European Child & Adolescent Psychiatry (2019) 28:877–897
https://doi.org/10.1007/s00787-018-1150-z

REVIEW

Users' experiences of trauma-focused cognitive behavioural therapy for children and adolescents: a systematic review and metasynthesis of qualitative research

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Received: 20 July 2017 / Accepted: 27 March 2018 / Published online: 25 May 2018

Abstract

Trauma-focused cognitive behavioural therapy (TF-CBT) is an effective intervention for post-traumatic stress disorder, yet implementation may be hindered by practitioners' concerns about how treatment is experienced by users. This metasynthesis systematically reviews qualitative evidence on youth and caregivers' experiences of TF-CBT to better understand user perspectives on process and outcomes of treatment. A systematic review and metasynthesis were undertaken for qualitative studies of treatment experience related to TF-CBT. Data were extracted according to Evidence for Policy and Practice Information and Coordinating Centre guidelines, and studies were critically appraised using Critical Appraisal Skills Programme checklists. Findings from included studies were coded and synthesized using thematic synthesis methodology. Eight studies were selected after a full-text review of 39 papers. Findings were organised around nine sub-themes, under three broad thematic categories: 'engagement in TF-CBT'; 'experience of treatment components'; and 'therapeutic outcomes'. Youth were often unclear about what to expect from treatment and concerned about (in)compatibility with their therapist. Youth reports indicated how such misgivings can be addressed through early psychoeducation and efforts to strengthen the therapeutic alliance. Once underway, treatment was viewed as a place of refuge and validation, aided by therapist competence and confidentiality. Youth and caregivers felt that constructing a trauma narrative was instrumental for recovery. Cognitive-behavioural coping techniques were useful during treatment and in the long-term. While participants in TF-CBT may begin treatment with unclear expectancies, careful attention to early engagement and other process issues can optimise process and outcomes. Implications for clinical practice and further research are discussed.

Keywords Cognitive behavioural therapy · Trauma · User experience · Metasynthesis · Systematic review

Introduction

Exposure to traumatic events in early life is associated with a range of adverse health outcomes that can extend well into adulthood [1, 2]. One potential outcome is the development of Posttraumatic Stress Disorder (PTSD), characterized by re-experiencing aspects of the trauma, intense or prolonged

Electronic supplementary material The online version of this article (https://doi.org/10.1007/s00787-018-1150-z) contains supplementary material, which is available to authorized users.

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psychological distress, physiological reactions to internal or external cues, and avoidance of trauma reminders [3, 4]. Symptoms usually manifest within one month of the traumatic event, but up to 15% of cases have onset after several months or longer [4]. A meta-analysis of PTSD incidence rates from studies in the USA, UK, Australia, Afghanistan, China, and South Africa, estimated that approximately 16% of children and adolescents (aged 2–18 years) developed PTSD after exposure to trauma [5]. PTSD is also highly comorbid with other disorders, such as depressive, bipolar, anxiety, or substance abuse disorders [3].

Trauma-focused cognitive behavioural therapy (TF-CBT) is recommended as a first-line treatment for children and adolescents (henceforth referred to collectively as "youth") who present with PTSD within three months of a traumatic event [6]. Individual TF-CBT is more effective than treatment as usual in reducing PTSD symptoms [7, 8], and is well-established for the treatment of children and adolescents exposed to trauma [9]. TF-CBT is defined as a psychological therapy that predominantly uses trauma-focused cognitive and behavioural techniques in individual or group formats [7]. All variants of TF-CBT aim to confront trauma reminders and memories through the development of a trauma narrative in a form preferred by the child (e.g. involving writing, drawing, music, dance), and mastery of trauma reminders (in vivo or imaginal) by gradual exposure to trauma-related cues (ibid). The theoretical rationale for exposure to trauma-related stimuli is rooted in the cognitive model of PTSD [10]. This model posits that individuals experiencing PTSD are characterized by (i) negative appraisals of the traumatic event and/or its sequelae that create a sense of serious threat in the present, and (ii) poor elaboration and inadequate contextualization of the trauma memory in the autobiographical memory of the individual, which result in the triggering of intrusive memories. Therefore, to achieve recovery in PTSD, the negative appraisals of the traumatic memory need to be modified; the trauma memory needs to be elaborated and integrated into the individual's experiences; and dysfunctional behavioural or cognitive strategies (e.g. rumination, substance abuse, avoidance, heightened vigilance) need to be discontinued (ibid). Specific trauma-focused strategies are combined with more generic practice elements such as relaxation training (e.g. deep breathing, muscle relaxation) and cognitive coping skills to help identify negative thought patterns, manage emotional arousal, and modify cognitive distortions contributing to negative appraisals, such as self-blame, shame, and low self-esteem [11, 12]. TF-CBT protocols for children and adolescents often include parallel sessions for caregivers, to teach supportive strategies and address family factors that may be maintaining PTSD symptoms.

Despite the demonstrated efficacy of TF-CBT in numerous trials with trauma-affected youth populations, practitioner surveys indicate concerns about treatment acceptability (i.e. the perception that a given treatment is agreeable or satisfactory) [13, 14]. Studies have found that only 17% of clinical psychologists used imaginal exposure to treat PTSD, despite at least half being familiar with the technique [15]. This may be because imaginal or prolonged exposure is less likely to be used when practitioners are concerned about exacerbating symptoms or increasing treatment dropouts [15–17]. Generic psychoeducation about anxiety and coping skills are also more likely to be used than trauma-specific components, which require a focus on the trauma memory [13]. This runs counter to evidence that links change mechanisms in TF-CBT to processing of the traumatic experience through exposure to trauma-related stimuli [18]. On the other hand, TF-CBT is associated with higher dropout rates among adults compared with therapies that do not include exposure components, suggesting that practitioners' concerns may partly reflect clinical experience [7].

It is also important to examine treatment experiences directly from the users' perspective. Previous research in this area has tended to prioritise adult perspectives, reflecting assumptions about developmental constraints on children's and adolescents' reflective capacity and understanding of mental health care [19]. However, when youth are positioned as knowledge agents and consulted about their experiences, this can lead to novel insights into different components and outcomes of treatment [20]. Studies have shown that youth can reliably report on their experiences of care, and their views can diverge in important ways from adults [21, 22]. Direct evidence from youth is therefore vital in understanding how intervention content and delivery can be optimised. It is also notable that caregiver involvement is a core component in TF-CBT, usually implemented through conjoint caregiver–child sessions. Caregiver involvement is associated with added benefits, such as improved communication between youth and caregivers, and enhanced skills for caregivers in supporting the traumatised child or adolescent [12]. In view of this, caregivers' experiences are also highly relevant to optimising intervention content and delivery.

