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The Impacts of TF-CBT for Child and Adolescent Survivors of Sexual Abuse: A Systematic Review

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Abstract

The purpose of this systematic review is to expand on previous literature by examining the treatment impacts of TF-CBT on the specific population of child and adolescent survivors of sexual abuse. The review analyzed peer-reviewed journal articles from the years of 1991-2023. Using the software tool Covidence, 551 studies were initially imported, following thorough review by the first author, the final sample consisted of 16 studies. The results of the review are presented in three categories: studies without comparison groups, studies with comparison groups, and studies analyzing treatment components. All three categories reported significant improvements for outcome measures such as anxiety, depression, PTSD, shame, sexualized behavior, and others. The results indicate that TF-CBT has positive treatment impacts, including improvement in PTSD scores, symptom reduction for anxiety and depression, and behavioral improvement. In addition, TF-CBT was found to be effective for vulnerable populations that have survived CSA. Given the limitations of the studies, further research should be conducted. This systematic review concluded with policy and clinical implications for TF-CBT with survivors of CSA.

Keywords: *child sexual abuse, trauma-focused cognitive behavioral therapy, treatment impacts*

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Child sexual abuse or CSA has long lasting negative impacts on individuals and their families, as well as societies throughout the world. For this review, a broader definition of childhood sexual abuse is used. According to the Centers for Disease Control and Prevention (2022, para. 1), CSA is defined as "the involvement of a child (person less than 18 years old) in sexual activity that violates the laws or social taboos of society and that he/she: does not fully comprehend, does not consent or is unable to give informed consent to, or is not developmentally prepared for and cannot give consent to." To better understand the problem of CSA, the epidemiology, impacts, and theories of the issue itself must be discussed. Following the encapsulation of the problem, examination of an intervention that best relieves its impacts is essential to combating the global problem of child sexual abuse.

Literature Review

The exact number of child sexual abuse incidents is difficult to fully assess, due to variation in reporting. However, findings from 65 studies, conducted in 22 different countries, indicate that around 19.7% of females and 7.9% of males experienced sexual abuse before the age of 18. Prevalence rates were more than one fifth for females in several countries including: 37.8% in Australia, 30.7% in Tanzania, and 25.3% in the U.S. (Pereda et al., 2009). In the U.S., an estimated 59,328 children were reported to be sexually abused in 2021, which increased since the prior year (U.S. Department of Health & Human Services, 2020, 2021). A similar study done in the U.S. took a large national sample and found the prevalence of child sexual abuse to be around 10.14% (Pérez-Fuentes et al., 2013).

The demographics of those that are sexually abused at a young age show that there are populations that are more vulnerable to CSA than others. For instance, females seem to be more likely to face CSA than males (Martin & Silverstone, 2013). Another review found that one out of five females and one out of ten males are affected by CSA on a global scale (Collin-Vézina et al., 2013). Of the 10.14%. individuals experiencing child sexual abuse in the U.S., it is estimated that 24.8% were men and approximately 75.2% were women (Pérez-Fuentes et al., 2013). Youth with physical and intellectual disabilities and members of the LGBT community are also at a higher risk of being sexually abused (Friedman et al., 2011; Horner-Johnson & Drum, 2006). Other risk factors include being in a lower socioeconomic status, "the absence of one or both biological parents, marital conflicts, and/or parental substance abuse" (Haile et al., 2013; Singh et al., 2014, p. 432; Verelst et al., 2014; Wolfe, 2007). Some customs such as child marriages can make children more prone to be victims of child sexual abuse (Krug et al., 2002).

From a study done by Perez-Fuentes et al. (2013), 70% of those that experienced CSA were White, around 13% were Black, around 11% were Hispanic, about 4% were Native American, and about 2% were Asian. However, Black or Native American individuals were more likely to report a history of CSA compared to other demographic groups. Of those that were survivors of child sexual abuse, 13.15% had less than a high school education, 21.41% were high school graduates, and 65.44% went to some college or higher. As for the locations of those sexually abused at a young age (within the U.S.), about 39% were in the South, around 25% were in the West, and about 18% were in the Northeast and Midwest separately (Pérez-Fuentes et al., 2013). Furthermore, those that experienced child sexual abuse were less likely to be male or have completed a high school education. Additional risk factors for CSA found in the study were low

levels of perceived familial support, witnessing domestic violence, and experiencing physical abuse, maltreatment, and neglect (Pérez-Fuentes et al., 2013).

Consequences of CSA

The impacts of CSA can be categorized into behavioral, interpersonal, physical, psychological, and social. Engaging in high-risk behaviors is often seen with survivors of child sexual abuse (Pérez-Fuentes et al., 2013). Specifically, the behavioral adverse effects of CSA are poor academic performance, violating laws, violent behaviors, sexualized behaviors, and growing up later to be a perpetrator (Kacker et al., 2007; Krug et al., 2002). In regards to the interpersonal consequences of CSA, communication problems, reduced social competence, lack of trust, and insecure relationships are the main issues that those that were sexually abused during their youth face (Barrett, 2009; Kacker et al., 2007; Mullen & Fleming, n.d.).

Individuals with a history of CSA are more likely than those without a history of CSA to have psychiatric disorders in their lifetime (Pérez-Fuentes et al., 2013). Child sexual abuse is associated with 47% of all childhood psychiatric disorders, and 26-32% of adult-onset disorders (Green et al., 2010). Some of the psychiatric disorders that fall under the psychological effects of CSA include major depressive disorder, specific phobia, bipolar disorder, alcohol use disorder, and drug use disorder. Those that have experienced child sexual abuse have higher rates of suicide attempts when compared to those that have not experienced CSA (Pérez-Fuentes et al., 2013). Further psychological adverse effects of CSA are self-harm, psychosis, eating disorders, borderline personality disorder, and sexual dysfunction in adulthood (Gewirtz-Meydan & Lahav, 2020; Liu, 2019; Menon et al., 2016; Smolak & Murnen, 2002; Varese et al., 2012).

Studies show that the association between child sexual abuse and psychiatric disorders occurs regardless of "gender, socioeconomic status, relationship to the abuser, number of abuse episodes, and type of CSA that may have occurred" (Shrivastava et al., 2017, p. 5). Given that CSA is a form of trauma, survivors often develop the psychiatric disorder called PTSD, or post-traumatic stress disorder. One study done with 83 female adolescents that experienced CSA showed that their PTSD scores were above the clinical cut-off levels (McLean et al., 2014). Similarly, a review concluded that across five different studies, higher rates of PTSD diagnosis or symptomatology was observed in women with a history of CSA (Wosu et al., 2015). The symptoms of PTSD include flashbacks, nightmares, avoidance of trauma-related thoughts and feelings, negative thoughts, negative affect, hyperarousal, irritability, aggression, and trouble sleeping (American Psychiatric Association, 2013). In addition, individuals with CSA histories also report feelings of low self-esteem, guilt and shame, and hopelessness (Krug et al., 2002).

The more immediate physical impacts of CSA include vaginal bleeding or infection, UTI (urinary tract infection), menstrual irregularities, STI's (sexually transmitted infections) including HIV, early pregnancy, gastrointestinal problems, and genital injury (Collin-Vézina et al., 2013; Kacker et al., 2007; Krug et al., 2002; Mollamahmutoglu et al., 2014). Survivors of child sexual abuse are more likely to develop physical health conditions later on in life such as continuous pain, fibromyalgia, somatic symptoms, categorial pain, and obesity (Hailes et al., 2019). The cognitive and emotional development of an individual is similarly affected by CSA through physiological impacts. Specific brain structure has been found to be different in individuals that went through sexual abuse as a child. For instance, those with a history of CSA have shown to have reduced cortical thickness in the brain, specifically, in areas that involve emotional processing (Gold et al., 2016). Findings show that the volume loss, that is related to

CSA, within the following brain structures: hippocampus, prefrontal cortex, corpus callosum, and the visual cortex, play a role in the development of psychiatric disorders later in life (M. C. Chen et al., 2010; Sheffield et al., 2013).

The negative effects of child sexual abuse not only affect the individual that is abused, but also the family, community, and society. Those with a history of CSA are more likely to be widowed, separated, or divorced as an adult (Pérez-Fuentes et al., 2013). Around one-third of CSA cases are intrafamilial, where a family member is the perpetrator (Seto et al., 2015). Therefore, the family often is associated with the survivor and perpetrator. A family of a survivor of CSA also must process and heal from the traumatic event. A lack of treatment for those that experience CSA can lead to negative behaviors that affect the community. Child sexual abuse may lead to adults that have difficulties functioning in communities (Tyler, 2002). As for the societal consequences, one study estimated the economic burden that CSA had on the U.S. in 2015. According to Letourneau et al., (2018) costs included in the calculations were "health care costs, productivity loss, child welfare costs, violence/crime costs, special education costs, and suicide death costs" (p. 413). The total economic burden was around $9.3 billion (Letourneau et al., 2018).

Theoretical Framework

One of the theories regarding the causes of the negative impacts of child sexual abuse is the ecological systems theory, or EST. The ecological systems theory states that there are various systems that affect a child. The microsystem acts as the system closest to the individual, in the case of CSA it can be the child's family, perpetrator, etc. The mesosystem represents the interaction between the child's systems. For instance, the interaction between the child's family

and perpetrator would be a part of the mesosystem. Another system within EST is the exosystem, which consists of broader influences (like media or school curriculum). The final system is the macrosystem, where the child's beliefs, values, ideologies, and cultures shape the child's culture and community (Bronfenbrenner, 1977).

The ecological systems theory implies that intervention for CSA should include education, along with the noting of risk and resiliency factors, at multiple levels (individual, family, etc.). Those that experience child sexual abuse can benefit from open communication within the family as well. Educating parents to support their child's healthy sexual development is key to prevention and intervention of CSA. Often perpetrators are a part of the child's microsystem, therefore, intervention should address if the offender is known and not a stranger to the child (Martinello, 2020). Similarly, within the mesosystem, offenders usually have a relationship with the child's family. Research indicates that in 88% of incidents children knew their abuser and 70-90% of incidents the family knew the abuser (Y.-C. Chen et al., 2012). According to EST, interactions between the systems of the family, child, school, etc. are all important in understanding what factors impact a child's sexual abuse experience (Martinello, 2020).

