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RESEARCH ARTICLE

Trauma-Focused Cognitive Behavioral Therapy for Abused Children: Literature Review

Yoshihiro SAITO[1]*, Ko SASAKI[1], Satomi TAKESHITA[2], Mami NANRI[3], Asuka IKARI[4], Seiichi YOKOO[4], Yasumi ARIMOTO[5], Yuri FUKUHARA[6], Yuko WAKIZAKI[2]

[1]School of Nursing, Faculty of Nursing, Reiwa Health Sciences University, Japan.
[2]Department of Nursing, Faculty of Health Sciences, Junshin Gakuen University, Japan.
[3]Department of Nursing, Faculty of Nursing, Nishikyushu University, Japan.
[4]School of Nursing of Fukuoka International University of Health and Welfare, Japan.
[5]Medical Corporation Saiseikai Kawanonajima Hospital, Japan.
[6]General Incorporated Association Sionsgarden Joblabo Ohashi, Japan.

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Corresponding Author: Yoshihiro SAITO, School of Nursing, Faculty of Nursing, Reiwa Health Sciences University, Japan.

Abstract

The purpose of this study was to clarify the effectiveness of trauma-focused cognitive behavioral therapy (CBT) for abused children based on practice research using randomized controlled trial (RCT) methods, thereby obtaining implications for future support development. A literature review on trauma-focused CBT for abused children was conducted using the search engines CINAHL/MEDLINE and PubMed. Two RCTs met eligibility criteria and were reviewed by two researchers. Although the two studies differed in CBT skills and intervention duration, both showed reductions in post-traumatic stress disorder (PTSD) symptoms. It is suggested that CBT is useful for treating trauma in abused children, leading to not only reductions in maladaptive emotion regulation, quality of traumatic memories, depression, anxiety, and problem behaviors, but also increasing resilience and socially adaptive behaviors. However, due to the limited number of previous studies, the effectiveness of trauma-focused CBT for abused children cannot be fully verified, and accumulating research using RCTs remains a challenge.

Keywords: Children, Abuse, Trauma, Cognitive Behavioral Therapy, Literature Review.

1. Introduction

While the global situation regarding child abuse is gradually being revealed[1)], it is considered difficult to ascertain the true extent of child abuse worldwide because abuse is often perpetrated in secret and remains unreported.

It has been reported that abuse can develop into trauma. Reports indicate that, as a result of suffering immeasurable trauma from abuse, child victims may exhibit symptoms similar to the criteria for "developmental disorders," such as communication problems and behavioral issues, which can impact their development[2)]. Furthermore, it has been established that receiving inadequate care, including suffering abuse, hinders the formation of secure attachment and may lead to reactive attachment disorder (RAD) in some cases[2)]. Children with RAD exhibit extremely low self-esteem, significant difficulties with emotional regulation, and may experience severe social maladjustment[2)]. The impact of child abuse on children is profound. It has been suggested that patients with a history of childhood abuse may exhibit more severe symptoms of post-traumatic stress disorder (PTSD) or complex PTSD[3)], indicating an urgent need for trauma support for such individuals. However, it has been pointed out that, depending on the methodology of trauma-focused therapy applied, it may lead to less

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favorable outcomes in patients with a history of early and repeated trauma, such as childhood abuse[4-7]. Therefore, thorough consideration of the intervention methodology is necessary.

Against this backdrop, the efficacy of Cognitive Behavioral Therapy (CBT) as a treatment for childhood trauma has been verified[7]. Trauma-focused CBT is considered an effective evidence-based treatment for managing mental health and psychosocial problems in children and adolescents who have experienced traumatic events[8]. Research in high-income countries has established its effectiveness not only in specialized settings and community-based contexts, but also in populations with multiple traumas stemming from diverse experiences, including sexual and physical abuse, domestic violence, disasters, and so on[9-12].

However, studies targeting abused children are scarce, and verifying the effectiveness of trauma-focused CBT poses significant challenges for further research. Furthermore, studies focusing on trauma in abused children often employ recruitment methods such as convenience sampling, which can potentially introduce significant selection bias. This raises the question of whether the efficacy of TRAUMA-FOCUSED CBT for abused children has been sufficiently validated.