Using methods of metasynthesis, this study aims to consolidate and interpret existing qualitative research to generate new insights about how youth and caregivers experience the content and delivery of TF-CBT. Extrapolating from this evidence base, a second aim is to consider recommendations for TF-CBT practice and research.

Methods

Study methods and findings have been reported in line with the Enhancing Transparency of Reporting the Synthesis of Qualitative Research (ENTREQ) framework, detailed in electronic supplementary Appendix 4 [23].

Eligibility criteria

We used the SPIDER tool to structure the eligibility criteria and search strategy [24]. We included studies if: (i) the sample included a majority of children and adolescents aged up to 19 years of age (reflecting WHO/UNICEF age cut-offs), and/or their caregivers (no age limit) [25]; (ii) TF-CBT was employed, based on the following operational definition: an intervention that predominantly used exposure to trauma-related stimuli combined with generic cognitive-behavioural techniques, based on an identifiable protocol and delivered in individual or group formats [7]; (iii) qualitative data were collected by un/semi/structured individual interviews, and/or focus groups with children, adolescents, and/or their caregiver(s) who were participants in TF-CBT, with ethnographic designs considered if they included interviews and focus groups; and (iv) experience of TF-CBT was the main outcome of interest. We excluded studies if: (i) they used case reports and written narratives that described clinical response to treatment rather than users' experiences of TF-CBT; and (ii) ethnographic studies if they relied solely on observation.

Information sources

We adopted a comprehensive approach to searching and aimed to find both published and unpublished studies. Electronic searches on MEDLINE (1946–August Week 5 2016), PsycINFO (1987–Week 4 September 2016), and Embase (1988–2016 Week 36) were undertaken up to September 2016; searches on CINAHL. Pubmed, ERIC, IBSS, Cochrane CENTRAL Register of Controlled Trials, Conference Papers Index, and Social Services Abstract were undertaken up to June 2016. The grey literature was searched for using Conference Papers Index, Social Services Abstract, and ProQuest Dissertations and Theses (Global, and UK & Ireland), and scoping searches were conducted on Google Scholar. The Journal of Clinical Child Psychology and Psychiatry (1996–April 2016) and Journal of Clinical Child and Adolescent Psychology (1990–2016) were hand-searched. Reference lists of included studies were also searched. We aimed to find studies published after 1990, as previous systematic reviews of TF-CBT have shown that relevant studies are unlikely to have been published before this date [8]. Title and abstract screening, full-text review, and data extraction were carried out by the first author (LN), with queries discussed in consultation with a senior author (DM).

Search

The search terms used are listed in Table 1. A detailed search strategy is provided in electronic supplementary Appendix 1.

Data collection process

EPPI-Centre guidelines on data extraction were used to develop a data extraction form [26]. EPPI-Reviewer was used to extract data from the studies.

Quality assessment

We used the Critical Appraisal Skills Programme (CASP) checklist for qualitative research, along with two additional criteria from National Institute for Health and Care Excellence (NICE) guidelines for describing the study context and reliability of data collection methods [27]. The appraisal was initially carried out by LN, with subsequent amendments made after consultation with DM and SH. We specified that under a given quality criterion, a study marked as Yes/Clearly Described/Appropriate was scored as 1, a study marked as Partially Valuable/Relevant was scored as 0.5, and a study marked as Insufficient Information to Rate/No/Not Clearly Described/Inappropriate was scored as 0. We did not exclude lower quality studies, but used quality appraisal as a tool to assess trustworthiness and value of findings [28].

Table 1 Search Terms

Search category	Search terms
Sample (S)	child* or teen* or juvenile* or minor* or kid* or youth* or young* or adolescen* or pube* or pre-pube* or preschool* or pre-school* or paren* or mother* or father* or caregive*
Phenomenon of Interest (P of I)	Trauma-focused cognitive behavioural therapy or trauma focused cognitive behavioural treatment or trauma focused cognitive behavioural tx or (trauma focused adj cognitive behavioural) or (trauma-focused adj cognitive behavioural) or TF-CBT or (cognitive adj behavioural) or cognitive behavioural therapy or cognitive behavioural treatment or cognitive therapy or cognitive treatment or CBT
Design (D)	questionnaire* or survey* or interview* or focus group* or case stud* or observ* or qualitative* or thematic analy* or content analy* or ethnog* or phenomenol* or purpos* sampl or emic or etic or hermeneutic* or heuristic* or semiotics or (data adj1 satur*) or (participant adj1 observ*) or field study* or lived experience* or narrative analy* or (discourse adj3 analysis) or grounded theor* or multi-method* or mixed-method* or triangula* or formative evalua* or process evalua*
Evaluation (E)	view* or experienc* or opinion* or attitude* or perce* or belie* or feel* or know* or understand*
Research Type (R)	qualitati* or mixed-meth* or mixed meth* or multi-meth* or multi meth*
	[S AND P of I] AND [(D OR E) AND R]

Data analysis

We carried out a qualitative metasynthesis of studies, using a thematic synthesis methodology to integrate findings from individual studies and generate new interpretations of the phenomena of interest [29]. Our focus was on users' experiences of TF-CBT, including their perceptions of different components of TF-CBT, barriers and facilitators to positive outcomes, and whether treatment was ultimately helpful. The findings of studies were entered into EPPI-Reviewer, and line-by-line coding of the text was carried out primarily by the first author, as per established procedures [30]. Codes and descriptive themes were inductively generated, and then reviewed with the co-authors, resulting in modification and refinement of codes and descriptive themes. Direct quotes from participants and descriptors used by study authors were considered. Analytical themes, which went beyond describing the content of the included studies, were generated to address the aims of this metasynthesis.

Results

Study selection

After removing duplicates with the aid of EPPI-Reviewer, 4578 titles and abstracts were screened for eligibility. Screening identified 33 duplicate records, and we eliminated a further 4506 records based on title and abstract. We were left with 35 studies from database searches and four studies from other sources (searching the reference lists of included studies, scoping searches on Google Scholar, and hand searching past issues of specified journals). We excluded 31 studies during full-text screening (presented in electronic supplementary Appendix 2). In total, eight studies were included (details presented in Table 2). The details of the search and screening process are provided in a PRISMA Flow Diagram (Fig. 1).