Another theory behind the impacts of CSA on individuals is the attachment theory. The attachment theory describes how attachments are formed between children and their caregiver(s) during early childhood. According to the theory, the way in which a parent responds to the emotional needs of the child correlates with how emotionally secure the child will be. Throughout a child's development, they establish internal working models, or IWM's, that define their self-perception as well as their relationship to others. Attachment theory offers that if

a caregiver responds below the optimal way (e.g., if they are unresponsive), then a child's IWM will possibly be altered, which can interfere with development later (Bowlby, 1977).

Attachment theory suggests that there are secure and insecure attachments; with insecure having three subtypes: deactivation, hyperactivation, and disorganization. Deactivation involves "an inhibition of attachment signals by a child that is confronted with a distant or emotionally unavailable parent" (Charest et al., 2018, p. 474; Cyr et al., 2010). On the other hand, hyperactivation is an exaggeration of distress signals to get the attention of a parent that is inconsistent with their responses to a child's needs. Disorganization describes the inability to use organized attachment strategies when dealing with distress and is often found in victims of abuse (Cyr et al., 2010). The theory states that attachment security is a protective factor against adversity, such as CSA (Aspelmeier et al., 2007).

Interventions for CSA

Given that CSA subverts a child's trust in adults and interferes with their attachment security, interventions that rely on assisting interpersonal relationships should be used. Trauma-Focused Cognitive Behavioral Therapy, or TF-CBT, targets the parent-child relationship during shared therapeutic sessions (Charest et al., 2018). TF-CBT is an evidenced based treatment that utilizes both individual child and child-parent sessions. The overall components of TF-CBT can be summarized by the acronym PRACTICE. PRACTICE stands for psychoeducation and parenting skills, relaxation skills, affective regulation skills, cognitive coping skills, trauma narrative and processing, in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing safety (Cohen & Mannarino, 2008). TF-CBT is a subtype of CBT, as it follows similar

principles. The difference between the two modalities is that TF-CBT was designed for helping individuals with trauma symptoms.

TF-CBT was developed to treat youth suffering from significant traumas, such as CSA. The sessions can range in number; from 8-25. There are three phases in TF-CBT, with the first being stabilization skills. During this phase parenting, relaxation, affective, and cognitive processing skills are provided to the child and their nonoffending caregiver. The second phase is the trauma narration and processing stage, where individuals form their own trauma narrative. Trauma narratives are ways for children to describe and cognitively process their trauma. The final phase, phase three, is termed as consolidation. The consolidation phase consists of in vivo mastery (which addresses fear and avoidance of trauma reminders), conjoint child-parent sessions and enhancement of safety. Within the conjoint child-parent sessions, communication between the caregiver and child is worked on. Similarly, the child's loss of safety and trust towards their parent is addressed in the third phase (Cohen et al., 2018).

Attachment theory informs TF-CBT as the treatment values the important attachment between a non-offending caregiver and the child (Mannarino et al., 2014). For TF-CBT to increase the positive attachment for those that experienced complex trauma a secure attachment style must be shared with a caregiver and the child or be sought out via counseling. The caregiver must also have an "ability to tolerate frustration, parental reflective functioning… and an ability to notice affect regulation needs in themselves and in their children" (Pleines, 2019, p. 346). Research indicates that positive parental behavior, instead of avoidance or blaming, during a child's trauma narrative sessions is associated with better outcomes for the child; furthering attachment theory's influence on TF-CBT (Yasinski et al., 2016). When youth experience

trauma, their attachment with their parent can become disorganized. TF-CBT, being attachment-informed, can meet the needs of both the parent and child to work on their disorganized attachment (Pleines, 2019).

Cognitive behavioral therapy is an intervention that helps individuals challenge cognitive distortions and improve their thoughts and behaviors. When focusing on traumas, such as CSA, CBT acknowledges that children will often have negative thoughts about the event. The treatment modality registers that the unhelpful thoughts lead to avoidance of any trauma reminders (McTavish et al., 2021). CBT is then used to assist children and their non-offending caregiver on managing the outcomes of child sexual abuse (Macdonald et al., 2012). As a subset of CBT, TF-CBT is used to treat those that undergo trauma. For youth that have experienced trauma, TF-CBT utilizes gradual exposure to the traumatic event. As the child and parent attend the TF-CBT sessions, the graded exposure's intensity increases. Additionally, TF-CBT adheres to PRACTICE when working with children that have been through trauma (Cohen & Mannarino, 2008). For this review, TF-CBT will be examined for child and adolescent survivors of CSA.

While systematic reviews have shown the effectiveness of CBT for children that have been sexually abused (Macdonald et al., 2012; Passarela et al., 2010), and other reviews demonstrate the generalized effectiveness of TF-CBT on the children and adolescent population with histories of trauma (Ramirez de Arellano et al., 2014), there has yet to be a review, consolidation, and summary of empirical evidence supporting the use of TF-CBT for survivors of CSA. Most literature focusses on children who have experienced various forms of trauma, wherein this review will center around multiple studies regarding children and adolescents that have experienced a specific trauma type, sexual abuse. This systematic review intends to expand on

previous literature on the treatment impacts of TF-CBT. The review will include suggestions for improving therapeutic treatment for youth survivors of sexual abuse and where further research should be conducted.

Methods

Search Strategy

This systematic review integrated Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA), a tool used to conduct and enhance systematic reviews. The research included the electronic databases Academic Search Complete, APA PsycInfo, CINAHL, ERIC, and Social Work Abstracts. In order to select search terms, a university librarian was consulted. The search terms included four lines. On the first line was child* OR adolesc* OR teen* OR "young adult" OR pediatric OR juvenile OR youth. The second line used terms "sexual abuse*" OR "sexual trauma" OR "sexual violence" OR "sexual assault" OR rape OR incest OR (advers* N3 child*) OR "human traffic*" OR (sexual* N3 exploit*) OR "sex traffic" OR molest*. The third line included trauma-informed OR TF-CBT OR trauma-focused. The fourth line had the terms therapy OR (cognitive N3 behav*).

Inclusion and Exclusion Criteria

This systematic review used studies that meet the inclusion criteria. The inclusion criteria being that a) the study was empirical and had quantitative data b) the study was in English c) the study was on youth ages 21 and younger d) the study evaluated the impacts of TF-CBT e) the study focused on the specific trauma of childhood sexual abuse. Since many children mental health services can serve ages up to 21, the included age was 21 and under. The review included

published, peer-reviewed studies from the years 1991-2023. The quantitative data must have shown pre-test and post-test scores for symptomology. Though the studies had to be in English, they were allowed to be from anywhere globally. The exclusion criteria for this systematic review is a) the study was on adults b) the study's treatment modality was not TF-CBT c) CSA was not listed as a separate trauma type d) the study used only qualitative data e) case studies f) the study did not measure the treatment impacts.

Study Identification, Screening, and Selection

The systematic review software tool known as Covidence was utilized to identify, screen, and select the included studies. A total of 551 studies were initially imported into Covidence for screening. With 202 duplicates removed, 349 studies remained to be screened. The remaining studies were screened for their title and abstract, where the screener, the first author, evaluated whether it met the inclusion criteria. Forty-three studies moved on to the full-text review portion of the selection. If the screener was uncertain about a selection, then they discussed it under the supervision of their research mentor. During the full-text review 27 studies were excluded for not having quantitative data, CSA not being separated, not being in English, having the wrong intervention, having the wrong study design, and having an abstract only. After the full-text review, the final study sample included sixteen studies, see Figure 1.

