *PLoS Medicine*, 17(4) Article e1003056. <https://doi.org/10.1371/journal.pmed.1003056>

- Mutamba, B. B., & Kumar, M. (2022). Comment: Dedicated and designated approaches to task-shared psychological interventions. *The Lancet*, *400*(10360), 1283–1285. [https://doi.org/10.1016/S0140-6736\(22\)01984-5](https://doi.org/10.1016/S0140-6736(22)01984-5)
- Na, S., Ryder, A. G., & Kirmayer, L. J. (2016). Toward a culturally responsive model of mental health literacy: Facilitating help-seeking among East Asian immigrants to North America. *American Journal of Community Psychology*, *58*(1–2), 211–225. <https://doi.org/10.1002/ajcp.12085>
- Naslund, J. A., & Deng, D. (2021). Addressing mental health stigma in low-income and middle-income countries: A new frontier for digital mental health. *Ethics, Medicine, and Public Health*, *19*, Article 100719. <https://doi.org/10.1016/j.jemep.2021.100719>
- Naslund, J. A., Shidhaye, R., & Patel, V. (2019). Digital technology for building capacity of nonspecialist health workers for task-sharing and scaling up mental health care globally. *Harvard Review of Psychiatry*, *27*(3), 181–192. <https://doi.org/10.1097/HRP.0000000000000217>
- Ng, L. C., Stevenson, A., Kalapurakel, S. S., Hanlon, C., Seedat, S., Harerimana, B., Chiliza, B., & Koenen, K. C. (2020). National and regional prevalence of posttraumatic stress disorder in sub-Saharan Africa: A systematic review and meta-analysis. *PLoS Medicine*, *17*(5), Article e1003090. <https://doi.org/10.1371/journal.pmed.1003090>
- 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 post-traumatic stress. *Psychological Medicine*, *50*(5), 781–792. <https://doi.org/10.1017/S0033291719000606>
- Nilsen, P., & Bernhardtsson, S. (2019). Context matters in implementation science: A scoping review of determinant frameworks that describe contextual determinants for implementation outcomes. *BMC Health Services Research*, *19*(1), 1–21. <https://doi.org/10.1186/s12913-019-4015-3>
- Osei Afriyie, D., Krasniq, B., Hooley, B., Tediosi, F., & Fink, G. (2022). Equity in health insurance schemes enrollment in low and middle-income countries: A systematic review and meta-analysis. *International Journal for Equity in Health*, *21*(1), 21. <https://doi.org/10.1186/s12939-021-01608-x>
- Padmanathan, P., & De Silva, M. J. (2013). The acceptability and feasibility of task-sharing for mental healthcare in low- and middle-income countries: A systematic review. *Social Science & Medicine*, *97*, 82–86. <https://doi.org/10.1016/j.socscimed.2013.08.004>
- Pascoe, S., Fox, M., Kane, J., Mngadi, S., Manganye, P., Long, L. C., Metz, K., Allen, T., Sardana, S., Greener, R., Zheng, A., Thea, D. M., & Murray, L. K. (2022). Study protocol: A randomised trial of the effectiveness of the common elements treatment approach (CETA) for improving HIV treatment outcomes among women experiencing intimate partner violence in South Africa. *BMJ Open*, *12*(12), Article e065848. <http://doi.org/10.1136/bmjopen-2022-065848>
- Patel, V. (2009). The future of psychiatry in low- and middle-income countries. *Psychological Medicine*, *39*(11), 1759–1762. <https://doi.org/10.1017/S0033291709005224>
- Petersen, I., Fairall, L., Egbe, C. O., & Bhana, A. (2014). Optimizing lay counsellor services for chronic care in South Africa: A qualitative systematic review. *Patient Education and Counseling*, *95*(2), 201–210. <https://doi.org/10.1016/j.pec.2014.02.001>
- Possemato, K., Kuhn, E., Johnson, E., Hoffman, J. E., Owen, J. E., Kanuri, N., De Stefano, L., & Brooks, E. (2016). Using PTSD Coach in primary care with and without clinician support: A pilot randomized controlled trial. *General Hospital Psychiatry*, *38*, 94–98. <https://doi.org/10.1016/j.genhosppsych.2015.09.005>
- Rahman, A., Hamdani, S. U., Awan, N. R., Bryant, R. A., Dawson, K. S., Khan, M. F., Azeemi, M. M., Akhtar, P., Nazir, H., Chiumento, A., Sijbrandij, M., Wang, D., Farooq, S., & van Ommeren, M. (2016). Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan: A randomized clinical trial. *JAMA*, *316*(24), 2609–2617. <https://doi.org/10.1001/jama.2016.17165>
- Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. Guilford Press.
- Robjant, K., Koebach, A., Schmitt, S., Chibashimba, A., Carleial, S., & Elbert, T. (2019). The treatment of posttraumatic stress symptoms and aggression in female former child soldiers using adapted narrative exposure therapy—a RCT in Eastern Democratic Republic of Congo. *Behaviour Research and Therapy*, *123*, Article 103482. <https://doi.org/10.1016/j.brat.2019.103482>
- Robjant, K., Schmitt, S., Carleial, S., Elbert, T., Abreu, L., Chibashimba, A., Hinkel, H., Hoeffler, A., Rukundo Zeller, A. C., Rockstroh, B., & Koebach, A. (2022). NETfacts: An integrated intervention at the individual and collective level to treat communities affected by organized violence. *Proceedings of the National Academy of Sciences of the United States of America*, *119*(44), Article e2204698119. <https://doi.org/10.1073/pnas.2204698119>
- Schäfer, S. K., Thomas, L. M., Lindner, S., & Lieb, K. (2023). World Health Organization’s low-intensity psychosocial interventions: A systematic review and meta-analysis of the effects of Problem Management Plus and Step-by-Step. *World Psychiatry*, *22*(3), 449–462. <http://doi.org/10.1002/wps.21129>
- Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders*. Hogrefe Publishing.
- Schneider, A., Conrad, D., Pfeiffer, A., Elbert, T., Kolassa, I. T., & Wilker, S. (2018). Stigmatization is associated with increased PTSD risk after traumatic stress and diminished likelihood of spontaneous remission—A study with east-African conflict survivors. *Frontiers in Psychiatry*, *9*, 423. <https://doi.org/10.3389/fpsy.2018.00423>
- Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. *Annual Review of Clinical Psychology*, *13*(1), 149–181. <https://doi.org/10.1146/annurev-clinpsy-032816-045217>
- Singla, D. R., Ratjen, C., Krishna, R. N., Fuhr, D. C., & Patel, V. (2020). Peer supervision for assuring the quality of non-specialist provider delivered psychological intervention: Lessons from a trial for perinatal depression in Goa, India. *Behaviour Research and Therapy*, *130*, Article 103533. <https://doi.org/10.1016/j.brat.2019.103533>
- Smith, J. R., Workneh, A., & Yaya, S. (2020). Barriers and facilitators to help-seeking for individuals with posttraumatic stress disorder: A systematic review. *Journal of Traumatic Stress*, *33*(2), 137–150. <https://doi.org/10.1002/jts.22456>