Study characteristics

Detailed characteristics of included studies are provided in Table 2. Studies were carried out in Bosnia and Herzegovina (1); Cambodia (1); Jordan (1); Norway (1); Sweden (1); USA (2); and Zambia (1). The TF-CBT protocol developed by Cohen et al. [1] was used in four studies, along with adaptations to incorporate contextual and cultural concerns [31–34]. Other variants of TF-CBT were used, including Stepped TF-CBT, a parent-led, therapist-assisted version of TF-CBT [35]; Cognitive–Behavioural Intervention for Trauma in Schools (CBITS) [36]; and two other manualised trauma-focused psychotherapeutic group interventions [37, 38]. Four studies described individual TF-CBT [31, 33–35], and four studies addressed group formats [32, 36–38]. Treatment was delivered in residential shelters for victims of trafficking and sexual exploitation [31], child protection centres [32], mental health clinics [33], schools [36, 37], and at home with some sessions at the therapist's office [35]. Four studies did not mention any caregiver involvement in treatment [31, 33, 37, 38], while caregiver involvement was described in four studies [32, 34–36].

The majority of study samples consisted of adolescents [31–37], with one study conducted among children aged 4–6 years [38]. Participants were exposed to a wide range of traumatic events, such as physical and sexual abuse, domestic violence, witnessing intimate partner violence, peer violence, accidents, sudden death of a parent, and war. Seven studies used individual interviews to access participant experiences [31–36, 38], while one study used focus groups for data collection [37].

Critical appraisal

Detailed quality assessments of included studies are provided in electronic supplementary Appendix 3. The quality of the studies varied, with four studies rated as high quality (scored 9 or above) [33, 34, 36, 38]; two studies rated as moderate quality (scored 6–9) [35, 37]; and two studies rated as low quality (scored below 6) [31, 32].

The research design was stated, but not justified under an existing theoretical framework, in a majority of studies. In most studies, the methods were judged to be appropriate to address the aims of the research. Sampling and recruitment strategies were rated less positively, with three studies providing sufficient information to assess these criteria [32, 33, 37]. Data collection procedures were generally well described, but two studies did not discuss data collection procedures in sufficient detail to rate this item [31, 32]. None of the studies considered reflexivity, or verification/triangulation of findings using multiple methods of data collection to improve reliability, which could have potential implications for the generalisability of findings [39]. Descriptions of data analyses were of moderate quality, with a majority of studies discussing the process of analysis in some depth, including how themes were derived from the data, and the number of researchers involved in coding the data. Two studies offered insufficient details in their presentation of findings [31, 32]. Regarding ethics procedures, the majority of studies were rated as having met all or most of the criteria [32, 33, 35, 36, 38].

Synthesis of results

Three thematic categories emerged from the data: 'engagement in TF-CBT' [33, 35, 38]; 'experience of treatment components' [32–36]; and 'therapeutic outcomes' [31–38]

Table 2 List and Characteristics of Included Studies

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Bass (2011)	**Search Strategy** Reference lists **Language** English **Type of Study** Feasibility **Support for the Study** Source of funding stated	**Country** Cambodia **Service Context** Conducted in shelters associated with two participating NGOs, World Vision Cambodia and Hagar Cambodia **Sample Size** $n=12$	**Age** Mean age of 15 years, with most having completed grade 4 or less. Age range was 12-20 years **Clinical Characteristics** Exposure to a wide range of traumatic events, such as sexual abuse, kidnapping, witnessing a dead body, hearing about the death of a loved one **Demographic Characteristics** $n=8$ were of Khmer ethnicity, with 1 Khmer Muslim participant and 3 Vietnamese participants; $n=11$ females and $n=1$ male	**Manual** Based on manual by Cohen and Mannarino (2004) **Therapists** Khmer counsellors and supervisors were trained in two phases moving from familiarization with TF-CBT components, and practical knowledge of implementation in a culturally flexible manner, to practice groups and more detailed training in specific components such as the trauma narrative. A system of program monitoring and general supervision was employed by TF-CBT trainers and participating NGOs **Structure** 12-15 sessions, though some needed fewer sessions, and others needed more **Delivery** Individual sessions. Joint sessions with parents were not conducted due to geographical distance and lack of safety in familial relationships **Content** Psychoeducation, relaxation, affect regulation, trauma narrative, safety and social skills, and positive parenting skills if parents/caregivers were involved	**Data Collection** In-depth interviews **Data Analysis** Thematic analysis

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Cox (2007)	**Search Strategy** Database search **Language** English **Type of Study** Qualitative, linked to an evaluation of a school-based psychosocial program for war exposed adolescents **Support for the Study** Source of funding stated	**Country** Bosnia and Herzegovina **Service Context** Participants recruited from 10 secondary schools located across three central Bosnian cities **Sample Size** $n = 34$ (5 focus groups)	**Age** Age not mentioned (secondary school students with a majority in the tenth grade) **Clinical Characteristics** Adolescents with histories of severe war trauma who continued to experience significant psychosocial problems after the war **Demographic Characteristics** Bosnian adolescents (predominantly Muslim). Mixed sex; two-thirds female	**Manual** Based on manual by Layne et al. (2003) **Therapists** School counsellors; multiple training seminars were held in pulsed fashion each fall, winter, and spring to equip counsellors and supervisors with knowledge and skills **Structure** 16-to-20 sessions **Delivery** Group treatment **Content** Presentation of trauma-related psychoeducational information; learning and/or practicing one or more coping skills; therapeutically processing issues related to trauma exposure; maintaining healthy adolescent development. Four sequential modules, titled Cohesion–Building, Psychoeducation, and Coping Skills; Constructing the Trauma Narrative; Coping with Traumatic Loss and Grief; and Resuming Developmental Progression. Involved didactic psychoeducational exercises, trauma processing work, grief processing work, interactive group activities and small-group therapeutic processing	**Data Collection** Focus groups **Data Analysis** Grounded theory

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Damra (2014)	**Search Strategy** Database search **Language** English **Type of Study** Feasibility study of TF-CBT **Support for the Study** Source of funding not stated	**Country** Jordan **Service Context** Participants were referred from Community Local Organizations (CLOs) and child protection institutes, where they were had been referred due to experience of physical abuse from parental caregivers **Sample Size** $n = 18$	**Age** 10-12 years. Parents' age was not mentioned **Clinical Characteristics** All adolescents were suffering from PTSD symptoms and depression for at least five weeks prior to treatment. Most of the adolescents had been physically abused 4-6 months before the intervention **Demographic Characteristics** Sample was entirely male	**Manual** Based on the manual by Cohen, Mannarino, and Deblinger (2006) **Therapists** 10 Jordanian experts in psychotherapy and four authorized, accredited children counsellors also participated in the adaptation and feasibility of the intervention. Counsellors were trained in the adapted version, and monitoring and supervision sessions were conducted **Structure** Ten sessions of adapted group TF-CBT were delivered. First session consisted of pre-test assessments relating to PTSD and depression, obtaining informed consent from adolescents and parents, general discussions about participation, and Better Parenting Skills Education training for parents. Active treatment took place over 2–9 sessions. The tenth session discussed impact, experiences, and was carried out post-assessment of the intervention **Delivery** Group TF-CBT. Parental involvement was limited to mostly mothers; fathers were not involved **Content** Content was based on original manual with adaptations relating to length of treatment sessions, number of sessions spent on each TF-CBT component, and suitable activities tailored to Jordanian culture. Experiences of adolescents undergoing physical abuse in Jordan were also considered	**Data Collection** Interview **Data Analysis** Thematic content analysis