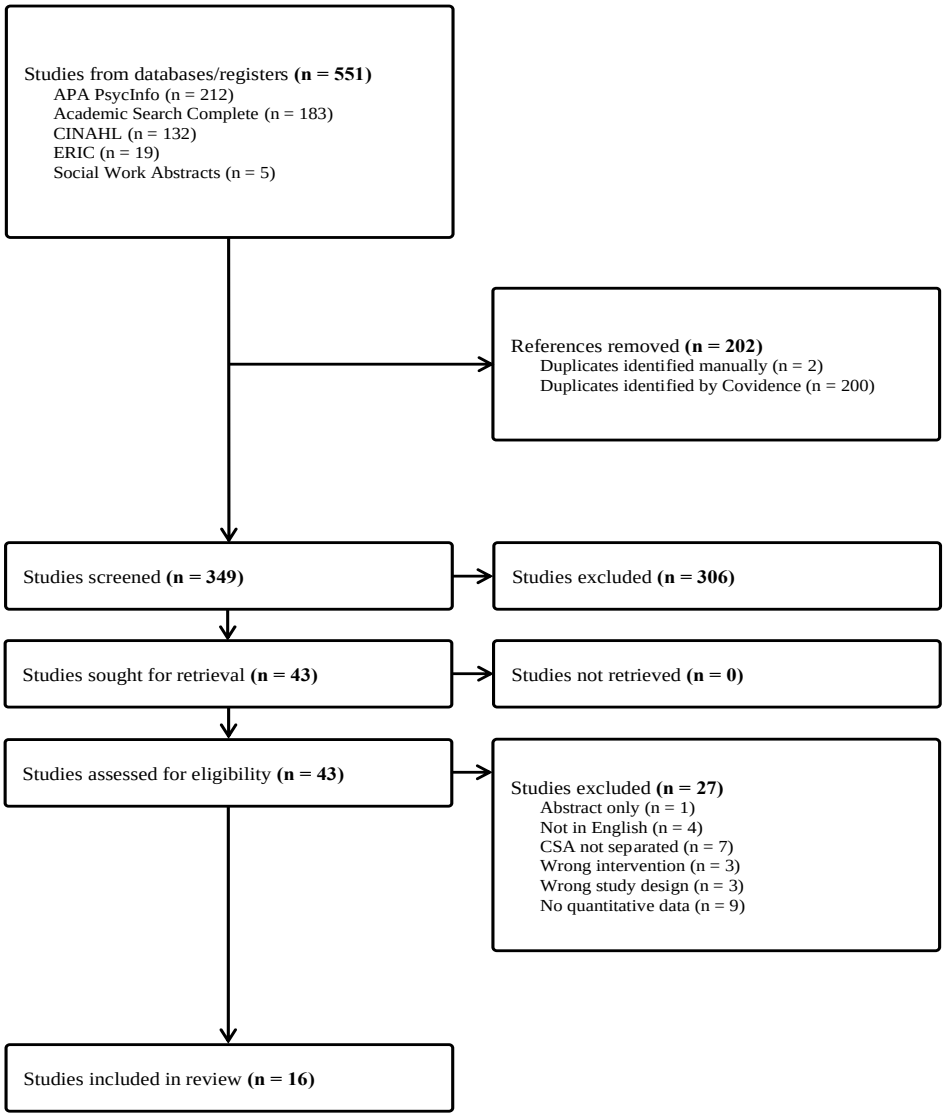

Figure 1

PRISMA Diagram of Literature Search Process

Data Extraction and Analysis

Relevant data was extracted from the studies; including the study design, study setting, sample size, sample description (age, gender, race, etc.), treatment model type (including any specific treatment components), and outcomes measured. Specifically, the measured outcomes were pre and post trauma or PTSD symptom scores, along with depression and anxiety measures. Any study limitations were examined during the data analysis. In addition, the data analysis sought to understand what impacts TF-CBT has for CSA survivors and emphasized populations it best serves.

Table 1

Study and Population Description for 16 Included Publications

Title	Authors	Country in which the study conducted	Study design	Method of recruitment of participants	Total number of participants	Age	Sex/Gender	Race	Type of sexual abuse	Number of times sexual abuse occurred	Setting
A Treatment Study for Sexually Abused Preschool Children: Outcome During a One-Year Follow-up	Cohen, Judith A.; Mannarino, Anthony P., 1997	United States	Randomized controlled trial	Phone	43	Mean: 5 yr 9 mo	56% female, 44% male	56% Caucasian, 44% African American	26% genital fondling only, 9% vaginal/anal intercourse only, 19% oral-genital contact only, 7% other/unknown, 39% multiple types of abuse	26% once, 33% 2-5 times, 14% 6-10 times, 23% > 10 times, 47% unknown	not reported
Interventions for Sexually Abused Children: Initial Treatment Outcome Findings	Cohen, Judith A.; Mannarino, Anthony P., 1998	United States	Randomized controlled trial	Phone	49	7 to 14	69% female, 31% male	59% Caucasian, 37% African American, 2% Hispanic, 2% Biracial	54% Intercourse, 44% Fondling, 2% Oral-genital	36% once, 20% 2-5 times, 8% 6-10 times, 33% more than 10 times, 3% unknown	not reported
A Treatment Outcome Study for Sexually Abused Preschool Children: Initial Findings	Cohen, Judith A.; Mannarino, Anthony P., 1996	United States	Randomized controlled trial	Phone	67	2.11 to 7.1 years	58% female, 42% male	54% Caucasian, 42% African American, 4% other	46% genital fondling, 26% vaginal and/or anal intercourse, 22% oral-genital contact, 3% fondling of breasts, 3% other or unknown	25% abused once, 26% abused 2-5 times, 15% abused 6-10 times, 29% abused more than 10 times, 5% number of abuse episodes unknown	not reported
A Pilot Randomized Controlled Trial of Combined Trauma-Focused CBT and Sertraline for Childhood PTSD Symptoms	Cohen, Judith A.; Mannarino, Anthony P.; Perel, James M.; Staron, Virginia, 2007	United States	Randomized controlled trial	Phone	22	10 to 17	100% female	77.3% White, 22.7% African American	13.6% Genital touching, 22.2% Digital penetration, 4.5% Simulated intercourse, 18.2% Oral-genital contact, 37.7% Penile penetration	not reported	not reported

Trauma Symptoms in a Diverse Population of Sexually Abused Children	Ruiz, Elizabeth, 2016	United States	Non-randomized experimental study	Clinic patients	176	8 to 16	88.6% female, 11.4% male	38.4% African American, 42.8% Latino, 14.5% Caucasian, 1.3% Asian, 0.6% Native American, 2.5% Other	not reported	not reported	Nonprofit social service organization in Chicago
Challenges in treatment of sexually abused preschoolers: A pilot study of TF-CBT in Quebec	Hébert, M.; Daignault, I. V., 2015	Canada	Non-randomized experimental study	Clinic patients	25	3 to 6	15 females, 10 males	not reported	8.7% clothed touching, 17.4% unclothed touching, 73.9% penetration or attempted	18.2% once, 54.5% few episodes, 27.3% chronic	Specialized intervention setting in Montreal, Quebec, Canada
Treating sexually abused children: 1 year follow-up of a randomized controlled trial	Cohen, Judith A.; Mannarino, Anthony P.; Knudsen, Kraig, 2005	United States	Randomized controlled trial	Clinic patients	82	mean age of 11.4 years (TF-CBT) and 10.8 years (NST)	56 females, 26 males	60% Caucasian, 37% African American, 2% Biracial, and 1% Hispanic	46% Intercourse, 4% Oral-genital contact, 34% Fondling, 16% Unknown	31% once, 14% 2-5 episodes, 11% 6-10 episodes, 27% more than 10 episodes, 17% unknown	Urban outpatient child psychiatric program in general hospital
A Follow-up Study of a Multisite, Randomized, Controlled Trial for Children With Sexual Abuse-Related PTSD Symptoms	Deblinger, Esther; Mannarino, Anthony P.; Cohen, Judith A.; Steer, Robert A., 2006	United States	Randomized controlled trial	Clinic patients	183	8 to 14	not reported	not reported	not reported	not reported	not reported
A Multisite, Randomized Controlled Trial for Children With Sexual Abuse-Related PTSD Symptoms	Cohen, Judith A.; Deblinger, Esther; Mannarino, Anthony P.; Steer, Robert A., 2004	United States	Randomized controlled trial	Clinic patients	203	8 to 14	79% female, 21% male	60% White, 28% African American, 4% Hispanic American, 7%	2.9% Sexual touching over clothes, 4.4% Nongenital touching under clothes, 22% Digital penetration, 10.3%	Median: 4	2 sites: large metropolitan area and suburban area (outpatient clinical treatment programs for abused/traumatized children)

								Biracial, 1% Other	Simulated intercourse, 20.1% Oral-genital abuse, 37.4% Penile penetration, 3.9% Other		
Trauma-Focused Cognitive-Behavioral Therapy for Children Sustained Impact of Treatment 6 and 12 Months Later	Mannarino, Anthony P.; Cohen, Judith A.; Deblinger, Esther; Runyon, Melissa K.; Steer, Robert A., 2012	United States	Randomized controlled trial	Clinic patients	158	4 to 11	not reported	not reported	not reported	not reported	Two sites; Pittsburgh, PA and Stratford, NJ
Trauma-Focused Cognitive Behavioral Therapy for Children: Impact of the Trauma Narrative and Treatment Length	Deblinger, Esther; Mannarino, Anthony P.; Cohen, Judith A.; Runyon, Melissa K.; Steer, Robert A., 2011	United States	Randomized controlled trial	Clinic patients	210	Average: 7.7 years	61% female	65% Caucasian, 14% African American, 7% Hispanic, and 14% Other	not reported	not reported	Two treatment sites in Pittsburgh, PA and Stratford, NJ
Improvements in personal resiliency among youth who have completed trauma-focused cognitive behavioral therapy: A preliminary examination	Deblinger, Esther; Pollio, Elisabeth; Runyon, Melissa K.; Steer, Robert A., 2017	United States	Randomized controlled trial	Clinic patients	115	7 to 17	73% females, 27% males	46% Caucasian, 24% Latino, 18% African American, 11% Other, 9% Biracial	28% penile penetration, 48% oral sexual contact, 64% direct digital touching	Mean number: 10 (SD=25)	Medical school-based clinic specializing in assessment and treatment of child abuse
Moderators of treatment response to trauma-focused cognitive behavioral therapy among youth in Zambia	Kane, Jeremy C.; Murray, Laura K.; Cohen, Judith; Dorsey, Shannon; Skavenski van Wyk, Stephanie; Galloway Henderson, Jennica; Imasiku,	Other: Zambia	Randomized controlled trial	Other: Site staff members from five low-resource communities within Lusaka	257	5 to 18	mean for male: 68 (TF-CBT) and 61 (TAU)	not reported	not reported	not reported	Five low-resource communities within Lusaka: a home-based care center, a public health clinic, two schools, and a center for street children

	Mwiya; Mayeya, John; Bolton, Paul, 2016										
Posttraumatic Stress Disorder and Childhood Traumatic Loss: A Secondary Analysis of Symptom Severity and Treatment Outcome	Unterhitzenberger, Johanna; Sachser, Cedric; Rosner, Rita, 2020	Other: Germany	Randomized controlled trial	Clinic patients	139	mean: 12.84 (SD= 2.80)	73.0% female	not reported	not reported	not reported	Child and adolescent mental health clinic
Latent class analysis of post-traumatic stress symptoms and complex PTSD in child victims of sexual abuse and their response to Trauma-Focused Cognitive Behavioral Therapy	Hébert, Martine; Amédée, Laetitia Mélissande, 2020	Canada	Non-randomized experimental study	Clinic patients	384	6 to 14	67.2% female	not reported	66.2% penetration or attempted penetration, 27.4% unclothed touching, 6.4% clothed touching	38.5% chronic abuse (more than 6 months)	Child Advocacy Centre in Montreal, Quebec, Canada
Effectiveness of TF-CBT with sex trafficking victims in a secure post-adjudication facility	Schmidt, Claudia; Lenz, A. Stephen; Oliver, Marvarene, 2022	United States	Other: Mixed-methods	Clinic patients	3	14 to 16	100% female	100% Hispanic	Sexual abuse, sexual assault, and DMST	Not reported	Secure post-adjudication juvenile facility

Results

Description of Studies

The included studies and their general findings are shown in Table 1. Ten out of the sixteen studies were conducted by the authors Cohen, Deblinger, and/or Mannarino. Most, 12, of the studies took place in the United States. Other countries included Canada, Germany, and Zambia. The studies can be divided into three groups: those without comparison groups, those with comparison groups, and those analyzing treatment components. Twelve of the studies are randomized controlled trials, or RCTs. The remaining three studies are non-randomized experimental studies, and one is a mixed-methods study design. Two of the studies are secondary analyses.