Therefore, this study aimed to clarify the effectiveness of trauma-focused CBT for abused children through a practice-based study using a randomized controlled trial (RCT) design.

2. Research Methods

2.1 Database Search

Search engines used were CINAHL/MEDLINE and PubMed. Search keywords were "child," "abuse," "trauma," and "Cognitive Behavioral Therapy (CBT)". The search criteria focused on studies examining the effectiveness of TRAUMA-FOCUSED CBT for abused children using the RCT method (last search date: August 3, 2025). From the literature extracted using the search keywords and criteria, the following studies were excluded: Those ① not involving abused children, ② not focusing on trauma, ③ not employing CBT, ④ not RCTs, and ⑤ review articles.

Initial screening was conducted independently by two researchers. Titles and abstracts were reviewed to exclude studies that did not address the clinical question of this research. Studies with identical themes or author names were considered duplicates and excluded from the target literature. For secondary screening, two researchers independently read the full texts, selected papers meeting the criteria, compared their results, and consulted a third party when opinions differed to determine the final selection of papers.

2.2 Data Extraction and Review Methods

2.2.1 Literature Selection

From the search results, studies were selected after excluding those that did not meet the eligibility criteria or were inconsistent with the objectives of this study. Researchers extracted information and organized it in a matrix table.

2.2.2 Setting PICOS

PRISMA 2020[13-14] is a revised version of the QUOROM statement[15], a systematic reporting guideline for RCTs published in 1999, and consists of a 27-item checklist. This study adhered to PRISMA 2020 to set PICOS. Eligible studies compared children with/experiencing trauma from abuse (P) who received CBT intervention (I) with a comparison group (C). The outcome of this study was the evaluation of the CBT intervention in each study (O). The study design was restricted to RCTs (S) and no specific conditions were set for the comparison group.

2.2.3 Ethical Considerations

Efforts were made to protect the copyright of the literature included in this study. Results were extracted by two researchers to ensure that the content of each study was not compromised. No conflicts of interest exist in this study.

3. Results

3.1 Literature Search Results

Ten papers were retrieved from CINAHL/MEDLINE and 20 from PubMed. After removing duplicates and studies meeting the exclusion criteria, a final total of two studies were analyzed after researchers confirmed after researchers confirmed their eligibility.

3.2 Trauma-Focused CBT for Abused Children

3.2.1 Overview of Included Studies

Table 1 summarizes information relevant to conducting RCTs, such as participant recruitment methods, from the included studies.

Regarding participant selection, both included studies measured the severity of PTSD. However, the eligibility criteria differed: One study (Study 2) required participants to have experienced at least

one traumatic event a minimum of one month prior to the screening assessment, while the other (Study 1) required participants to have either witnessed or experienced rape or inappropriate sexual contact. Study 2 did not include a specific classification of traumatic experiences, whereas Study 1 listed inappropriate sexual contact, parental divorce, and neglect as life events constituting the most severe traumas/forms of trauma. Both studies compared an intervention group with a control group: an intervention group and a control group. Although specific details regarding dropout rates within each group were not provided, results were extracted from both included studies, resulting in a dropout rate of 0%.