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Dittman (2014)	**Search Strategy** Database search **Language** English **Type of Study** Qualitative, linked to an effectiveness study of TF-CBT **Support for the Study** Source of funding stated	**Country** Norway **Service Context** Mental health clinics **Sample Size** $n=30$	**Age** 11–17 years **Clinical Characteristics** All had experienced at least one traumatic incident such as sexual abuse, domestic violence, violence from peers, life threatening accidents, or the sudden death of a parent. Most had completed their treatment except for four youth who had ended treatment prematurely (dropout defined as not completing 6 sessions of TF-CBT) **Demographic Characteristics** 23 were girls and seven were boys; the majority of participants had at least one European-born parent and lived in one-parent households; seven youth had parents from a minority background	**Manual** Based on the manual by Cohen, Mannarino, and Deblinger (2006) **Therapists** 26 TF-CBT therapists volunteered to receive training in TF-CBT. Most were psychologists, and the rest were psychiatrists, educational therapists, and clinical social workers. On average, therapists had 10.2 years of experience. All therapists received between four and six days of initial training with initial session-by-session supervision provided by trained TF-CBT therapists. Fidelity was controlled for using the TF-CBT Fidelity Checklist **Structure** Not mentioned (implied 12 sessions per treatment manual) **Delivery** Individual TF-CBT was delivered (caregiver involvement not mentioned) **Content** Psychoeducation about trauma and trauma reactions, stress management training, work with affect expression and modulation skills, creation of a trauma narrative and alteration of maladaptive appraisals	**Data Collection** Semi-structured interview carried out over the phone **Data Analysis** Thematic analysis

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Murray (2014)	**Search Strategy** Database search **Language** English **Type of Study** Qualitative, linked to a feasibility study of TF-CBT **Support for the Study** Source of funding stated	**Country** Zambia **Service Context** Adolescents and caregivers were referred from a centre that serves youth who have experienced sexual violence. **Sample Size** Youth: $n = 18$ Caregivers: $n = 16$	**Age** Mean age of 12.76 years (SD = 1.75) **Clinical Characteristics** The sample was exposed to a number of traumatic events, and all had been sexually abused. Inclusion criteria were a score of 39 or higher on the modified PTSD-RI and indication of a traumatic event **Demographic Characteristics** Youth participants were all female	**Manual** Based on the manual by Cohen, Mannarino, and Deblinger (2006) **Therapists** 22 Zambians were trained using a phased, apprenticeship model. 3 counsellors had formal clinical training, and the majority did not have an educational background in teaching or psychology **Structure** 12 to 16 1-hr sessions, individualized to meet the needs of each child/youth and family **Delivery** Individual TF-CBT was delivered, and caregivers were involved **Content** Treatment modules as outlined in the original manual, with adaptations of parenting skills due to differing parenting practices in Zambia	**Data Collection** Semi-structured interview **Data Analysis** Grounded theory

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Pernebo and Almqvist (2016)	**Search Strategy** Hand searching **Language** English **Type of Study** Process evaluation **Support for the Study** Source of funding stated	**Country** Sweden **Service Context** Children were recruited from two agencies supporting children exposed to domestic violence **Sample Size** $n = 9$	**Age** Aged between 4 and 6 years (M = 5.5 years) **Clinical Characteristics** All children had experienced interpersonal violence (IPV) against the mother for a significant period of their lives **Demographic Characteristics** Five girls and four boys. All children lived in one of the two major urban areas in Sweden and were Swedish speaking. Six children had at least one parent who was not native Swedish. Seven children lived with the abused parent, one child lived in foster care and one child lived alternately with both parents	**Manual** Children Are People Too program, and developmentally informed trauma-focused psychotherapy (group treatment) **Therapists** Experienced group leaders, either psychologists or social workers, led each group **Structure** Both program were highly structured, and consisted of weekly sessions in a group setting for children and parallel groups for abused parents. Treatment length was 12–15 weeks, with weekly sessions on a fixed day and time **Delivery** Group TF-CBT was delivered, with parallel group sessions for abused parents **Content** Every session was structured around a theme such as violence, security, family relations, separation, recognition and expression of feelings or affect regulation	**Data Collection** Semi-structured interview conducted over phone **Data Analysis** Interpretative phenomenological analysis

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Salloum (2015)	**Search Strategy** Scoping searches **Language** English **Type of Study** Qualitative, linked to a randomised evaluation of Stepped Care TF-CBT **Support for the Study** Source of funding stated	**Country** USA **Service Context** Community-based non-profit agency in a city. **Sample Size** Children: $n = 16$ Caregivers: $n = 17$	**Age** 8-12 years (mean age 9.53 years), and mean age of caregivers was 36.53 years **Clinical Characteristics** Identified index trauma that the children/adolescents reported included significant exposure to sexual abuse, and the remaining to domestic violence, death of someone close, and accident **Demographic Characteristics** 6 children/adolescents were Hispanic/Latino. 11 White and 6 African American/Black participants. Participating parents were female; 12 were biological mothers, 3 grandmothers, and 2 great-aunts. 10 parents were married/partnered; 3 single and divorced/separated respectively; and 1 widowed. 11 parents were employed	**Manual** Stepped Care TF-CBT based on the manual by Salloum, Scheeringa, Cohen and Storch (2014) **Therapists** Treatment was provided by four masters-level therapists who worked at the community-based agency **Structure** Parents and children/adolescents met with the therapist three times, once every other week, and the parent was given one section of a three part parent–child workbook called Stepping Together in each session. The parents and children/adolescents completed the workbook at home by having 11 parent–child meetings over the course of Step One **Delivery** Delivered via parent–child meetings **Content** Workbook activities consisted of learning skills (e.g., identifying feelings; relaxation exercises); developing a trauma narrative and a fear hierarchy of trauma reminders; and completing exposures to trauma reminders by drawing, imagining, and completing in vivo activities. After Step One, an assessment occurred to determine 'responder status' which indicated if the child/adolescent entered the maintenance phase or proceeded to Step Two, which consisted of all of the components of standard TF-CBT	**Data Collection** Interview **Data Analysis** Thematic analysis

Table 2 (continued)