The studies consisted of twelve separate samples of children and adolescents, with 1,650 participants total. The samples consisted of ages 2-18, with eleven of the studies having 60% or more female participants. Two of the studies had only female subjects and two studies did not report the gender of their subjects. Out of the sixteen studies, seven had 50% or more participants that were Caucasian. One study had subjects that were all Hispanic and another had 42.8% Latino and 38.4% African American participants. The types of sexual abuse, if reported, included genital fondling, intercourse, oral-genital contact, fondling of breasts, clothed and unclothed touching, digital penetration and other.

The treatments consisted of anywhere from 8-20 sessions, ranging from 60-90 minutes. Three of the sixteen studies have CBT-SAP (cognitive-behavioral therapy adapted for sexually abused preschool children) or SAS-CBT (sexual abuse-specific cognitive behavioral therapy) as their experimental treatment. Studies examining CBT-SAP and SAS-CBT were included as they were created by the same authors of TF-CBT and have similar components. The studies had

numerous outcome measures (both child and parent reports), including depression, sexual behavior, anxiety, PTSD, shame, etc. The measures reporting the parent's symptoms or behaviors were not analyzed, as this systematic review is focused on the treatment impacts for children and adolescents.

Table 2

Outcome Measures for Studies without Comparison Groups

Title	Measures	Experimental Group Mean (Pre)	Experimental Group SD (Pre)	Experimental Group Mean (Post)	Experimental Group SD (Post)
Trauma Symptoms in a Diverse Population of Sexually Abused Children	Trauma Symptom Checklist for Children (TSCC) a. Anxiety b. Depression c. Anger d. Posttraumatic Stress e. Dissociation f. Overt Dissociation g. Fantasy Dissociation h. Sexual concerns i. Sexual preoccupation j. Sexual distress	a. 54.32 b. 51.32 c. 51.71 d. 52.66 e. 52.17 f. 51.71 g. 53.29 h. 60.10 i. 53.70 j. 66.35	not reported	a. 50.78 (-3.54) b. 45.39 (-5.93) c. 47.12 (-4.59) d. 49.34 (-3.32) e. 49.76 (-2.41) f. 49.83 (-1.88) g. 48.10 (-5.19) h. 56.30 (-3.8) i. 50.33 (-3.37) j. 63.60 (-2.75)	not reported
Challenges in treatment of sexually abused preschoolers: A pilot study of TF-CBT in Quebec	Behavior problems: Child Behavior Checklist (CBCL) Internalizing Externalizing Post-traumatic stress disorder (PTSD): Child Post-Traumatic Stress Reaction Index- Parent Questionnaire (CPTS-RI-PQ) Total Re-experieincing Avoidance Hypervigilance Dissociation symptoms: Child Dissociate Checklist (CDC)	1. Behavioral problems a. Internalizing: 62.68 b. Externalizing: 60.64 c. Dissociation: 8.84 2. Post-traumatic stress symptoms a. Total: 29.59 b. Re-experiencing: 12.71 c. Avoidance: 5.94 d. Hypervigilance: 7.29 Parent symptoms 1. Psychological distress: 33.53 2. Post-traumatic stress symptoms: 39.13	1. Behavioral problems a. Internalizing: 11.61 b. Externalizing: 11.68 c. Dissociation: 4.74 2. Post-traumatic stress symptoms a. Total: 18.33 b. Re-experiencing: 8.12 c. Avoidance: 5.95 d. Hypervigilance: 4.10 Parent symptoms 1. Psychological distress: 21.43 2. Post-traumatic stress symptoms: 24.39	1. Behavioral problems a. Internalizing: 53.76 (-8.92) 12 mo: 51.31 b. Externalizing: 52.28 (-8.36) 12 mo: 53.92 c. Dissociation: 4.48 (-4.36) 12 mo: 4.46 2. Post-traumatic stress symptoms a. Total: 15.88 (-13.71) 12 mo: 19.00 b. Re-experiencing: 6.65 (-6.06) 12 mo: 9.00 c. Avoidance: 3.88 (-2.06) 12 mo: 3.80 d. Hypervigilance: 3.29 (-4) 12 mo: 4.10	1. Behavioral problems a. Internalizing: 12.39 12 mo: 10.01 b. Externalizing: 11.48 12 mo: 11.10 c. Dissociation: 4.41 12 mo: 6.42 2. Post-traumatic stress symptoms a. Total: 14.74 12 mo: 18.53 b. Re-experiencing: 4.62 12 mo: 8.74 c. Avoidance: 5.46 12 mo: 4.05 d. Hypervigilance: 4.01 12 mo: 5.69
Improvements in personal resiliency among youth who have completed trauma-focused cognitive behavioral therapy: A preliminary examination	1. Resiliency Scales for Children and Adolescents (RSCA) a. Sense of Mastery b. Sense of Relatedness c. Emotional Reactivity 2. Beck Depression Inventory-II (BDI-II) 3. Children's Depression Inventory (CDI)	1a. 54.40 1b. 70.01 1c. 23.16 2. 12.20 3. 8.79 4a. 2.64 4b. 3.05 4c. 2.36	1a. 12.78 1b. 15.75 1c. 13.74 2. 11.29 3. 6.28 4a. 1.52 4b. 1.59 4c. 1.64	1a. 58.99 (+4.50) 1b. 74.37 (+4.36) 1c. 18.76 (-4.4) 2. 5.63 (-6.57) 3. 6.04 (-2.75) 4a. 0.94 (-1.7) 4b. 1.21 (-1.84) 4c. 0.76 (-1.6)	1a. 12.81 1b. 14.93 1c. 12.82 2. 8.23 3. 4.86 4a. 1.18 4b. 1.20 4c. 0.96

	4. Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version-PTSD Module (K-SADS-PTSD) a. Re-experiencing b. Avoidance c. Hypervigilance				
Latent class analysis of post-traumatic stress symptoms and complex PTSD in child victims of sexual abuse and their response to Trauma-Focused Cognitive Behavioral Therapy	Post-traumatic Stress Disorder (PTSD): Children's Impact of Traumatic Events Scale II (CITES II) Re-Experienicng Avoidance Hypervigilance Complex PTSD (C-PTSD): CITES II, Revised Children's Manifest Anxiety Scale, Self-Perception Profile for Children, Children's Depression Inventory Affect dysregulation Dissociation: Child Dissociative Checklist Behavior problems: Child Behavior Checklist (CBCL) Internalizing Externalizing	1. C-PTSD a. PTSD: 62.63 b. Dissociation: 10.03 c. Internalizing behavior problems: 64.23 d. Externalizing behavior problems: 65.51 2. PTSD a. PTSD: 38.52 b. Dissociation: 7.77 c. Internalizing behavior problems: 62.15 d. Externalizing behavior problems: 62.78 3. Resilient a. PTSD: 20.54 b. Dissociation: 7.48 c. Internalizing behavior problems: 60.03 d. Externalizing behavior problems: 60.32	1. C-PTSD a. PTSD: 10.12 b. Dissociation: 6.11 c. Internalizing behavior problems: 9.40 d. Externalizing behavior problems: 9.08 2. PTSD a. PTSD: 12.16 b. Dissociation: 5.85 c. Internalizing behavior problems: 10.07 d. Externalizing behavior problems: 10.34 3. Resilient a. PTSD: 11.43 b. Dissociation: 6.44 c. Internalizing behavior problems: 10.08 d. Externalizing behavior problems: 10.80	1. C-PTSD a. PTSD: 43.97 (-18.66) b. Dissociation: 5.45 (-4.58) c. Internalizing behavior problems: 55.67 (-8.56) d. Externalizing behavior problems: 58.96 (-6.55) 2. PTSD a. PTSD: 31.08 (-7.44) b. Dissociation: 5.31 (-2.46) c. Internalizing behavior problems: 55.84 (-6.31) d. Externalizing behavior problems: 58.05 (-4.73) 3. Resilient a. PTSD: 20.25 (-0.29) b. Dissociation: 4.23 (-3.25) c. Internalizing behavior problems: 52.45 (-7.48) d. Externalizing behavior problems: 56.00 (-4.32)	1. C-PTSD a. PTSD: 20.61 b. Dissociation: 4.89 c. Internalizing behavior problems: 9.79 d. Externalizing behavior problems: 10.04 2. PTSD a. PTSD: 16.31 b. Dissociation: 5.21 c. Internalizing behavior problems: 10.78 d. Externalizing behavior problems: 10.36 3. Resilient a. PTSD: 13.95 b. Dissociation: 4.50 c. Internalizing behavior problems: 10.90 d. Externalizing behavior problems: 10.45
Effectiveness of TF-CBT with sex trafficking victims in a secure post-adjudication facility	1. CPSS (Child PTSD Symptom Scale)	Flower: 35 Erica: 30.50 Rose: 25.67	Flower: 2.67 Erica: 3.00 Rose: 3.56	Flower: 16.42 (-18.58) Erica: 21.50 (-9) Rose: 27.67 (+2)	Flower: 4.49 Erica: 15.33 Rose: 4.72

