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Users' Experiences of Trauma-Focused Cognitive Behavioural Therapy for Children and Adolescents: A Systematic Review and Metasynthesis of Qualitative Research

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Abstract

Background 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, in order to better understand user perspectives on process and outcomes of treatment. **Methods** 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. **Results** 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. **Conclusion** While participants in TF-CBT may begin treatment with unclear expectancies, careful attention to early engagement and other process issues can optimise progress and outcomes. Implications for clinical practice and further research are discussed.

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 psychological distress, physiological reactions to internal or external cues, and avoidance of trauma reminders [3-4]. Symptoms usually manifest within a 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 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 Behavioral 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 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, in order to teach supportive strategies and address family factors that may be maintaining PTSD symptoms.

Despite 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 drop-out 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 youth 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 to 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 children and caregivers, and enhanced skills for caregivers in supporting the traumatised youth [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 Appendix 5 [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 outlined above, 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, and 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. Grey literature was searched for using Conference Papers Index, Social Services Abstract, and ProQuest Dissertations & 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 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 Appendix 1.

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 behavioral therapy or trauma focused cognitive behavioral treatment or trauma focused cognitive behavioral tx or (trauma focused adj cognitive behavioral) or (trauma-focused adj cognitive behavioral) or TF-CBT or (cognitive adj behavioral) or cognitive behavioral therapy or cognitive behavioral 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 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 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].

Data Analysis

We carried out a qualitative metasynthesis of studies, using the 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. Following [30], 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 (LN). Codes and descriptive themes were inductively generated, and then reviewed with the co-authors, resulting in modification and refinement of codes and descriptive themes. Eligible data were classified as text under sections titled 'Results'/'Findings'. Direct quotes from participants and descriptors used by study authors were considered. Analytical themes, which go 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 4 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 thirty-one studies during full-text screening (presented in Appendix 2). In total, 8 studies were included (details presented in Table 2). The details of the search and screening process are provided in a PRISMA Flow Diagram (Figure 1).

Table 2. List and Characteristics of Included Studies

Study	Found Via	Document Type	Study Details	Study Setting	Study Sample	Intervention	Data Collection & Analysis
Bass (2011)	Reference lists	Study by charity and university research centre Linked to a feasibility study of TF-CBT in Cambodia	**Search Strategy** Reference List **Language of report** English **Status of report** Published **Abstract** Not included **Format** Study by children's charity and university research centre **Type of Study** Feasibility **Support for the study** Source of funding stated	**Country** Cambodia **Service Context** Feasibility of TF-CBT with sexually exploited girls. **Sample Size** n=12. female =11, male =1.	**Child age** Average 15 years of age, 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 etc. **Other criteria** n=8 were of Khmer ethnicity, with 1 Khmer Muslim participant and 3 Vietnamese	**Manual (title/authors)** TF-CBT. Manual not mentioned. Mention of TF-CBT's effectiveness in the context of Cohen and Mannarino (2004). **Therapists (background/training/supervision)** 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.	**Data Collection** In-depth interviews **Data Analysis** Not explicitly mentioned, but appears to be thematic analysis.

					participants. **Criteria for recruitment**: Caseload which involved each counsellor picking up 1 TF-CBT case as a 'training case', which then involved a shelter supervisor identifying participants from 'training cases' who displayed significant symptoms based on their own judgment. Assessment tool was not identified.	**Structure (number/length of sessions, programme duration)** 12-15 sessions, though some need fewer sessions, and others need more. **Delivery (group/individual/parental involvement)** Individual sessions. Joint sessions with parents were not conducted due to geographical distance and lack of safety in familial relationships. Conducted in shelters associated with two participating NGOs, World Vision Cambodia and Hagar Cambodia. **Content (focus of individual and/or family sessions, and change strategies)** TF-CBT consisting of components relating to psychoeducation, relaxation, affective regulation, trauma narrative, safety and social skills, and positive parenting skills if parents/caregivers are	