Study	Study Details	Study Setting	Study Sample	Intervention	Data Collection and Analysis
Santiago (2016)	**Search Strategy** Database search **Language** English **Type of Study** Qualitative, linked to a quasi-experimental pilot study of CBITS (with a family component) **Support for the Study** Source of funding stated	**Country** USA **Service Context** Schools serving low-income and/or Latino families **Sample Size** Children $n = 21$ Caregivers: $n = 15$	**Clinical Characteristics** Exposure to violence and trauma (specific clinical characteristics of sample not discussed) **Demographic Characteristics** All participating parents were Latino/Hispanic; 12 were mothers, and 3 were fathers. 12 students were female. Ten parents reported being married or cohabiting, and the others were single, divorced/separated or widowed. A majority of parents reported not finishing high school. Twelve parents reported being born outside the U.S. **Age** Mean age of children was 11.59 years; mean age of parents was 38.07 years	**Manual** Cognitive–behavioural Intervention for Trauma in Schools (CBITS), based on a manual by Jaycox (2003) **Therapists** School-based social workers **Structure** 10 group sessions for children/adolescents, with 1-3 individual sessions (for the trauma narrative) and 1-2 group meetings with parents. The family component offered additional parent modules aimed at increased parental engagement, and involved 4 more sessions with parents. **Delivery** Predominantly delivered in group formats for children and parents. Parents' group sessions were typically held in Spanish or conducted bilingually (in both Spanish and English) **Content** Psychoeducation, relaxation training, cognitive therapy, stress or trauma exposure, and social problem-solving. Family component offered parent engagement, psychoeducation, parent–child communication, positive parent and family coping strategies, positive parenting strategies, and a joint parent–child session to review the program	**Data Collection** Semi-structured interview conducted over phone **Data Analysis** Grounded theory

with three corresponding sub-themes for each category. Illustrative quotations from youth and caregivers are presented in Table 3, with all quotations from youth unless otherwise specified.

1. Engagement in TF-CBT

    1. Unclear Expectancies of Treatment

        Youth participants were generally uninformed about what treatment would entail. Reports also suggested negative anticipation around potential incompatibility with the therapist, and fear of being pressured to talk about personal histories [33, 35]. Having positive expectancies of treatment was uncommon, and closely related to previous positive experiences with therapy (ibid).
    2. Therapy as a Place of Refuge

        Therapy was described as a safe space, where youth felt protected and supported [38]. In group treatment, physical and emotional safeties were reinforced by predictability in terms of the room, furniture, timings, and consistency in meeting other participants and group leaders (ibid). The therapist's commitment to confidentiality was also cited as being important in fostering a safe therapeutic space [33, 35, 38]. Youth further reported that they felt validated in therapy, because it was a space devoted exclusively to understanding them (ibid). This was in contrast with other environments that did not afford the same sort of singular dedication to understanding and addressing their needs. This notion was also present in group treatment, where children reported developing empathic relationships with their peers and group leaders [38].
    3. Therapist Role and Characteristics

        Therapist characteristics were reported to have an important influence on treatment experience and outcomes, with reports of youth dropping out of therapy because they did not like their therapist [33]. Youth described feeling reassured about the therapist's formal qualifications and professional experience (ibid). Therapists' expertise and knowledge of trauma reactions and difficulties allowed youth to discuss their experiences openly without fearing how the therapist might react, which otherwise made them hesitant about discussing their experiences with caregivers and other adults (ibid). Competence in terms of well-organised, structured, and sensitively paced sessions contributed to the development of therapeutic alliance [38]. The therapist was also perceived as an advocate who respected youth preferences and priorities, and sought permission before discussing sensitive topics with caregivers [33]. Caregivers also emphasised the utility of the therapist in imparting psychoeducation, and providing flexible support by telephone [35].

2. Experience of Treatment Components

    1. Cognitive-behavioural Elements

        Youth and caregivers endorsed the utility of various cognitive-behavioural coping techniques [33–35]. Affective expression and modulation strategies allowed youth to express themselves and provided a release for negative feelings [33]. Cognitive restructuring and coping strategies were identified as helpful in changing maladaptive thought patterns, self-blame and guilt [ibid]. Relaxation strategies were also viewed positively, including specific endorsements of breathing exercises, "happy place" imagery, and muscle relaxation exercises. Benefits were noted in feeling calm, managing stressful situations, and providing practical coping strategies that could be used in everyday situations over the longer term [32, 35].
    2. Trauma-focused Elements

        Youth commonly experienced heightened negative affect and physiological arousal prior to, and during, exposure work [33]. Nevertheless, youth and caregivers generally emphasised the benefits of exposure after its completion, highlighting that they achieved habituation to anxiety-provoking memories and situations through exposure work [33, 35]. The process of exposure was facilitated by relaxation exercises while constructing the trauma narrative; drawings and demonstrations/physical reenactments; empathy and kindness on the part of the therapist; clear psychoeducation; and sensitive pacing [33]. On the other hand, youth were more likely to emphasise the negative experience of exposure when they had felt pressured to talk about the traumatic event(s), and where the therapist had failed to acknowledge their discomfort [33, 35].
    3. Caregiver Involvement

        In caregiver-facilitated treatment models, youth and caregivers reported that they appreciated one-on-one time with each other during sessions, as it allowed them to work at their own pace, discuss traumatic events, and build a trusting relationship [35]. Caregiver involvement also increased caregivers' understanding about how to support a traumatised young person, and was perceived to be culturally relevant [36]. Caregiver-facilitated treatment was impeded by initial reluctance of the traumatised

child to embark upon treatment, and procedural difficulties for caregivers such as a lack of sufficient information about facilitating treatment, particularly in the initial sessions [35, 36]. Structural barriers to caregiver involvement (e.g. fitting in sessions alongside work and childcare commitments) were also highlighted [36].

3. Therapeutic Outcomes

1. Improved Coping and Reduced Symptoms

Youth and caregivers expressed overall satisfaction with treatment effects, with positive outcomes described broadly in terms of improved coping and symptom reduction [32–35, 38]. Youth reported improvements in a range of cognitive, emotional, behavioural and interpersonal domains, including reduced avoidance, suicidal thoughts, self-harm, aggression, physiological arousal, anger, negative peer influence, alcohol use and risky sexual behaviour, reduction in intrusive traumatic memories, increased concentration and academic focus, improved sleep hygiene, self-worth, self-esteem and self-care [31–34, 36, 38]. Caregivers noted improvements in their own coping skills and their capacity to support children with implementing coping strategies [32, 35, 36]. In terms of adverse outcomes, one study reported a single case of persistent suicidal thoughts after the conclusion of TF-CBT, occurring mainly in situations of peer conflict [31].