Table 3

Outcome Measures for Studies with Comparison Groups

Title	Measures	Experimental Group Mean (Pre)	Experimental Group SD (Pre)	Comparison Group Mean (Pre)	Comparison Group SD (Pre)	Experimental Group Mean (Post)	Experimental Group SD (Post)	Comparison Group Mean (Post)	Comparison Group SD (Post)
A Treatment Study for Sexually Abused Preschool Children: Outcome During a One-Year Follow-up	1) CBCL (Child Behavior Checklist) a) Soc (Social Competence) b) BPT (Behavior Profile Total) c) Int (Internalizing) d) Ext (Externalizing) 2) CSBI (Child Sexual Behavior Inventory) 3) WBR (Weekly Behavior Report) a) Types b) Total	1a) 36.89 1b) 66.76 1c) 64.79 1d) 64.66 2) 25.16 3a) 6.57 3b) 25.30	1a) 12.74 1b) 10.85 1c) 10.62 1d) 10.49 2) 18.84 3a) 3.71 3b) 18.54	1a) 39.56 1b) 64.37 1c) 62.70 1d) 62.59 2) 25.37 3a) 6.38 3b) 24.50	1a) 11.72 1b) 12.25 1c) 12.90 1d) 11.37 2) 19.36 3a) 3.01 3b) 18.27	1a) 41.57 (+4.68) 6 mo: 39.36 12 mo: 42.92 1b) 54.39 (-12.37) 6 mo: 55.84 12 mo: 53.82 1c) 52.87 (-11.92) 6 mo: 55.35 12 mo: 52.89 1d) 54.58 (-10.08) 6 mo: 54.39 12 mo: 53.57 2)11.47 (-13.69) 6 mo: 10.43 12 mo: 8.75 3a) 3.57 (-3) 6 mo: 3.43 12 mo: 2.14 3b) 7.92 (-17.38) 6 mo: 10.60 12 mo: 4.86	1a) 12.22 6 mo: 11.19 12 mo: 12.76 1b) 9.54 6 mo: 11.83 12 mo: 12.22 1c) 9.55 6 mo: 10.77 12 mo: 11.45 1d) 10.04 6 mo: 11.39 12 mo: 11.08 2) 8.18 6 mo: 7.77 12 mo: 6.16 3a) 3.25 6 mo: 2.98 12 mo: 2.27 3b) 9.45 6 mo: 12.85 12 mo: 5.75	1a) 44.00 (+4.44) 6 mo: 43.88 12 mo: 42.41 1b) 61.81 (-2.56) 6 mo: 58.56 12 mo: 59.53 1c) 61.89 (-0.81) 6 mo: 59.28 12 mo: 57.53 1d) 59.04 (-3.55) 6 mo: 57.61 12 mo: 59.84 2) 17.85 (-7.52) 6 mo: 16.78 12 mo: 16.79 3a) 4.73 (-1.65) 6 mo: 4.50 12 mo: 5.00 3b) 14.38 (-10.12) 6 mo: 15.67 12 mo: 18.58	1a) 8.72 6 mo: 9.78 12 mo: 10.50 1b) 14.66 6 mo: 14.39 12 mo: 12.84 1c) 13.49 6 mo: 13.83 12 mo: 11.41 1d) 12.75 6 mo: 12.71 12 mo: 12.47 2) 13.38 6 mo: 13.23 12 mo: 18.17 3a) 3.12 6 mo: 3.15 12 mo: 3.15 3b) 13.09 6 mo: 12.50 12 mo: 19.62
Interventions for Sexually Abused Children: Initial Treatment Outcome Findings	1) CSBI (Child Sexual Behavior Inventory) 2) CDI (Children's Depression Inventory) 3) CBCL (Child Behavior Checklist) a) Social Competence b) Behavior Profile Total	1) 12.33 2) 12.67 3a) 34.52 3b) 61.77 3c) 59.17 3d) 59.77 4a) 36.67 4b) 39.44	1)10.18 2) 8.79 3a) 9.91 3b) 11.76 3c) 12.12 3d) 10.94 4a) 8.96 4b) 9.35	1) 11.95 2) 10.33 3a) 42.21 3b) 60.42 3c) 60.00 3d) 57.74 4a) 35.72 4b) 36.78	1) 9.43 2) 7.27 3a) 10.05 3b) 11.23 3c) 11.34 3d) 10.15 4a) 7.95 4b) 7.31	1) 8.31 (-4.02) 2) 5.89 (-6.78) 3a) 38.75 (+4.23) 3b) 57.56 (-4.21) 3c) 55.48 (-3.69) 3d) 57.14 (-2.63) 4a) 29.59 (-7.08) 4b) 32.78 (-6.66)	1) 8.70 2) 5.39 3a) 10.21 3b) 10.17 3c) 8.79 3d) 9.64 4a) 6.19 4b) 7.55	1) 10.42 (-1.53) 2) 9.89 (-0.44) 3a) 40.11 (-2.1) 3b) 58.21(-2.21) 3c) 58.11 (-1.89) 3d) 56.16 (-1.58) 4a) 30.06 (-5.66) 4b) 34.06 (-2.72)	1) 9.20 2) 8.11 3a) 8.44 3b) 9.24 3c) 9.37 3d) 10.00 4a) 4.68 4b) 6.28

	c) Internalizing d) Externalizing 4) STAIC (State-Trait Anxiety Inventory for Children) a) STAIC b) Trait								
A Treatment Outcome Study for Sexually Abused Preschool Children: Initial Findings	CBCL (Child Behavior Checklist) scale SOC (Social Competence) BPT (Behavior Profile Total) Int (Internalizing) Ext (Externalizing) CSBI (Child Sexual Behavior Inventory) WBR (Weekly Behavior Record) Types Total	CBCL Scale Soc: 36.89 BPT: 66.76 Int: 64.79 Ext: 64.66 CSBI: 25.16 WBR Types: 6.57 Total: 25.30	CBCL Scale Soc: 12.74 BPT: 10.85 Int: 10.62 Ext: 10.49 CSBI: 18.84 WBR Types: 3.71 Total: 18.54	CBCL Scale Soc: 39.56 BPT: 64.37 Int: 62.70 Ext: 62.59 CSBI: 25.37 WBR Types: 6.38 Total: 24.50	CBCL Scale Soc: 11.72 BPT: 12.25 Int: 12.90 Ext: 11.37 CSBI: 19.36 WBR Types: 3.01 Total: 18.27	CBCL Scale Soc: 41.57 (+4.68) BPT: 54.39 (-12.37) Int: 52.87 (-11.92) Ext: 54.58 (-10.08) CSBI: 11.47 (-13.69) WBR Types: 3.57 (-3) Total: 7.92 (-17.38)	CBCL Scale Soc: 12.22 BPT: 9.54 Int: 9.55 Ext: 10.04 CSBI: 8.18 WBR Types: 3.25 Total: 9.45	CBCL Scale Soc: 44.00 (+4.44) BPT: 61.81 (-2.56) Int: 61.89 (-0.81) Ext: 59.04 (-3.55) CSBI: 17.85 (-7.52) WBR Types: 4.73 (-1.65) Total: 14.38 (-10.12)	CBCL Scale Soc: 8.72 BPT: 14.66 Int: 13.49 Ext: 12.75 CSBI: 13.38 WBR Types: 3.12 Total: 13.09
Treating sexually abused children: 1 year follow-up of a randomized controlled trial	1. CSBI (Child Sexual Behavior Inventory) 2. CDI (Children's Depression Inventory) 3. STAIC (State-Trait Anxiety Inventory for Children) a. State b. Trait 4. TSCC (Trauma Symptom Checklist for Children) a. PTSD (Post-Traumatic Stress Disorder)	1) 11.44 2) 12.37 3a) 35.32 3b) 37.98 4a) 10.63 4b) 8.07 4c) 7.44 4d) 5.29 4e) 9.02 4f) 8.51 5a) 35.73 5b) 56.24 5c) 57.61 5d) 57.77	1) 10.70 2) 8.84 3a) 9.69 3b) 8.66 4a) 5.17 4b) 4.67 4c) 4.66 4d) 4.02 4e) 5.29 4f) 5.07 5a) 13.11 5b) 15.40 5c) 14.74 5d) 17.08	1) 11.10 2) 11.70 3a) 34.45 3b) 36.02 4a) 10.83 4b) 7.65 4c) 6.40 4d) 5.28 4e) 8.43 4f) 8.85 5a) 39.45 5b) 56.95 5c) 56.23	1) 8.91 2) 7.46 3a) 9.87 3b) 9.22 4a) 5.84 4b) 4.68 4c) 4.49 4d) 3.78 4e) 4.32 4f) 5.86 5a) 13.45 5b) 17.38 5c) 16.41	1) 8.59 (-2.85) 6 mo: 8.32 12 mo: 6.93 2) 7.61 (-4.76) 6 mo: 9.20 12 mo: 8.85 3a) 30.78 (-4.54) 6 mo: 29.68 12 mo: 30.73 3b) 34.12 (-3.86) 6 mo: 33.34 12 mo: 33.12 4a) 8.78 (-1.85) 6 mo: 7.66 12 mo: 7.17 4b) 5.90 (-2.17) 6 mo: 5.34 12 mo: 5.76 4c) 5.56 (-1.88) 6 mo: 5.10	1) 9.52 6 mo: 8.52 12 mo: 7.87 2) 7.04 6 mo: 7.88 12 mo: 7.37 3a) 8.16 6 mo: 7.51 12 mo: 6.32 3b) 7.44 6 mo: 6.39 12 mo: 7.87 4a) 4.88 6 mo: 3.94 12 mo: 4.17 4b) 3.82 6 mo: 3.15 12 mo: 3.92 4c) 4.35 6 mo: 3.45 12 mo: 4.49	1) 10.37 (-0.73) 6 mo: 9.20 12 mo: 9.28 2) 11.45 (-0.25) 6 mo: 11.03 12 mo: 10.17 3a) 32.48 (-1.97) 6 mo: 32.73 12 mo: 32.38 3b) 35.37 (-0.65) 6 mo: 34.80 12 mo: 34.18 4a) 9.92 (--0.91) 6 mo: 9.60 12 mo: 9.58 4b) 6.88 (-0.77) 6 mo: 7.02 12 mo: 6.23	1) 8.77 6 mo: 7.72 12 mo: 7.92 2) 7.97 6 mo: 8.22 12 mo: 7.51 3a) 8.96 6 mo: 9.02 12 mo: 8.87 3b) 8.98 6 mo: 9.23 12 mo: 8.83 4a) 5.28 6 mo: 5.79 12 mo: 5.81 4b) 3.75 6 mo: 3.81 12 mo: 4.06 4c) 3.95 6 mo: 3.87 12 mo: 3.79