						involved, was used.	
Short Title	**Found Via**	**Document Type**	**Study Identification**	**Study Setting**	**Study Sample**	**Intervention**	**Data Collection & Analysis**
Cox (2007)	Database Searching	Journal article Linked to quantitative evaluation of the same program	**Search Strategy** Electronic Search **Language of report** English **Status of report** Published **Abstract** Included **Format** Journal Article **Type of Study** Qualitative Program evaluation **Support for the study** Source of funding not stated	**Country** Bosnia and Herzegovina **Service Context** Evaluation of Trauma/Grief-Focused Group Intervention with Bosnian Adolescents in schools **Sample Size** 5 focus groups, n=34 participants	**Child age** Age not mentioned (secondary school students with a majority in the tenth grade). **Sample** Bosnian adolescents (predominantly Muslim). Mixed sex; two-thirds female. Recruited from treatment participants from ten secondary schools, out of 26 schools that participated in the program, located throughout three central Bosnian cities. **Clinical characteristics** Adolescents with histories of severe war trauma who	**Manual (title/authors)** Trauma/Grief-Focused Group Treatment. Based on manual by Layne et al., (2003). **Therapists** (background/training/supervision) School counsellors with supervisors conducted sessions. Multiple training seminars were held in pulsed fashion each fall, winter, and spring to equip counsellors and supervisors with knowledge and skills. **Structure (number/length of sessions, programme duration)** Short-term (i.e.,16-to-20 session) groups following a manualized yet flexible group–based approach. **Delivery (group/individual/parental involvement)** Group treatment in a school setting.	**Data Collection** Focus Group **Data Analysis** Grounded Theory

					continue to experience significant psychosocial problems after the war **Other criteria** Bosnian adolescents (predominantly Muslim). Mixed sex; two-thirds female.	**Content (focus of individual and/or family sessions, and change strategies)** 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. Involves didactic psychoeducational exercises, trauma processing work, grief processing work, interactive group activities and small-group therapeutic processing.	
Short Title	**Found Via**	**Document Type**	**Study Identification**	**Study Setting**	**Study Sample**	**Intervention**	**Data Collection & Analysis**
Damra (2014)	Database searching	Journal article	**Search Strategy** Electronic Search	**Country** Jordan	**Child age** 10-12 years. Parents' age was not	**Manual (title/authors)** Group TF-CBT. Based on the manual by Cohen,	**Data Collection** Interview

			Language of report English **Status of report** Published **Abstract** Included **Format** Journal Article **Type of Study** Feasibility **Support for the study** Source of funding not stated	**Service Context** Assessing acceptability and validity of TF-CBT in Jordan **Sample Size** n=18	mentioned. **Clinical characteristics** 18 abused children referred from Community Local Organizations (CLOs) and child protection institutes for their experience with physical abuse in their homes by their parents. All children were suffering from PTSD symptoms and depression for at least five weeks prior to treatment. Most of the children had been physically abused 4-6 months before the intervention. **Other criteria** Sample was entirely male.	Mannarino, and Deblinger (2006). **Therapists (background/training/supervision)** Ten Jordanian experts in psychotherapy and four authorized, accredited children counselors also participated in the adaptation and feasibility of the intervention. Counselors were trained in the adapted version, and monitoring and supervision sessions were conducted. **Structure (number/length of sessions, programme duration)** 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 children and parents, general discussions about participation, and Better Parenting Skills Education training for parents. Active treatments took place in sessions 2-9 with the	**Data Analysis** Thematic Content Analysis

						components of TF-CBT and their adapted versions being implemented. The tenth session discussed impact, experiences, and carried out post-assessment of the intervention. **Delivery (group/individual/parental involvement)** Group TF-CBT was delivered in Child Care Units by child counselors. Parental involvement was limited to mostly mothers; fathers were not involved. **Content (focus of individual and/or family sessions, and change strategies)** Content of TF-CBT was as laid out in treatment manuals, and adaptations of components relating to length of treatment sessions, number of sessions spent on each TF-CBT component, and suitable activities for each component to tailor it to Jordanian culture by reviewing literature and considering other adaptations implemented in	

						Jordanian/Arabic cultural settings. Experiences of children undergoing physical abuse in Jordan were also considered.	
Short Title	**Found Via**	**Document Type**	**Study Identification**	**Study Setting**	**Study Sample**	**Intervention**	**Data Collection & Analysis**
Dittman (2014)	Database searching	Journal article	**Search Strategy** Electronic Search **Language of report** English **Status of report** Published **Abstract** Included **Format** Journal Article **Type of Study** Qualitative **Support for the study** Source of funding stated	**Country** Norway (inferred from study, not explicitly mentioned) **Service Context** Youth experiences of TF-CBT in regular mental health clinics **Sample Size** n=30	**Child age** 30 youth interviewed were 11–17 years old. 23 were girls and seven were boys, and all had received TF-CBT. **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	**Manual (title/authors)** TF-CBT. Based on the manual by Cohen, Mannarino, and Deblinger (2006). **Therapists (background/training/supervision)** TF-CBT therapists (n=26) volunteered to receive training in TF-CBT. Most of them 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 by using the TF-CBT Fidelity Checklist.	**Data Collection** Semi-structured interview Carried out over the phone **Data Analysis** Thematic Analysis