Table 1. *Overview of the target literature*

No	Lead author (Year)	Recruitment Methods	PTSD Severity (Measurement Scale)	Allocation Method	Eligibility Criteria・Exclusion Criteria	Age	Traumatic Events	Subject count / Dropout count / Dropout rate
1	Paul O.. et al... 2013	a group of 60 girls comprising minors rescued from brothels by a nongovernmental organization (NGO; Conférence Régionale de l'Afrique de l'Ouest Francophone [CERAO]), victims of military and militia sexual violence, and relatives of CERAO workers	The UCLA PTSD Reaction Index (Revised)	A single-center, qual-randamization, single-blind (outcome assessors), parallel-group (active and waitlist control) study	【eligibility criteria】 either having witnessed or having personally experienced rape or inappropriate sexual touch 【exclusion criteria】 Intellectual disability, psychosis, or severe emotional and behav- ioral problems that prevented group participation	【TF-CBT】 15.83±1.27 【Wait-list contorl group】 16.18±1.34	Parental separation, divorce or abandonment 12(23) Rape, sexual exploitation, working in a brothel, underage pregnancy 12(23) Death of a parent/parents 10(19) Family abuse, neglect, threats, or taunts 6(12) ※The contents of "()" indicate %	【TF-CBT】 24/0/0 【Wait-list contorl group】 28/0/0
2	Jina L.. et al... 2024	in two cities of Henan Province 234 school-aged children were recruited from six promary schools	The UCLA PTSD Reaction Index for DSM-5	NA	【eligibility criteria】 aged 9-12 years, having experienced at least one traumatic event (traumatic events occurred at least one month before the initial screening assessment), and meeting full or subthreshold PTSD (only one symptom missing) diagnostic criteria of children's PTSD Checklist-5 【exclusion criteria】 NA	10.41±0.88 ※average of the intervention group and control group	The content of the trauma is not specified (Traumatic events were similar across the two groups)	【TF-CBT】 118/0/0 【TAU】 116/0/0

3.2.2 Trauma-Focused CBT

Session structure, content, and intervention outcomes from the target literature are presented in Table 2.

3.2.2.1 Session Structure and Content

The therapists practicing trauma-focused CBT in this study included a social worker employed by a company providing psychosocial support (Study 1) and a university student (Study 2). The social worker (Studt 1) studied the manualized intervention content before each session. Daily pre- and post-intervention meetings were conducted with a facilitator and a researcher experienced in CBT interventions to confirm understanding of module content, discuss cultural adaptation, and address operational issues (e.g., time management). The university student (Study 2) received training and guidance based on a concise manual explaining the trauma-focused CBT intervention. Regarding session structure, Study 1 consisted of 15 sessions (two hours daily, three days weekly for a five-week period) held in a local middle school hall, with all modules conducted in group format except Module 5, which consisted of three individual sessions. Study 2 differed, involving seven group sessions and three to five individual sessions over approximately two months. Session content also differed: Study 1 covered introduction, stress management, emotions, and cognitive coping strategies, while Study 2 covered relaxation training, emotion management and regulation, cognitive coping strategies, cognitive processing, seeking social support, and safety planning. For the intervention involving constructing participants' trauma narratives and processing trauma-related cognitions, both studies used individual sessions.

3.2.2.2 Intervention Effects

Although the CBT skills, intervention duration, and session structure differed across the two studies, both showed a reduction in PTSD symptoms. As post-intervention outcomes for trauma-focused CBT, Study

1 showed reduced depression and anxiety, decreased problem behaviors, and increased socially adaptive behaviors. Study 2 showed reduced maladaptive emotion regulation, decreased quality of trauma memories, and increased resilience. Study 1 also conducted a three-month follow-up, which showed further reductions in PTSD symptoms, depression, and anxiety.