2. Functioning and Recovery

Youth related their functional gains indirectly to symptomatic relief [36]. They also described how changes in negative thought patterns and trauma beliefs contributed to optimism for the future and agency over life choices [33]. Youth participants noted more patience with parents and peers, and improved interpersonal relationships overall [31]. Caregivers reported improvements in relationships with their own children and family, in addition to increased social support obtained by forming networks with other caregivers [36]. Youth participants noted that their caregivers were more likely to listen to their concerns [34, 36, 37].

3. Barriers to Treatment

Identified barriers included teachers' disapproval of youth attending school-based group treatment [37]. Lack of clarity about structure and appropriateness of topics for discussion in group treatment were also reported [38]. Youth and caregivers suggested that written materials could be improved by inclusion of more visually appealing and age-appropriate content; there were also suggestions about employing alternative technology-facilitated modalities such as websites or DVDs [35, 36].

Discussion

This metasynthesis aimed to investigate youth and caregivers' experiences of TF-CBT. We found that youth commonly reported apprehension about initiating treatment, related to uncertainty about the content and process of TF-CBT, and negative expectancies about their prospective therapist. However, youth were generally positive about the experience of TF-CBT after completing a course of treatment. Engagement and clinical outcomes were aided by the therapist's expertise, respect for confidentiality, and sensitive pacing, particularly in the implementation of trauma-focused exposure. The experiences of youth and caregivers with TF-CBT highlight that treatment components with a focus on trauma memory are beneficial for recovery and acceptable to clients, if carefully implemented. Constructing a trauma narrative was reported to be instrumental for recovery, which lends weight to findings in other studies that exposure treatment is an essential component of TF-CBT [40–42]. On this point, the surveyed evidence indicated that creative and age-appropriate narrative techniques (including drawings and demonstrations/physical reenactments), empathy and kindness on the part of the therapist, as well as core elements of most TF-CBT protocols (clear psychoeducation about trauma reactions, sensitive pacing, and graded exposure) are key to achieving positive therapeutic outcomes.

Many of the positively endorsed aspects of treatment using TF-CBT are consistent with the wider literature related to children's and young people's experiences of mental health care. Our finding that youth felt apprehensive before beginning treatment is consistent with other studies that have linked a lack of information about treatment with anticipatory anxiety [21, 43]. Consistent with these studies, youth expressed feeling ill-informed and unprepared at the outset of treatment, and harboured apprehension that the therapeutic process would be intrusive and generally uncomfortable (ibid). Among our included studies, youth emphasised the central importance of the therapeutic relationship in building trust and overcoming initial reluctance around treatment participation [44, 45]. We found that the factors that promoted therapeutic engagement in TF-CBT—perceived competence, collaboration and confidentiality—overlap with other studies that have found these factors to be instrumental to establishing an effective therapeutic relationship with youth [44, 46, 47]. We also found evidence that young people were keen to be consulted on caregiver involvement, and appreciated therapists' efforts to bridge parent–child communication gaps. This is consistent with

evidence that youth (particularly adolescents) strongly value their privacy and autonomy, and may be circumspect about caregiver involvement in therapy [21, 46]. For their part, caregivers reported personal benefits in terms of improved stress management skills. They appreciated being consulted on treatment goals, and were interested in acquiring skills that would help with managing traumatic symptoms experienced by youth [48].

Youth reports in our included studies highlighted that notions of safety/refuge are especially salient in TF-CBT and may be closely related to the impacts of trauma itself. The theoretical rationale for TF-CBT recognises the central importance of safety, which allows for the secure elaboration of traumatic memories in their appropriate autobiographical context [49]. When youth are exposed to trauma, they may go on to experience heightened perceptions of threat more generally and reduced trust in relationships, affecting their everyday functioning in physical and social environments [50, 51]. Some youth may also be facing ongoing threats to safety, which helps to explain why physical/emotional safety in the teatment process and the development of specific safety skills in TF-CBT may be highly valued by participants [11].

Strengths and limitations

To the authors' knowledge, this is the first systematic metasynthesis of youth and caregivers' experiences of TF-CBT. Our metasynthesis is strengthened by its use of transparent, auditable, and reproducible methods, and its presentation of detailed characteristics of included studies and their contexts. However, there are several limitations. First, only English literature was searched, although we searched grey literature and contacted topic experts to identify additional potentially relevant studies. Second, screening, extraction, and appraisal of studies were carried out primarily by one author, although coding and development of sub-themes and themes were undertaken collaboratively by co-authors. Third, the generalisability of findings may be limited due to lack of evidence from specific sub-populations (e.g. younger children) and users who dropped out of treatment. On the other hand, the main themes to emerge from our metasynthesis appeared to be fairly consistent across the included samples, suggesting broad applicability [30].