					defined as not completing 6 sessions of TF-CBT). **Other criteria** Majority of participants had at least one European-born parent and lived in one-parent households; seven youth had parents with a minority background. Recruitment was ceased once saturation was attained.	**Structure (number/length of sessions, programme duration)** Not mentioned (impliedly 12 sessions per treatment manual) **Delivery (group/individual/parental involvement)** TF-CBT was delivered in mental health clinics by psychologists, psychiatrists; educational therapists and clinical social workers. Interviewers were 3 clinical psychologists (two of whom were the authors of the study), who were not involved in the youth therapy. **Content (focus of individual and/or family sessions, and change strategies)** Treatment content consisted of psycho-education 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.	

Short Title	Found Via	Document Type	Study Identification	Study Setting	Study Sample	Intervention	Data Collection & Analysis
Murray (2014)	Database searching	Journal article Part of a feasibility study of TF-CBT in Zambia	**Search Strategy** Electronic Search **Language of report** English **Status of report** Published **Abstract** Included **Format** Journal Article **Type of Study** Qualitative **Support for the study** Source of funding not stated	**Country** Zambia **Service Context** Examination of Zambian counselors', children, and caregivers' perceptions of TF-CBT **Sample Size** n=21 (all female) received TF-CBT Qualitative interviews were held with children n=18 and caregivers n=16	**Child age** Sample was all female, with a mean age of 12.76 (SD= 1.75). **Clinical characteristics** The sample was exposed to a number of traumatic events, and 100% had been sexually abused. Inclusion criteria for the clients were a score of 39 or higher on the modified PTSD-RI and indication of a traumatic event. **Other criteria** Children and caregivers were referred to the linked feasibility study from a center that serves youth who have experienced sexual violence.	**Manual (title/authors)** TF-CBT along with some adaptations pertaining to methods of implementation. Based on the manual by Cohen, Mannarino, and Deblinger. **Therapists (background/training/supervision)** 22 Zambians (f=13 m=9) were trained using a phased, apprenticeship model. 3 counselors had formal clinical training, and the majority did not have an educational background in teaching or psychology. **Structure (number/length of sessions, programme duration)** 12 to 16 1-hr sessions, although it may be flexible and individualized to meet the needs of each child/youth and family **Delivery (group/individual/parental involvement)** Parenting skills was hypothesized to be modified	**Data Collection** Semi-structured interview **Data Analysis** Grounded Theory

						due to the local context in Zambia, but it is not mentioned if the training of counselors was based on an adapted intervention or not. **Content (focus of individual and/or family sessions, and change strategies)** Treatment modules as outlined in the manual, with adaptations of parenting skills due to changes in parenting practices in Zambia.	
Short Title	**Found Via**	**Document Type**	**Study Identification**	**Study Setting**	**Study Sample**	**Intervention**	**Data Collection & Analysis**
Pernebo and Almqvist (2016)	Hand-searching of Journal of Clinical Child Psychology and Psychiatry (1996-April 2016)	Journal article	**Search Strategy** Hand-searching **Language of report** English **Status of report** Published **Abstract** Included **Format** Journal Article **Type of Study**	**Country** Sweden **Service Context** Children's experiences of taking part in group treatment for exposure to Intimate Partner Violence **Sample Size** n=9	**Child age** Five girls and four boys, aged between 4 and 6 years (M = 5.5 years, Med = 5.5 years, no siblings). **Clinical characteristics** All children had experienced IPV against the mother for a significant period of their lives. Children were	**Manual (title/authors)** Children Are People Too programme, and developmentally informed trauma-focused psychotherapy (group treatment) **Therapists** (background/training/supervision) Experienced group leaders, either psychologists or social workers, led each group	**Data Collection** Semi-structured interview **Data Analysis** Interpretative Phenomenological Analysis