	b. ANX (Anxiety) c. DEP (Depression) d. SEX (Sexual problems) e. DIS (Dissociation) f. ANG (Anger) 5. CBCL (Child Behavior Checklist) a. Social b. Internal c. External d. Total					12 mo: 5.90 4d) 4.10 (-1.19) 6 mo: 3.68 12 mo: 4.17 4e) 7.80 (-1.22) 6 mo: 6.88 12 mo: 6.68 4f) 6.49 (-2.02) 6 mo: 6.80 12 mo: 6.85 5a) 39.56 (+3.83) 6 mo: 40.29 12 mo: 39.21 5b) 53.93 (-2.31) 6 mo: 52.88 12 mo: 52.46 5c) 55.93 (-1.68) 6 mo: 56.12 12 mo: 55.93 5d) 57.30 (-0.47) 6 mo: 55.78 12 mo: 55.41	4d) 3.39 6 mo: 2.84 12 mo: 3.66 4e) 5.72 6 mo: 4.49 12 mo: 4.97 4f) 4.87 6 mo: 4.17 12 mo: 4.92 5a) 12.01 6 mo: 11.42 12 mo: 10.76 5b) 13.38 6 mo: 14.11 12 mo: 13.67 5c) 13.83 6 mo: 14.63 12 mo: 15.96 5d) 16.74 6 mo: 15.22 12 mo: 15.87	4c) 6.30 (-0.1) 6 mo: 6.15 12 mo: 5.50 4d) 4.85 (-0.43) 6 mo: 5.67 12 mo: 4.55 4e) 8.20 (-0.23) 6 mo: 8.73 12 mo: 7.78 4f) 8.40 (-0.45) 6 mo: 8.68 12 mo: 7.70 5a) 40.07 (+0.62) 6 mo: 41.97 12 mo: 42.55 5b) 56.43 (-0.52) 6 mo: 54.05 12 mo: 54.43 5c) 56.10 (-0.13) 6 mo: 54.95 12 mo: 55.40	4d) 3.81 6 mo: 4.64 12 mo: 3.75 4e) 4.74 6 mo: 5.03 12 mo: 4.53 4f) 5.48 6 mo: 6.70 12 mo: 5.43 5a) 11.55 6 mo: 11.12 12 mo: 11.42 5b) 16.54 6 mo: 16.22 12 mo: 16.28 5c) 16.91 6 mo: 16.01 12 mo: 16.39
A Follow-up Study of a Multisite, Randomized, Controlled Trial for Children With Sexual Abuse-Related PTSD Symptoms	1.The Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime version PTSD section (K-SADS) a. Reexperiencing b. Avoidance c. Hypervigilance 2. Child Behavior Checklist (CBCL) a. Internalizing b. Externalizing c. Total 3. Children's Depression Inventory (CDI) 4. State-Trait Anxiety Inventory for Children	1a) 3.98 1b) 4.13 1c) 3.67 2a) 13.97 2b) 15.59 2c) 48.48 3) 9.92 4a) 37.27 4b) 30.51 5a) 7.82 5b) 12.46 5c) 12.45 6) 2.84	1a) 1.31 1b) 1.33 1c) 1.21 2a) 9.24 2b) 10.47 2c) 27.90 3) 7.50 4a) 6.83 4b) 6.84 5a) 3.05 5b) 3.14 5c) 3.97 6) 2.28	1a) 4.08 1b) 4.35 1c) 3.68 2a) 17.04 2b) 17.18 2c) 54.29 3) 12.11 4a) 39.10 4b) 31.48 5a) 8.58 5b) 13.82 5c) 13.13 6) 3.03	1a) 1.30 1b) 1.13 1c) 1.26 2a) 9.88 2b) 9.88 2c) 28.03 3) 8.59 4a) 7.96 4b) 8.32 5a) 2.91 5b) 3.98 5c) 3.97 6) 2.18	1a) 1.53 (-2.45) 6 mo: 1.19 12 mo: 1.00 1b) 1.81 (-2.32) 6 mo: 1.69 12 mo: 1.41 1c) 1.69 (-1.98) 6 mo: 1.46 12 mo: 1.11 2a) 8.02 (-5.95) 6 mo: 8.51 12 mo: 7.10 2b) 11.10 (-4.49) 6 mo: 11.67 12 mo: 11.51 2c) 31.45 (-17.03) 6 mo: 32.44 12 mo: 29.17 3) 5.70 (-4.22) 6 mo: 4.08 12 mo: 4.15 4a) 30.78 (-6.49) 6 mo: 29.70	1a) 1.39 6 mo: 1.33 12 mo: 1.14 1b) 1.36 6 mo: 1.50 12 mo: 1.24 1c) 1.28 6 mo: 1.32 12 mo: 1.15 2a) 7.21 6 mo: 8.36 12 mo: 7.32 2b) 8.52 6 mo: 10.40 12 mo: 10.68 2c) 21.75 6 mo: 27.05 12 mo: 24.70 3) 5.47 6 mo: 4.36 12 mo: 5.28 4a) 7.20 6 mo: 7.20 12 mo: 7.29 4b) 5.10	1a) 2.32 (-1.76) 6 mo: 1.91 12 mo: 1.33 1b) 2.89 (-1.46) 6 mo: 2.13 12 mo: 1.93 1c) 2.23 (-1.45) 6 mo: 1.75 12 mo: 1.36 2a) 11.41 (-5.63) 6 mo: 9.43 12 mo: 9.54 2b) 13.82 (-3.36) 6 mo: 12.67 12 mo: 10.34 2c) 40.79 (-13.5) 6 mo: 34.58 12 mo: 31.13 3) 8.79 (-3.32) 6 mo: 5.77 12 mo: 5.25 4a) 33.69 (-	1a) 1.81 6 mo: 1.66 12 mo: 1.41 1b) 1.62 6 mo: 1.48 12 mo: 1.51 1c) 1.59 6 mo: 1.33 12 mo: 1.23 2a) 8.87 6 mo: 9.07 12 mo: 8.69 2b) 10.22 6 mo: 10.74 12 mo: 9.22 2c) 27.09 6 mo: 30.00 12 mo: 24.88 3) 9.37 6 mo: 7.11 12 mo: 7.29 4a) 8.57 6 mo: 8.76 12 mo: 8.02 4b) 6.96

	(STAIC) a. Trait b. State 5. Children's Attributions and Perceptions Scale (CAPS) a. Negative events b. Credibility c. Trait 6. Shame Questionnaire (Shame)					12 mo: 28.61 4b) 26.22 (-4.29) 6 mo: 24.89 12 mo: 25.44 5a) 6.46 (-1.36) 6 mo: 6.44 12 mo: 6.00 5b) 10.37 (-2.09) 6 mo: 10.86 12 mo: 9.73 5c) 9.86 (-2.59) 6 mo: 9.32 12 mo: 9.06 6) 0.87 (-1.97) 6 mo: 0.76 12 mo: 0.74	6 mo: 4.62 12 mo: 4.81 5a) 2.46 6 mo: 2.49 12 mo: 1.94 5b) 3.38 6 mo: 4.01 12 mo: 3.67 5c) 3.81 6 mo: 3.44 12 mo: 3.62 6) 1.35 6 mo: 1.16 12 mo: 1.35	5.41) 6 mo: 31.42 12 mo: 30.74 4b) 27.76 (-3.72) 6 mo: 26.14 12 mo: 26.55 5a) 7.24 (-1.34) 6 mo: 6.51 12 mo: 6.40 5b) 12.15 (-1.67) 6 mo: 11.08 12 mo: 10.22 5c) 11.38 (-1.75) 6 mo: 9.90 12 mo: 9.73 6) 1.60 (-1.43) 6 mo: 1.29 12 mo: 1.07	6 mo: 5.80 12 mo: 6.65 5a) 2.89 6 mo: 2.58 12 mo: 2.55 5b) 4.26 6 mo: 4.44 12 mo: 3.54 5c) 4.11 6 mo: 3.41 12 mo: 4.30 6) 1.87 6 mo: 1.63 12 mo: 1.78
A Multisite, Randomized Controlled Trial for Children With Sexual Abuse-Related PTSD Symptoms	1. K-SADS-PL (Schedule for Affective Disorders and Schizophrenia for School-Age Children) a. Reexperiencing b. Avoidance c. Hypervigilance 2. CBCL (Child Behavior Checklist) a. Competence b. Internalizing c. Externalizing d. Total 3. CDI (Children's Depression Inventory) 4. STAIC (Spielberger Stat-Trait Anxiety Inventory for Children) a. Trait b. State	1a) 3.98 1b) 4.13 1c) 3.67 2a) 15.84 2b) 13.97 2c) 15.59 2d) 48.48 3) 9.92 4a) 37.27 4b) 30.51 5a) 9.28 5b) 7.82 5c) 12.46 5d) 12.45 6) 10.38 7) 2.84	1a) 1.31 1b) 1.33 1c) 1.21 2a) 3.59 2b) 9.24 2c) 10.47 2d) 27.90 3) 7.50 4a) 6.83 4b) 6.84 5a) 3.01 5b) 3.05 5c) 3.14 5d) 3.97 6) 9.02 7) 2.28	1a) 4.08 1b) 4.35 1c) 3.68 2a) 15.45 2b) 17.04 2c) 17.18 2d) 54.29 3) 12.11 4a) 39.10 4b) 31.48 5a) 10.81 5b) 8.58 5c) 13.82 5d) 13.13 6) 11.42 7) 3.03	1a) 1.30 1b) 1.13 1c) 1.26 2a) 3.60 2b) 9.88 2c) 9.88 2d) 28.03 3) 8.59 4a) 7.96 4b) 8.32 5a) 3.42 5b) 2.91 5c) 3.98 5d) 3.97 6) 10.99 7) 2.18	1a) 1.53 (-2.45) 1b) 1.81 (-2.32) 1c) 1.69 (-1.98) 2a) 16.60 (+0.76) 2b) 8.02 (-5.95) 2c) 11.10 (-4.49) 2d) 31.45 (-17.03) 3) 5.70 (-4.22) 4a) 30.78 (-6.49) 4b) 26.22 (-4.29) 5a) 8.55 (-0.73) 5b) 6.46 (-1.36) 5c) 10.37 (-2.09) 5d) 9.86 (-2.59) 6) 6.26 (-4.12) 7) 0.87 (-1.97)	1a) 1.39 1b) 1.36 1c) 1.28 2a) 3.53 2b) 7.21 2c) 8.52 2d) 21.75 3) 5.47 4a) 7.20 4b) 5.10 5a) 2.96 5b) 2.46 5c) 3.38 5d) 3.81 6) 6.02 7) 1.35	1a) 2.32 (-1.76) 1b) 2.89 (-1.46) 1c) 2.23 (-1.45) 2a) 16.33 (+0.88) 2b) 11.41 (-5.63) 2c) 13.82 (-3.36) 2d) 40.79 (-13.5) 3) 8.79 (-3.32) 4a) 33.69 (-5.41) 4b) 27.76 (-3.72) 5a) 9.36 (-1.45) 5b) 7.24 (-1.34) 5c) 12.15 (-1.67) 5d) 11.38 (-1.75) 6) 8.20 (-3.22) 7) 1.60 (-1.43)	1a) 1.81 1b) 1.62 1c) 1.59 2a) 3.43 2b) 8.87 2c) 10.22 2d) 27.09 3) 9.37 4a) 8.57 4b) 6.94 5a) 3.57 5b) 2.89 5c) 4.26 5d) 4.11 6) 10.45 7) 1.87