Table 2. *Trauma focused cognitive behavioural Theraphy*

Table 2. Trauma-Focused Cognitive Behavioral Therapy

No	Author (Year)	Group	Therapist	Session Structure	Session Content	Control Group	ITT Analysis	Analysis Method	Measurement Scale	Intervention Results
1	Paul O., et al., 2013	[Intervention Group] trauma-focused cognitive behavior therapy (TF-CBT) [Control Group] wait list control	social workers ● the manualized inter- vention in French to study before each session and raise any questions or suggest any cultural adaptations required before delivering the session ● daily pre- and postintervention meetings took place with the facilitators and lead authors (who had previous experience deliver- ing CBT interventions with young people in Northern Ireland) to ensure that module content was understood	A Web-based learning course for Trauma-Focused Cognitive Behavioral Therapy 15-session, manual -ized (There was one intervention group with sessions that ran for 2 hours per day, 3 days per week for five weeks in a hall in the local secondary school)	●introduction (ground rules, psy- choeducation on rape and trauma, and a safe place) ●stress management (controlled breathing, progressive muscle relaxation, and thought stopping) ●feelings (affect expression and modulation) ●cognitive coping (the cognitive triangle, the relationship between thoughts, feelings, and behavior; trauma narratives; and identifying and changing in accurate or unhelpful cognitions) All of the modules were delivered in a group, with the exception of module 6, for which three individual sessions were provided.	NA	Implementation	analysis of covariance analysis of covariance	【TF-CBT】 【psychosocial functioning】 African Youth Psychosocial Assessment Instrument (AYPA) 【wait list control】	【TF-CBT】 ●PTSD: Baseline 40.88 ± 10.03, Posttreatment 18.38 ± 10.53, Follow-up 15.08 ± 8.79 ●Depression/anxiety: Baseline 37.96 ± 10.16, Posttreatment 13.96 ± 10.30, Follow-up 9.17 ± 7.26 ●Conduct problem: Baseline 8.58 ± 6.33, Posttreatment 1.96 ± 3.17, Follow-up 2.64 ± 3.04 ●Prosocial behavior: Baseline 16.50 ± 4.95, Posttreatment 21.67 ± 4.70, Follow-up 24.96 ± 5.06 【wait list control】 ●PTSD: Baseline 40.29 ± 10.91, Posttreatment 42.93 ± 13.67 ●Depression/anxiety: Baseline 39.18 ± 10.57, Posttreatment 40.04 ± 15.18 ●Conduct problem: Baseline 8.07 ± 6.67, Posttreatment 9.36 ± 8.93 ●Prosocial behavior: Baseline 16.43 ± 5.28, Posttreatment 18.46 ± 5.35
2	Jina L., et al., 2024	[Intervention Group] trauma-focused cognitive behavior therapy (TF-CBT) [Control Group] treatment as usual (TAU)	15 college students ●received a 2-day training by an expert in the field of child and adolescent mental health ●all trained and supervised by brief manual describing TF-CBT intervention	7 group sessions and 3 to 5 individual sessions within about 2 months	●relaxation tranning, ●emotional management and regulation, ●cognitive coping, ●cognitive processing, ●looking for social support ●safety plans ●create a narrative about trauma, and to process trauma-related cognitions.	Children in the TAU group continued to receive routine practice delivered by school psychologists. (e.g., massage chairs, psychodrama, relaxation music, stress balls)	Implementation	analysis of linear regression	【Emotion regulation strategies】 the short version of Cognitive emotion regulation questionnaire (CERQ-short) 【trauma memory quality】 the Trauma Memory Quality Questionnaire (TMQQ) 【Resilience】 the Resilience Scale for Chinese Adolescents (RSCA)	【TF-CBT】 ●PTSD: Baseline 39.63 ± 16.66, Posttreatment 30.98 ± 17.22 ●CERQ-short ・Maladaptive emotion regulation strategies: Baseline 19.72 ± 6.96, Posttreatment 18.57 ± 6.48 ・Adaptive emotion regulation strategies: Baseline 27.96 ± 7.55, Posttreatment 27.44 ± 8.50 ●TMQQ: Baseline 30.07 ± 7.35, Posttreatment 25.85 ± 7.00 ●RSCA: Baseline 78.33 ± 15.96, Posttreatment 84.01 ± 17.78 【TAU】 ●PTSD: Baseline 41.28 ± 17.75, Posttreatment 39.22 ± 21.10 ●CERQ-short ・Maladaptive emotion regulation strategies: Baseline 21.24 ± 7.08, Posttreatment 21.10 ± 7.24 ・Adaptive emotion regulation strategies: Baseline 26.89 ± 7.19, Posttreatment 26.20 ± 7.55 ●TMQQ: Baseline 30.39 ± 7.23, Posttreatment 27.81 ± 7.31 ●RSCA: Baseline 74.43 ± 16.45, Posttreatment 74.85 ± 17.50

4. Discussion

4.1. Overview of the Subject Literature

In subject selection for the subject literature, Study 1 established experiencing sexual trauma as an eligibility criterion. It has been reported that sexual abuse has the highest rate of developing into PTSD across all trauma types[16] and is associated with higher PTSD severity[17-18]. On the other hand, while the specific type of trauma in Study 2 is not clearly defined, both studies showed no significant difference in the severity of pre-intervention PTSD symptoms. In the two studies examined in this research, it is possible that the intervention and control groups shared similar characteristics. Considering this, it is necessary to examine the effectiveness of trauma-focused CBT for abused children, which is the theme of this study.