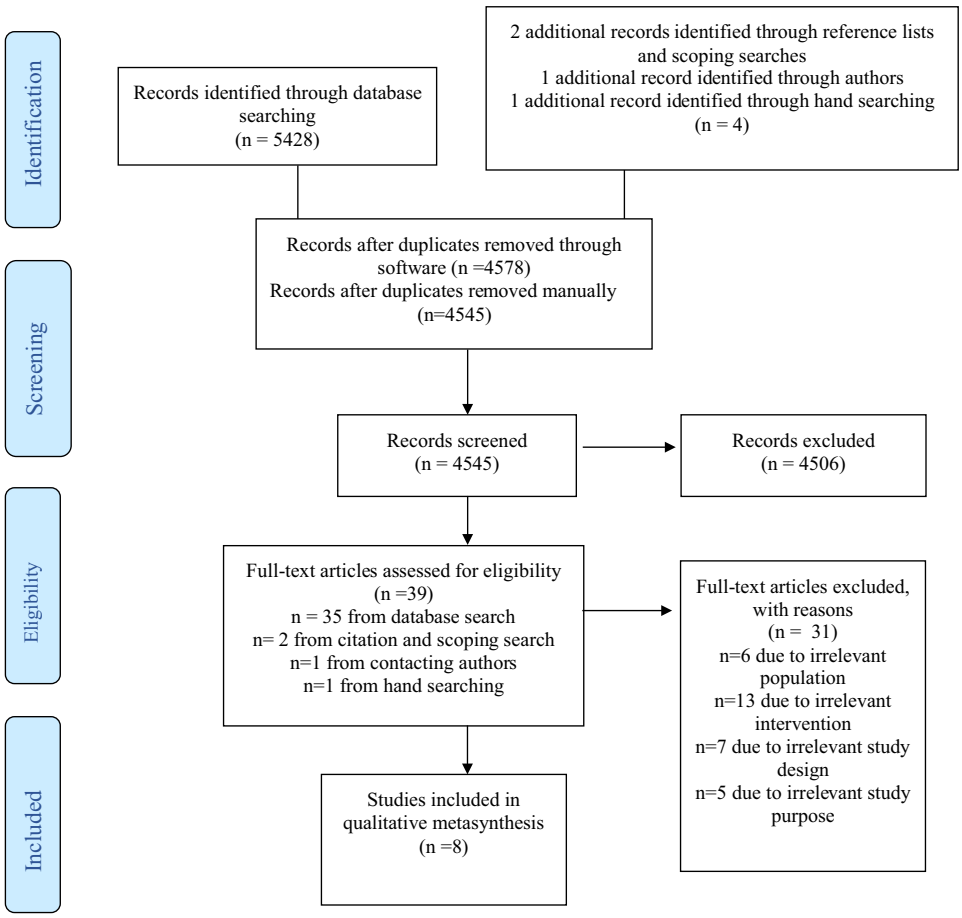

Fig. 1 PRISMA flow diagram for qualitative metasynthesis

Table 3 Illustrative Quotations Organised around Themes, Sub-themes and Codes

Codes	Quotations from participants in primary studies
1. Engagement in TF-CBT	
1. Unclear expectancies of treatment	
Unclear expectancies of treatment	"I dreaded telling a strange lady what I had experienced." [33] "When you are going to sit down and talk to another person about personal stuff and the other person doesn't know you and you don't know the person … in the beginning you are wondering what things will be like and what they will expect from you." [33]
2. Therapy as a place of refuge	
Safety in group treatment	"What's good about the group is that you can play, feel happy; nobody is frightening, you are not afraid, nobody is fighting and stuff"' [38] "It is so pleasant to be here, to come here, other times it is not so pleasant, so I like most to be here a lot." [38]
Feeling listened to and understood	"I have Mommy all the time, but the therapist I can go to once a week and talk a little more and we are just doing that, not preparing dinner at the same time and stuff." [33] "It feels bad to talk about it…because, because nobody understands what I'm saying…when I was at, when I was at the police, there, I, I talked about what happened and then, but she did not understand what I said… because I speak slowly, when I was at the police I spoke too fast … and [group leaders] they listen, they don't talk'…" [38]
Therapy as a space to explore trauma	"It was nice talking to her because I knew I got help at the same time… And then I wanted to talk to her a lot more than Mommy because I knew Mommy could not do anything about it. The only thing I knew when I talked to Mommy was that I made her more and more upset." [33]
3. Therapist role and characteristics	
Expertise is valued	"The psychologist has studied how the patient may feel, and how he can make the patient feel better, and they know how they are supposed to talk and what to say and not say." [33]
Empathy is appreciated	"My friends said 'Oh, everything will be all right, I understand, I know…' and that bothered me very, very much. I wanted to punch them! Because they don't know and they don't understand! So there's no point in saying that. However, when I went to (the therapist's name) she never said 'I understand', she said 'I think it would have been the same for me if I had been in your situation'. She never said 'Oh, I know how you are feeling'." [33]
Therapist as respectful advocate	"I thought it was okay that mummy spoke to the therapist because then she got information about what she could do regarding what had happened to me." [33]
Therapy was not helpful due to absence of alliance	"Since I didn't get along with the therapist I didn't get much out of it really." [33]
2. Experience of treatment components	
1. Cognitive-behavioural elements	
Value of affective expression and modulation strategies	"It's really fun and I think this program is for people to get their feelings out and express how they feel inside so they don't have to keep it to themselves or tell their friends, and you don't tell an adult or anything. And when I did it, it made me feel good inside and proud of what I did." [35]

Table 3 (continued)

Codes	Quotations from participants in primary studies
Value of breathing and other relaxation exercises	*Caregiver* "I loved the way she was building like a toolbox of resources to help herself; to me that was the most important thing. Like the breathing exercises, that was very good and I even asked her, 'what do you think is helping you with this,' and she talked about the breathing and she told me it does help." [35] "The breathing … It helped calm me down". [35] "We do, we do a relaxation. It is like, you do a jellyfish, you lay down, and then you relax and you are a jellyfish, first you are a fishbone and become tense [shows] … and then you, you calm down, then you're calm, then you are the jellyfish, and then you feel: ah! It's really easy, a piece of cake! Look!" [38]
2. Trauma-focused elements	
Scared and anxious before talking about the trauma	"I started crying even when we only talked about doing it because I felt so scared." [33]
Building hierarchies for exposure	"The scary ladder … How things that were like not so scary and things that are really scary" [35]
Value of breathing exercises during trauma narrative	"She (the therapist) said that if it was difficult we could stop and do some breathing exercises and that helped very much." [33]
Reduced distress after completion of trauma narrative	"The whole purpose of the treatment was that the assault was to become like an ordinary memory and not something to be afraid of. And that turned out very well. The first time she read the story we had written out loud, I started crying, but after a while she could read it many times and I could read it myself without feeling overwhelmed." [33]
Not helpful to construct a trauma narrative when not ready	"It was the fact that I had to drag up the things that had happened and that I didn't have time to think about it and that I felt pressured to talk about it when I didn't feel ready. I wished we could have done it another time when I was more ready and that I could have decided when, but I felt that I couldn't…that I had to say it right away. And when I said 'no' many times and that I couldn't do it, she didn't listen to me so at the end I had to say it to her. That was difficult for me." [33]
Constructing the trauma narrative was ultimately helpful even if not shared	*Caregiver* "And then sometimes it was just difficult for her to do what was requested of her because she was so closed. Like she would find other ways to avoid having the meeting with me or discuss what was required of her. She would do it if I gave her space and gave her the opportunity to write down what happened or how she felt, but she would not want to necessarily express it to me…So I think her behaviour changed and I think it made her feel better knowing that someone else knew what happened and that she didn't have to keep it to herself." [35]
3. Caregiver involvement	
Building a better relationship with the child	*Caregiver* "I liked that we were able to work on the stuff together; that he was able to build trust in me and being able to talk to me about what happened, and that he and I kind of worked on those feelings together." [35] *Caregiver* "The time it created for me and her to- it created time where she knows she can open up, you know, even if she knows she can do it anytime, but she at least knows that if we sit down, that's time where we can talk and she doesn't have to worry about anybody else being around. It's just for me and her." [36]
Helped the caregiver improve coping skills	"They helped my mom forget about the event [trauma] too and I think it was fun for them because they got better at problems too." [36]
Flexibility in treatment structure	*Caregiver* "I liked the fact of not having to come in every week for a meeting, or specifically doing it a certain way." [35]
Increase in knowledge and skills for caregivers	*Caregiver* "We don't know, and we think that us as parents are perfect and correct, and it is not true. You need to know how to guide your kids." [36]

Table 3 (continued)