	5. CAPS (Children's Attributions and Perceptions Scale) a. Feeling Different b. Negative Events c. Credibility d. Trust 6. CSBI (Child Sexual Behavior Inventory) 7. Shame (Shame Questionnaire)								
Moderators of treatment response to trauma-focused cognitive behavioral therapy among youth in Zambia	PTSD Reaction Index (PTSD-RI) **95% Confidence Intervals (CI) instead of SD	PTSD: 2.24	PTSD: 2.13, 2.35	PTSD: 1.86	PTSD: 1.63, 2.08	PTSD: 0.44 (-1.8)	PTSD: 0.24, 0.65	PTSD: 1.63 (-0.23)	PTSD: 1.27, 2.00
Posttraumatic Stress Disorder and Childhood Traumatic Loss: A Secondary Analysis of Symptom Severity and Treatment Outcome	Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA) The Children's Depression Inventory (CDI)	CAPS-CA: 61.76 CDI: 19.67	CAPS-CA: 16.22 CDI: 8.32	CAPS-CA: 61.17 CDI: 22.52	CAPS-CA: 17.73 CDI: 8.03	CAPS-CA: 30.40 (-31.36) CDI: 12.63 (-7.04)	CAPS-CA: 24.51 CDI: 8.38	CAPS-CA: 45.25 (-15.92) CDI: 21.30 (-1.22)	CAPS-CA: 23.92 CDI: 10.84

Table 4

Outcome Measures for Studies Analyzing Treatment Components

Title	Measures	Experimental Group Mean (Pre)	Experimental Group SD (Pre)	Comparison Group Mean (Pre)	Comparison Group SD (Pre)	Experimental Group Mean (Post)	Experimental Group SD (Post)	Comparison Group Mean (Post)	Comparison Group SD (Post)
A Pilot Randomized Controlled Trial of Combined Trauma-Focused CBT and Sertraline for Childhood PTSD Symptoms	K-SADS-PL (Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime version) PTSD Symptom Re-experience Avoidance Hyperarousal Total Symptoms CGAS (Children's Global Assessment Scale)	PTSD Symptom Re-experience: 3.91 Avoidance: 4.18 Hyperarousal: 3.82 Total Symptoms: 11.09 CGAS: 45.09	PTSD Symptom Re-experience: 0.94 Avoidance: 1.33 Hyperarousal: 0.98 Total Symptoms: 3.08 CGAS: 5.24	PTSD Symptom Re-experience: 3.91 Avoidance: 4.73 Hyperarousal: 4.55 CGAS: 46.64	PTSD Symptom Re-experience: 0.94 Avoidance: 1.19 Hyperarousal: 0.52 CGAS: 5.03	PTSD Symptom Re-experience: 1.36 (-2.55) Avoidance: 2.00 (-2.18) Hyperarousal: 1.45 (-2.37) Total Symptoms: 4.82 (-6.27) CGAS: 66.64 (+21.55)	PTSD Symptom Re-experience: 0.92 Avoidance: 1.41 Hyperarousal: 1.44 Total Symptoms: 3.25 CGAS: 10.12	PTSD Symptom Re-experience: 1.91(-2.00) Avoidance: 2.82 (-1.91) Hyperarousal: 2.36 (-2.19) CGAS: 59.55 (+12.91)	PTSD Symptom Re-experience: 1.70 Avoidance: 1.94 Hyperarousal: 1.96 CGAS: 9.70
Trauma-Focused Cognitive-Behavioral Therapy for Children Sustained Impact of Treatment 6 and 12 Months Later	1. The Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K SADS) a. Reexperiencing b. Avoidance c. Hyperarousal/hypervigilance 2. Child Behavior Checklist (CBCL) a. Internalizing b. Externalizing 3. Child Sexual Behavior Inventory (CSBI) 4. The Children,Äôs Depression Inventory (CDI) 5. The Multidimensional Anxiety scale for children (MASC) 6. The Shame Questionnaire (Shame)	not reported	not reported	not reported	not reported	1a) 1.41 6 mo: 1.62 12 mo: 1.46 1b) 1.35 6 mo: 1.36 12 mo: 1.38 1c) 1.33 6 mo: 1.22 12 mo: 1.56 2a) 6.64 6 mo: 7.69 12 mo: 7.61 2b) 10.35 6 mo: 10.34 12 mo: 10.34 3) 3.13 6 mo: 2.43 12 mo: 2.10 4) 4.61 6 mo: 4.03 12 mo: 4.90 5) 41.98 6 mo: 42.84 12 mo: 37.81 6) 2.93 6 mo: 1.57 12 mo: 2.48 7) 1.97	1a) 0.21 6 mo: 0.24 12 mo: 0.25 1b) 0.20 6 mo: 0.22 12 mo: 0.23 1c) 0.21 6 mo: 0.23 12 mo: 0.24 2a) 0.98 6 mo: 1.06 12 mo: 1.12 2b) 0.99 6 mo: 1.10 12 mo: 1.19 3) 0.66 6 mo: 0.73 12 mo: 0.78 4) 0.96 6 mo: 1.10 12 mo: 1.19 5) 2.83 6 mo: 3.17 12 mo: 3.34 6) 0.52 6 mo: 0.56 12 mo: 0.62 7) 0.22	1a) 1.02 6 mo: 0.92 12 mo: 0.71 1b) 1.09 6 mo: 1.00 12 mo: 0.74 1c) 0.78 6 mo: 0.80 12 mo: 0.60 2a) 4.01 6 mo: 5.99 12 mo: 5.25 2b) 6.08 6 mo: 7.66 12 mo: 8.06 3) 1.68 6 mo: 2.58 12 mo: 2.39 4) 6.09 6 mo: 3.32 12 mo: 4.61 5) 36.51 6 mo: 37.64 12 mo: 35.81 6) 1.85 6 mo: 1.53 12 mo: 1.41 7) 2.66	1a) 0.24 6 mo: 0.26 12 mo: 0.26 1b) 0.22 6 mo: 0.24 12 mo: 0.25 1c) 0.23 6 mo: 0.25 12 mo: 0.26 2a) 1.08 6 mo: 1.15 12 mo: 1.19 2b) 1.10 6 mo: 1.19 12 mo: 1.25 3) 0.73 6 mo: 0.79 12 mo: 0.82 4) 0.97 6 mo: 1.04 12 mo: 1.08 5) 2.88 6 mo: 3.08 12 mo: 3.13 6) 0.49 6 mo: 0.54 12 mo: 0.55 7) 0.24

	7. The Fear Thermometer 8. The What If Situations Test (WIST) **adjusted mean and standard error of adjusted mean					6 mo: 2.35 12 mo: 2.14 8) 19.07 6 mo: 18.83 12 mo: 18.68	6 mo: 0.24 12 mo: 0.26 8) 0.59 6 mo: 0.66 12 mo: 0.71	6 mo: 2.18 12 mo: 2.20 8) 19.86 6 mo: 20.58 12 mo: 19.72	6 mo: 0.26 12 mo: 0.27 8) 0.65 6 mo: 0.72 12 mo: 0.73
Trauma-Focused Cognitive Behavioral Therapy for Children: Impact of the Trauma Narrative and Treatment Length	1. Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS) a. Reexperiencing b. Avoidance c. Hypervigilance 2. Child Behavior Checklist (CBCL) a. Internalizing b. Externalizing 3. Child Sexual Behavior Inventory (CSBI) 4. The Children's Depression Inventory (CDI) 5. Multidimensional Anxiety Scale for Children (MASC) 6. The Shame Questionnaire (Shame) 7. Fear Thermometer (Fear) 8. What if Situations Test (WIST) **adjusted mean and standard errors of outcome measures; change in pre and post-test measures (no pre-test)	not reported	not reported	not reported	not reported	1a) 8>16 sessions: 0.44 1b) 8>16 sessions: 0.44 1c) not reported 2a) not reported 2b) TN>no TN: 0.45 3) not reported 4) not reported 5) 8 no TN>8 sessions TN: 0.55 8 no TN>16 sessions no TN: 0.57 6) not reported 7) no TN>TN: 0.54 8) not reported	not reported	n/a	not reported

Studies without Comparison Groups

Five of the selected studies, see Table 2, did not have comparison groups, and only analyzed TF-CBT. One study utilized the Trauma Symptom Checklist for Children (TSCC) to measure anxiety, depression, anger, posttraumatic stress, etc. The study reported improvements in every area after three months of treatment, with significant improvement for anxiety, depression, anger, posttraumatic stress, and fantasy dissociation (Ruiz, 2016). A study without a comparison group done by Hébert and Daignault (2015) was conducted with twenty-five participants, and had follow-ups taken a year after treatment. The study used the Child Behavior Checklist (CBCL), Child Post-Traumatic Stress Reaction Index-Parent Questionnaire (CPTS-RI-PQ), and the Child Dissociate Checklist (CDC) for their measures. The pre and post-test scores of the article show that the total post-traumatic stress symptoms score decreased by 13.71. However, there was not a significant decrease (2.06) in the avoidance scores. In addition, the follow-up scores showed sustained improvements over time (Hébert & Daignault, 2015).