- Stein, D. J., Kazdin, A. E., Munthali, R. J., Hwang, I., Harris, M. G., Alonso, J., Andrade, L. H., Bruffaerts, R., Cardoso, G., Chardoul, S., de Girolamo, G., Florescu, S., Gureje, O., Haro, J. M., Karam, A. N., Karam, E. G., Kovess-Masfety, V., Lee, S., ... Medina-Mora, M. E. (2023). Determinants of effective treatment coverage for posttraumatic stress disorder: Findings from the World Mental Health Surveys. *BMC Psychiatry*, 23(1), 226. <https://doi.org/10.1186/s12888-023-04605-2>
- Thornicroft, G., Evans-Lacko, S., Koenen, K. C., Kovess-Masfety, V., Williams, D. R., & Kessler, R. C. (2018). Patterns of treatment and barriers to care in posttraumatic stress disorder. In E. J. Bromet, E. G. Karam, K. C. Koenen, & D. J. Stein (Eds.), *Trauma and post-traumatic stress disorder: Global perspectives from the WHO World Mental Health surveys*, pp. 137–152. Cambridge University Press.
- Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, 387(10023), 1123–1132. [https://doi.org/10.1016/S0140-6736\(15\)00298-6](https://doi.org/10.1016/S0140-6736(15)00298-6)
- Watt, M. H., Dennis, A. C., Choi, K. W., Ciya, N., Joska, J. A., Robertson, C., & Sikkema, K. J. (2017). Impact of sexual trauma on HIV care engagement: Perspectives of female patients with trauma histories in Cape Town, South Africa. *AIDS and Behavior*, 21(11), 3209–3218. <https://doi.org/10.1007/s10461-016-1617-1>
- Weiss, W. M., Murray, L. K., Zangana, G. A., Mahmooth, Z., Kaysen, D., Dorsey, S., Lindgren, K., Gross, A., Murray, S. M., Bass, J. K., & Bolton, P. (2015). Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: A randomized control trial. *BMC Psychiatry*, 15, 249. <https://doi.org/10.1186/s12888-015-0622-7>
- World Health Organization. (2017). Mental health atlas. <https://iris.who.int/bitstream/handle/10665/272735/9789241514019-eng.pdf?sequence=1>
- World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). <https://icd.who.int/>
- World Health Organization. (2022). *World mental health report: Transforming mental health for all*. <https://www.who.int/publications/i/item/9789240049338>

**How to cite this article:** Kaminer, D., Booyesen, D., Ellis, K., Kristensen, C. H., Patel, A. R., Robjant, K., & Sardana, S. (2024). Improving access to evidence-based interventions for trauma-exposed adults in low- and middle-income countries. *Journal of Traumatic Stress*, 1–11. <https://doi.org/10.1002/jts.23031>