			Process evaluation **Support for the study** Source of funding stated		recruited from two treatment agencies with well-established, manual-based and documented group interventions for children exposed to domestic violence. Experience of IPV was a major problem for the child and the violence had to be ended before enrolment. **Other criteria** Five of the children attended one agency and four the other. Background data were obtained from the caregivers; eight mothers and one foster parent. 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	**Structure (number/length of sessions, programme duration)** Both programmes 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/individual/parental involvement)** Treatment took place in secure premises that had a locked entrance. **Content (focus of individual and/or family sessions, and change strategies)** Treatment included reoccurring rituals and trauma-focused components. Every session was structured around a theme such as	

					Swedish. Seven children lived with the abused parent, one child lived in foster care and one child lived alternately with both parents. Seven children had no contact with the abuser. Children and parents were asked for consent to participate, after information about the study had been provided. Children's consent was seen as an ongoing process, and they could influence the extent of their participation.	violence, security, family relations, separation, recognition and expression of feelings or affect regulation.	
Short Title	**Found Via**	**Document Type**	**Study Identification**	**Study Setting**	**Study Sample**	**Intervention**	**Data Collection & Analysis**
Salloum (2015)	Scoping searches	Journal article Linked to a treatment study (RCT) that consisted of a	**Search Strategy** Scoping Searches **Language of report** English **Status of report**	**Country** USA **Service Context** Parents' and children's perceptions and	**Child age** 8-12 years (mean age 9.53 years), and mean age of parents was 36.53 years **Clinical**	**Manual (title/authors)** Stepped Care TF-CBT based on the manual by Salloum, Scheeringa, Cohen and Storch (2014). **Therapists**	**Data Collection** Interview **Data Analysis** Thematic Analysis

		2:1 randomization ratio with 22 participants being assigned to Stepped Care TF-CBT	Published **Abstract** Included **Format** Journal Article **Type of Study** Qualitative **Support for the study** Source of funding stated	experiences of Stepped TF-CBT **Sample Size** n=33 (Children = 16, Parents = 17)	**characteristics** Identified index trauma that the children reported included significant exposure to sexual abuse, and the remaining to domestic violence, death of someone close, and accident. **Other criteria** 6 children were Hispanic/Latino. Race of the children was split into 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	**(background/training/supervision)** Parent-led and therapist-assisted treatment with meetings with therapists and workbook assistance. **Structure (number/length of sessions, programme duration)** Parent and child 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 parent and child completed the workbook at home by having 11 parent-child meetings over the course of Step One. **Delivery (group/individual/parental involvement)** Delivered via parent-child meetings. Treatment, assessment, and interviews took place at a community-based non-profit agency that	

					widowed. 11 parents were employed. All parents provided written consent to participate and children provided assent to participate.	provides trauma-focused treatment in a large metropolitan city. Treatment was provided by four masters level therapists who worked at the community-based agency. **Content (focus of individual and/or family sessions, and change strategies)** 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 entered the maintenance phase or proceeded to Step Two, which consisted of all of the components of standard TF-CBT.	

Short Title	Found Via	Document Type	Study Identification	Study Setting	Study Sample	Intervention	Data Collection & Analysis
Santiago (2016)	Database searching	Journal article Linked to a larger mixed-methods quasi-experimental pilot study comparing CBITS as usual with CBITS plus family components	**Search Strategy** Electronic Search **Language of report** English **Status of report** Published **Abstract/Summary of key findings** Included **Format** Journal Article **Type of Study** Feasibility Qualitative **Support for the study** Source of funding not stated	**Country** USA **Service Context** In-depth information regarding feasibility and acceptability of the family component of CBITS from the perspective of participating parents **Sample Size** n=36 (Parents: 15 Children: 21)	**Child age** Average age of parents and children were 38.07 years and 11.59 years respectively. **Clinical characteristics** Exposure to violence and trauma (specific clinical characteristics of sample not discussed). **Other criteria** 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	**Manual (title/authors)** Cognitive Behavioural Intervention for Trauma in Schools (CBITS), based on a manual by Jaycox (2003). **Therapists (background/training/supervision)** CBITS plus family groups were delivered in the Spring semester by school-based social workers. **Structure (number/length of sessions, programme duration)** 10 group sessions for children, with modules that were grouped across approximately 4 parent sessions that averaged 1.5 to 2 hours in length. **Delivery (group/individual/parental involvement)** Parent sessions are voluntary and held on school campuses. Groups were typically held in Spanish or conducted bilingually (in both Spanish and English). **Content (focus of**	**Data Collection** Semi-structured interview Conducted over phone **Data Analysis** Grounded Theory

					or widowed. A majority of parents reported not finishing high school. The average monthly income was USD1,286.67, and the average family size was 4.47. Twelve parents reported being born outside the U.S. Parents provided consent and received a gift card for participating in the interview.	**individual and/or family sessions, and change strategies)** 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.	