The results for the RCT conducted by Deblinger et al. (2017) show that the scores for resiliency, specifically the sense of mastery and sense of relatedness, increased by 4.50 and 4.36. The scores from the Beck Depression Inventory-II (BDI-II), CDI, and Schedule for Affective Disorders and Schizophrenia for School Age-Children- Present and Lifetime Version PTSD Module (K-SADS-PTSD) showed significant improvement after treatment (Deblinger et al., 2017). A similar study, done with 384 children ages 6-14, grouped the subjects into three categories: having complex PTSD (C-PTSD), having classic PTSD, and being resilient. For all categories there was a significant improvement in dissociation, internalizing, and externalizing problems. The treatment showed greater improvement for those with C-PTSD, with a decrease of 18.66 for PTSD scores (Hébert & Amédée, 2020). One mixed-methods study, with three female

participants, presented mixed results with two out of the three reporting an improvement in PTSD scores. For one subject, the PTSD scores increased from pre-treatment to post-treatment by 2 (Schmidt et al., 2022).

Studies with Comparison Groups

There were eight studies, all of which were RCTs, containing a comparison group, with three being follow-up studies, see Table 3. In Cohen and Mannarino (1996) CBT-SAP was compared to nondirective supportive therapy (NST), for preschool aged children. When compared to NST, CBT-SAP showed more improvement of symptoms for social competence, internalizing and externalizing behaviors, and child sexual behavior (Cohen & Mannarino, 1996). The follow-up study done in 1997 showed sustained improvement from the pre-test scores after 12 months, with more improvement for CBT-SAP than NST. CBT-SAP presented a better decrease in sexual behavior overtime, with lower Child Sexual Behavior Inventory (CSBI) scores than NST (Cohen & Mannarino, 1997). A third study done by Cohen et al. (2005) showed greater improvements for anxiety, depression, dissociation, and sexual problems with TF-CBT at the 6 month follow up. When compared to NST at 12 months, TF-CBT showed better scores for PTSD and dissociation (Cohen et al., 2005).

Another RCT compared SAS-CBT to NST, and the pre-test score for CBCL social competence for NST was higher than the SAS-CBT score. The CDI, CBCL social competence, and STAIC-Trait (State-Trait Anxiety Inventory for Children) scores showed significant improvement for SAS-CBT versus NST (Cohen & Mannarino, 1998). Furthermore, a multi-site study with a comparison group resulted in more improvement in the TF-CBT scores for depression, PTSD, behavior problems, abuse-related attributions (credibility and trust), and shame when compared to child-centered therapy (CCT) (Cohen et al., 2004). The follow-up

study for the RCT done by Cohen et al. (2004) exhibited maintained lower scores for PTSD symptoms and shame for TF-CBT at 6- and 12-months post-treatment. However, CCT showed more improvement in externalizing behavior at 12 months (Deblinger et al., 2006).

One secondary analysis conducted in Zambia studied TF-CBT for orphans and vulnerable children (OVC). For those that experienced sexual abuse and went through TF-CBT, there were greater reductions in PTSD scores than those that went through treatment as usual (TAU). Specifically, the PTSD scores went down by 1.8 for those in TF-CBT, and 0.23 for those in TAU (Kane et al., 2016). Additionally, a secondary analysis from Germany indicated lower CAPS-CA (Clinician Administered PTSD Scale for Children and Adolescents) and CDI scores for those in TF-CBT when compared to those in the waitlist (Unterhitzenberger et al., 2020).

Studies Analyzing Treatment Components

As listed on Table 4, There are three studies that examine specific treatment components for TF-CBT, with one being a follow-up. Cohen et al. (2007) analyzed TF-CBT with sertraline and TF-CBT with a placebo pill. The TF-CBT plus sertraline group had greater improvement in CGAS (Children's Global Assessment Scale) ratings. However, both groups showed improvements in PTSD symptoms such as re-experiencing, avoidance, and hyperarousal (Cohen et al., 2007). A second article tested the impact of the trauma narrative (TN), along with treatment length within TF-CBT. All conditions, including the presence of the TN and treatment length showed improvement for all outcomes. Those that received the TN component reported less fear and anxiety when compared to the absence of the TN. As for treatment length, participants that underwent sixteen sessions presented fewer symptoms of reexperiencing and avoidance than those that completed 8 sessions (Deblinger et al., 2011). The follow-up study

resulted in maintained improvements for all 14 outcome measures after 6 months and 12 months (Mannarino et al., 2012).

Discussion

Summary of Evidence

The goal of this systematic review was to assess the treatment impacts of TF-CBT for child and adolescent survivors of CSA found throughout literature. When analyzing the sixteen included studies, there were significant improvements overall. According to the results, TF-CBT was effective for most participants. However, one study did offer mixed results, as one subject's PTSD score increased after treatment. The increase in scores may indicate a lack of immediate treatment effect for the participant (Schmidt et al., 2022). These findings are consistent with other systematic reviews regarding CBT and TF-CBT for additional populations with trauma histories (Cary & McMillen, 2012; Sousa-Gomes et al., 2022; Tichelaar et al., 2020).

The positive treatment effects of TF-CBT, including CBT-SAP and SAS-CBT, were noticeable across the included publications. Specifically, PTSD scores improved throughout multiple studies. There was remarkable symptom reduction of anxiety and depression found within several studies. Furthermore, many participants experienced improved behavior problems. Another key finding from the results is that certain treatment components appear to be important for positive treatment effects. For instance, the use of a trauma narrative and longer treatment length showed further improvement for participants than those that did not have a trauma narrative or shorter treatment (Deblinger et al., 2011). In addition, the use of medication, like sertraline, indicates more improvement (Cohen et al., 2007).

As previously stated, other systematic reviews for CBT with survivors of CSA and TF-CBT with different trauma types reveal the overall effectiveness of CBT and TF-CBT

(Macdonald et al., 2012; Passarela et al., 2010; Ramirez de Arellano et al., 2014). This systematic review builds on the literature by analyzing the treatment impacts of TF-CBT for youth that have experienced CSA. The data analysis and results indicate that TF-CBT, along with specific treatment components, have positive impacts, such as reduction in PTSD, anxiety, and depression, as well as improvement in behavior. This review also found that TF-CBT has positive treatment effects for vulnerable populations that have underwent trauma (such as CSA).

Limitations and Future Research Implications

A main limitation of the included publications was a lack of diversity in cultural and ethnic backgrounds. Most of the studies took place in the United States and had participants that were primarily Caucasian. The lack of diversity indicates a need for further research to be done across multiple countries and amongst more diverse settings. Further studies could be conducted in child welfare agencies, community mental health programs, and similar ethnically diverse settings. Another limitation was that five of the studies did not include comparison groups and were not randomized. Without comparison groups or randomization, it is more difficult to determine whether the treatment was effective. For more thorough evidence, more RCTs should be done comparing various treatment methods to TF-CBT.

A third limitation found within some of the studies was the presence of small sample sizes. Small sample sizes are often not as reliable and valid as larger sample sizes (Faber & Fonseca, 2014). Similarly, several of the included publications did not offer follow-up data. The lack of follow-up data makes it difficult to ascertain the sustainability of the treatment's impacts. This review suggests research with larger sample sizes and follow-up data be produced. Additionally, a limitation exists with the sample populations being more female than male.

Future studies should be more balanced in the sex/gender of their sample populations in order to study the difference in treatment effects for a participant's gender.

Implications for Policy and Clinical Practice

This systematic review adds to the existing evidence that TF-CBT has positive treatment impacts for CSA survivors, therefore, policies regarding increased funding for implementation of TF-CBT (including training) in different settings should be examined. Policies that create more availability and accessibility for the treatment should be promoted as well. Currently, there is a gap in research when studying how widely TF-CBT is being used and by who. A national survey, such as the one performed by Herbell and Ault, (2021) could be conducted to further understand how much TF-CBT is being used and by what facilities. A similar implication for policy research is the analysis of barriers to the adoption of TF-CBT.

There is a general need for more sustainability and collaboration for evidence-based practices (EBPs) like TF-CBT (Bright et al., 2010). Sustainable funding could occur through the addition of TF-CBT as a reimbursable service through both public and private insurance programs. Having TF-CBT as a reimbursable service would allow for more accessibility and encourage providers to offer it as treatment. For instance, as Graaf and Snowden (2021) suggest, some states have billing codes for EBPs where the payment rates are tailored to the cost of the intervention (including training, supervision, etc.) along with the cost of living for certain areas in a state.

Clinically, TF-CBT seems to be effective for more vulnerable populations that have gone through moderate to severe trauma, such as CSA. This systematic review's results indicate positive treatment effects for CSA survivors, especially those diagnosed with PTSD. Therefore, clinicians that work with young clients that have been sexually abused should implement TF-

CBT. A second clinical practice implication of this review is that treatment should be tailored to the individual. Clinicians may find that certain components can be delivered in different ways. For instance, younger clients could draw their trauma narrative, instead of speaking about it. Given the effectiveness of treatment components such as the trauma narrative and sertraline, it is suggested that further research be done on other treatment components. In conclusion, conducting RCTs with larger and gender-balanced samples in more diverse settings, that examine treatment components and offer follow-up data, would bridge the research gaps, and provide further evidence for the implementation of TF-CBT for child and adolescent survivors of childhood sexual abuse.

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