Codes	Quotations from participants in primary studies
Uncertainty about "doing it right"	*Caregiver* "I'm not sure if I - even though I tried my best and I did follow the program strictly, I'm not sure that I did it the right way because I mean- yes I tried and everything, but I'm not a psychologist. So there was always that in my mind - 'did I do this right? Is this the way it should be? Maybe I should've done this, maybe." [35]
3. Therapeutic outcomes	
1. Improved coping and reduced symptoms	
Improved mood	"I'm in a much better mood and stuff …I even heard it from a class mate…and normally we boys don't talk about each other's mood and that kind of stuff, but I was actually told that I have become a much happier person …" [33]
Improved secondary appraisals about self-blame	"When I was raped I used to cry when I think about it. I would blame myself that it is because of me that's why I was raped. But due to the program and the counsellor I should not be blaming myself about what happened to me because it was not my fault." [33]
Reduced anxiety	"It has helped me to be free and not to be scared of anything and to tell when something is bothering me.'' [34]
Sense of hope and agency	"I used to think negatively… that life sucks…That there wasn't any hope for me and that I would turn out to be a bad person…But after starting therapy I started to think that things change and it's only me that controls the possibilities and that I should start doing my best and if I get…when I get the chance I shouldn't lose it." [33]
Acquisition of safety skills	"You should call the police, or tell the mum to call the police, and you should lock the door, or tell the mum to lock the door'." [38]
2. Functioning and recovery	
Increased social support	*Caregiver* "What was more helpful to me was listening to the other parents' experiences, and you can actually say that you are not by yourself. So it was just not a professional telling me for a better way to do things; you are actually hearing it from different parents." [36]
Reduction of negative coping strategies	"If that person had, for example, experienced the same thing as me, then I would have recommended that they found someone to talk to right away, because it helps so much. Because it is almost dangerous in a way to be by yourself and think … I used to cut myself and if I hadn't found someone to talk to, I could have … cut myself again. Because I had so much anxiety and stuff. It's really just about believing in oneself and not being afraid of receiving help. That is the most important thing." [33] *Caregiver* "She has changed like I said she now does not drink alcohol, does household chores, she plays with friends and does not sleep around with men.'' [34]
Improved relationships with peers	"I used it [skills from the program] in dealing with my friends from class, with peers. It [the group] helps us think more positively, to not only be concerned with ourselves, but to turn to our friends as well." [37] "The father of one of our friends died, and she was not in school for a couple of days. When she came to school, a teacher wanted her to report [take a verbal examination]. We advocated for her by asking the teacher to wait a day or two [so that] she would learn it [the material]." [37]
Improved relationships with family	"I had problems with my sister—we did not get along very well, and that influenced our mother … Our [group] leader helped me reconcile with my sister and now we have better relationships in our family." [37]
3. Barriers to treatment	
Lack of childcare	*Caregiver* "My work, since I am a single parent … my work place doesn't allow me to leave work so that was a big challenge." [36]

Table 3 (continued)

Codes	Quotations from participants in primary studies
Lack of time for participation	*Caregiver* "Not all want to lose time and listen to their kids or the talks. They are always busy, all the time, and they don't want to lose a day or a few hours for the sessions." [36]
Limited access to TF-CBT	*Caregiver* "I have learnt that this program is only in few areas, it would be appreciated if it would be made available in most areas of the country and made known to children so that even on their own they can access this service." [34]
Multiple modalities for resources	*Caregiver* " … I think it would help if [parents] would be able to go on a website and check it out, or also have a DVD and listen to it…but I like the format of a book." [36]
Lack of structure and appropriateness of topics in group treatment	"We have talked, first when only X and I were here [during intake], we talked about what it was about, about safety … what he has done; he hit us. No, no we don't talk about such things there [in the group], there you can't do that, it is only here … it feels bad to talk about it. No, you don't talk about that [being angry about somebody fighting] here, you talk about that at home." [38]

Clinical implications

Clinical guidelines for PTSD largely concur with the user experience data considered in the present review [52]. A key challenge for practice is that youth who appraise their coping ability to be low or do not understand the TF-CBT model may perceive attempts at exposure as coercive, which may lead to reduced treatment benefit and/or dropout [53]. As such, extended psychoeducation is recommended to explain the rationale and procedures for exposure, including the potential for distress and the likelihood that distress will pass. Therapists should also take active steps to manage arousal and accommodate client preferences, such as the development of adaptive coping strategies, use of creative techniques for building a trauma narrative/hierarchy, and sensitive pacing. The latter is important in all psychotherapies, but our findings suggest that it is especially critical for TF-CBT.

Our findings also indicated that youth participants favour a predictable and consistent therapeutic environment in TF-CBT. The therapist might usefully offer psychoeducation about the content of each session in advance; apply a consistent structure and schedule for each session, including recurring activities and regular days/times where possible; and/or ensure a predictable physical environment in terms of the room and furniture. Therapists can also promote agency and controllability by giving explicit choices to youth and fostering collaborative decision-making, e.g. about the extent and timing of caregiver involvement [54, 55].

Implications for research

The evidence in this review provides an empirical basis for developing testable hypotheses of use in experimental research, e.g. studies comparing treatment outcomes and engagement in standard TF-CBT against TF-CBT with enhanced psychoeducation, or studies comparing modes of TF-CBT with different levels of caregiver involvement. In addition, qualitative investigations of therapists' experiences of TF-CBT, and youth who dropped out of treatment, would provide complementary insights into the implementation of TF-CBT. These could be systematically triangulated with youth and caregiver perspectives. Given the lack of studies looking at children's experience of TF-CBT, additional research with pre-adolescents would help with understanding developmental influences on treatment experience across ages.

Conclusions

Traumatised youth and their parental caregivers generally reported positive experiences of receiving TF-CBT. There were indications that engagement challenges can be effectively addressed through sensitive pacing and proactive efforts to address information needs of participants. As well as identifying distinctive experiential aspects of TF-CBT (notably the emphasis placed on emotional and physical safety), we also found considerable overlap between TF-CBT experience and mental health service experience for youth more generally. These findings further emphasise the utility of exploring users' experiences of psychological interventions, providing valuable insights for treatment development and wider mental health service improvement.

Acknowledgements This manuscript is based on a dissertation originally submitted by Lakshmi Neelakantan in partial fulfilment of the MSc in Evidence-Based Social Intervention and Policy Evaluation at University of Oxford. Ms. Neelakantan was sponsored by the Chevening Scholarships, the UK Government's global scholarship programme,

funded by the Foreign and Commonwealth Office (FCO) and partner organisations.

Compliance with ethical standards

Conflict of interest On behalf of all authors, the corresponding author states that there are no conflicts of interest. The authors report that they have no clinical or financial interests as trainers or providers of TF-CBT.

Ethical standards All human and animal studies have been approved by the Departmental Research Ethics Committee (DREC), Department of Social Policy and Intervention, University of Oxford and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

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