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 [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 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 [31, 33, 37-38], while significant caregiver involvement was employed in four studies [32, 34, 35-36].

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 Appendix 4. 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 only 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 generalizability of findings. However, the triangulation methods employed in this metasynthesis by the use of multiple researchers, comprehensive searching of published and unpublished literature, and rich description and quotes from the data ameliorates this shortcoming [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 how many researchers were involved in coding the data. Presentation of study findings were rated positively, although two studies offered little information or 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] with three corresponding sub-themes for each category. Quotations from youth and caregivers to illustrate selected sub-themes are presented in Table 3.

Table 3. Quotations and codes from participants in primary studies to illustrate themes and select sub-themes

Select Codes	Quotations from participants in primary studies
1. Engagement in TF-CBT	
1. Unclear Expectancies of Treatment	
Talking to an unfamiliar person	"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]
Giving importance and validation to experiences in therapy	"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]
Role as a communicator	"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	

Liking 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]
Liking breathing and 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] Caregiver: "Believe it or not, I believe it was the drawings. Does that sound weird? Because he would draw the pictures, and then of course you're supposed to ask him to explain it to you, you know, tell the story about it…it was amazing how he related some of the abuse to….it helped me to have I guess a greater light into his little world of all that time…So the drawings were, I think, very important." [35]
Breathing exercises during trauma narrative were helpful	"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 behavior 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 manage their own trauma	"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]
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 counselor 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]
A sense of 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 e.g. self-harm, alcohol use	"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]
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]

Impact beyond the user, to peer support	"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]
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]
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 resource books	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]

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 safety 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 emphasized 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 the 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 and sensitive [36]. Caregiver-led treatment was impeded by initial reluctance of the traumatised child to embark upon treatment, and 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 effectiveness, 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, and improved sleep hygiene, self-worth, self-esteem and self-care [31-33, 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, occuring mainly in situations of peer conflict [31].

2. Functioning and Recovery

Youth related 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]. Young people 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 be improved generally by inclusion of more visually appealing and age-appropriate content, and made available in multiple modalities such as websites or DVDs and [35-36].

Discussion

This metasynthesis aimed to investigate youth and caregivers' experiences of TF-CBT and make recommendations for TF-CBT practice and research. 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 emphasized 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 therefore be circumspect about caregiver involvement in therapy [21, 46]. For their part, caregivers reported benefits in terms of improved stress management skills, which builds on findings from other studies that caregivers appreciated being consulted on treatment goals, and were interested in acquiring skills that would help the management of traumatic symptoms experienced by youth [48].

Apart from these results, youth pointed out the importance of physical and emotional refuge during treatment, specifically the therapeutic environment and relationship. These notions of safety/refuge appear more specific to TF-CBT and may be closely related to the impacts of trauma itself. The theoretical rationale for TF-CBT recognises the importance of safety; for instance, safety in treatment allows the secure elaboration of traumatic memories, which helps the patient develop a narrative account of the trauma events and place them in context [49]. When youth are exposed to trauma, they may also experience heightened threats to their safety and reduced trust in attachments and relationships, which in turn affects their ability to navigate their immediate environments as well as their physical and psychological development [50 - 51]. Some youth may also be facing ongoing threats to safety, which helps explain why physical/emotional safety and the development of violence and safety skills in TF-CBT may be highly appreciated by them [11]. These findings offer possible reasons for the value attached to safety in TF-CBT by youth.

Strengths & 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 gray literature and contacted topic experts to identify 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].

Clinical Implications

Clinical guidelines for PTSD largely concur with TF-CBT experience data [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 about 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 it is especially critical for TF-CBT.

The TF-CBT experience data also show that young people favour a predictable and consistent therapeutic environment. 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 young people and fostering collaborative decision-making, e.g. about the extent and timing of parental 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, which could be systematically triangulated with youth and parent 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

Our metasynthesis found that 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 young people more generally. These findings further emphasize the utility of exploring users' experiences of psychological interventions, as they contain valuable information for treatment development and wider mental health service improvement.

Ethical Standards

All human and animal studies have been approved by the Departmental Research Ethics Committee (DREC), Department of Social Policy & 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.

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.

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