Regarding participant dropout rates, while detailed descriptions are lacking, a review of the process from participant allocation to results indicates a 0% dropout rate in both studies. Considering that the subjects are children and the highly sensitive issues involved, participant recruitment is anticipated to be extremely challenging. In the studies reviewed here, assignment to the intervention and control groups was randomized. However, the initial recruitment process involved a non-governmental organization providing psychological support to children (Study 1) and a limited geographic recruitment area (Study 2). While the scope of participant selection differed, it is possible that recruitment was (relatively) easy, potentially contributing to the 0% dropout rate observed. Furthermore, both studies employed group CBT as the primary intervention. While individual CBT has been noted to carry a risk of dropout due to anxiety induction[19], group CBT has been shown to be effective because of its unique *functions*, including support, education and modeling, and reinforcement[20]. This session structure is also considered a factor contributing to the 0% dropout rate. However, given the limited number of studies, further RCTs are necessary to verify the effectiveness of effectiveness of trauma-focused CBT for abused children.

4.2. Effectiveness of Trauma-Focused CBT

Trauma-focused CBT has been reported to yield large effect sizes in treatment response, even among subjects who did not experience sexual abuse[7]. Furthermore, interventions focused on addressing sexual abuse trauma are considered more effective in reducing internalizing symptoms than interventions focused on other trauma types[21]. Although the type of trauma experienced by subjects in Study 2 is not specified, considering factors such as the lack of significant differences in PTSD symptom severity among subjects across the included studies, it is suggested that CBT is useful for all trauma types/is effective for all trauma types. For trauma experienced by abused children, CBT not only led to reductions in maladaptive emotion regulation, quality of traumatic memories, depression, anxiety, and problem behaviors, but also resulted in increased resilience and socially adaptive behaviors. Compared to Study 2, participants in Study 1 showed a significant reduction in PTSD symptom severity both immediately post-intervention and at the three-month follow-up. While not universally applicable, Study 1 involved a non-governmental organization providing psychological follow-up for children. Even without direct CBT treatment, participants likely received ongoing support and were in an environment maintaining psychological safety in interpersonal relationships. This background may have enhanced motivation to participate in trauma-focused CBT and contributed to greater effectiveness, compared with Study 2. Furthermore, while both studies involved therapists trained in trauma-focused CBT and who were supported by CBT specialists, Study 2 employed university students as therapists, whereas No. 1 employed professional social workers. Compared with university students, social workers possess backgrounds that allow them to broaden their specialized knowledge through regular work and other activities. Consequently, social workers were able to provide more effective CBT for the participants than university students, which may explain the significant reduction in PTSD symptoms observed in Study 1. The trauma-focused CBT used as the intervention in this study requires more specialized knowledge and practice compared with standard CBT. However, it has been noted that relatively few practitioners/therapists worldwide use CBT[22], necessitating the training of therapists and improvement of their practical skills to ensure the quality of intervention providers and accumulate research evidence.

Existing CBT typically consists of 16 sessions[23], and the literature reviewed in this study employed a similar number of sessions. Regarding session structure, both studies primarily used group CBT, with additional individual sessions conducted for constructing trauma narratives and cognitive processing. The efficacy of group trauma-focused CBT has been validated[24-25], and the RCTs included in this study also confirm its effectiveness. Therefore, it can be concluded that

combining group and individual CBT sessions is beneficial/effective for addressing trauma in abused children.

4.3. Study Limitations and Future Prospects

This study examined trauma-focused CBT for abused children using a literature review methodology. Although the scope was limited to studies employing RCTs, an overview of both included studies suggests that CBT may be useful for treating/addressing trauma in abused children, regardless of the type of trauma. However, recruitment is difficult/challenging because of the highly sensitive nature of the subject/abuse, and a certain bias in the selection of participants is anticipated. To build evidence for the efficacy of trauma-focused CBT for abused children, it is necessary to accumulate further results from ongoing RCTs.

Declaration of competing interests

Conflicts of interest and disclosure of public research funding None applicable to this study.

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