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Effectiveness of Trauma-focused CBT in Women Victims of Sexual Violence: A Systematic Review

Dulce María Díaz-Sosa,[1,2] Anabel De la Rosa Gómez,[1] Alfonso Mendoza Leal,[2] Centli Guillén-Díaz-Barriga,[3] Alejandra Mares Portillo[1]

[1] Laboratorio de Psicología e Innovación tecnológica, Facultad de Estudios Superiores Iztacala, Universidad Nacional Autónoma de México, Tlalnepantla, Edomex, México.

[2] División de Ciencias Biológicas y Salud, Universidad Autónoma Metropolita, Unidad Lerma, Lerma, Edomex, México.

[3] Facultad de Psicología, Universidad Nacional Autónoma de México, Ciudad de México, México.

Correspondence:
Dulce María Díaz Sosa
Laboratorio de Psicología e Innovación tecnológica, Facultad de Estudios Superiores Iztacala, Universidad Nacional Autónoma de México, Tlalnepantla, Edomex, México y División de Ciencias Biológicas y Salud, Universidad Autónoma Metropolita, Unidad Lerma, Lerma, Edomex, México Av. de las Garzas #10, El Pan-teón 52005 Lerma de Villada, México.
Phone: +52 (72) 8282-7002
E-mail: psc.dulce.diaz@gmail.com

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ABSTRACT

Introduction. A significant proportion of adult female victims of sexual violence develop post-traumatic stress disorder (PTSD). While numerous systematic reviews have demonstrated the efficacy of trauma-focused cognitive behavioral therapy (TF-CBT) in reducing PTSD symptoms in children and adolescents in high-income countries, there remains a lack of information regarding its effectiveness in adult women who are victims of sexual violence. **Objective.** This study aims to review the scientific literature on trauma-focused cognitive-behavioral interventions and their impact on PTSD outcomes in women who have experienced sexual violence. **Method.** The review followed PRISMA guidelines. **Results.** Seven studies were included, comprising three randomized, controlled clinical trials, three quasi-experimental studies, and one single-case study ($N = 1$). The total sample consisted of 378 female participants aged between 18 and 74 years. Six out of the seven studies reported a reduction in PTSD symptoms following the intervention. **Discussion and conclusion.** The findings suggest promise in reducing post-traumatic symptoms in adult female victims of sexual violence through TF-CBT interventions. However, there is a need for further evidence, particularly through randomized controlled trials conducted in low-income countries. These studies should aim to tailor intervention protocols to meet the specific needs and characteristics of the population, which may involve incorporating psychoeducational components addressing gender violence and implementing strategies to enhance women's access to TF-CBT, among other considerations.

Keywords: Trauma-focused cognitive behavioral therapy, graded exposure, sexual violence, posttraumatic stress disorder, women, systematic review.

RESUMEN

Introducción. Un alto porcentaje de mujeres adultas víctimas de violencia sexual desarrollan trastorno de estrés postraumático (TEPT). Numerosas revisiones sistemáticas han demostrado la eficacia de la terapia cognitivo conductual (TCC-CT) centrada en el trauma para reducir la sintomatología del TEPT en niños y adolescentes de países de altos ingresos. No obstante, no se tiene suficiente información sobre la terapia cognitivo conductual centrada en el trauma en mujeres adultas víctimas de violencia sexual. **Objetivo.** Revisar la literatura científica sobre la intervención cognitivo conductual centrada en el trauma y su efecto sobre los resultados del TEPT en mujeres víctimas de violencia sexual. **Método.** La revisión se desarrolló siguiendo las directrices PRISMA. **Resultados.** Se presentan siete estudios que evaluaron el TEPT antes y después de la intervención (tres ensayos clínicos controlados y aleatorizados, tres cuasiexperimentos y un estudio $N = 1$). Se incluyeron 378 mujeres participantes de entre 18 y 74 años. Seis de los siete estudios mostraron reducción del TEPT después de la intervención propuesta. **Discusión y conclusión.** Los resultados son prometedores para reducir los síntomas postraumáticos en mujeres adultas víctimas de VS. Sin embargo, es crucial generar más evidencia, donde los protocolos de intervención puedan adaptarse a las necesidades y características específicas de la población. Esto implica incorporar componentes psicoeducativos sobre violencia de género, diseñar estrategias para mejorar el acceso de las mujeres a la TCC-CT, entre otras consideraciones.

Palabras clave: Terapia cognitivo conductual centrada en el trauma, exposición gradual, violencia sexual, trastorno de estrés postraumático, mujeres, revisión sistemática.

INTRODUCTION

Gender-based violence is a manifestation of inequality between men and women, explained by sociocultural patterns, particularly gender roles contributing to the abuse of power (Ferrer & Bosch, 2004).

Global estimates indicate that one in three women aged 15 years and over has experienced sexual violence (SV) at some point in their life, the main aggressor being their intimate partner (27%; Pan American Health Organization, 2022).

The World Health Organization (WHO) defines SV as follows:

> "*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or actions to market or otherwise use a person's sexuality through coercion by another person, regardless of the relationship to the victim, in any setting, including the home and workplace*" (WHO, 2013, p. 1).

Sexual violence is known to cause a range of effects on mental health, with post-traumatic stress disorder (PTSD) being one of the main pathologies (Dworkin et al., 2017; Molina et al., 2020). Approximately 20.1 % of female victims of SV develop PTSD (Scott et al., 2018). The definition of PTSD, based on the criteria of the *Diagnostic and Statistical Manual of Mental Disorders 5th ed.* (DSM-5), comprises four core symptoms: re-experiencing, behavioral/cognitive avoidance, cognitive disturbances/negative mood, as well as psychophysiological arousal and reactivity, which can be expanded to include risk-taking or self-destructive behaviors, and dissociative symptoms (American Psychiatric Association, 2014). The specific characteristics contributing to the likelihood of developing PTSD in women victims of SV include having experienced more than one SV event, having suffered sexual violence in childhood, and experiencing intimate partner violence or family violence (Baker, et al., 2005).

Trauma-focused cognitive behavioral therapy (TF-CBT) has been widely used for the reduction of PTSD (Bisson et al., 2013). The main objective of TF-CBT is the processing of trauma based on two psychological principles (Cohen et al., 2012): classical and operant learning from a behavioral perspective (Lazarus, 1963) and maladaptive thoughts from a cognitive point of view (Beck, 1995), in other words when a person who has experienced a traumatic event gives an intense emotional response such as fear, anxiety, anger, guilt, or shame. To reduce emotional intensity, the person tends to avoid places, people, and thoughts that evoke the trauma, resulting in avoidant coping, which reduces the emotional response in the short term although these emotions return with greater intensity in the long term. In addition, avoidance limits a person's ability to develop adaptive strategies for emotional regulation. TF-CBT was therefore designed to gradually expose a person to the stressors evoking the trauma and enable them to cope adaptively, achieved through the implementation of various cognitive and behavioral techniques (Jaffe et al., 2021).

There is evidence supporting the efficacy of TF-CBT, which demonstrates significantly decrease in PTSD, depression and anxiety symptoms in children and adolescents who have experienced different types of trauma, such as domestic violence, SV, grief, and war (Xiang et al., 2021; Thielemann et al., 2022; Neelakantan et al., 2019). Moreover, TF-CBT has been shown to be equally effective for children and adolescents from high-, middle- and low-income countries (Thomas et al., 2022).The changes achieved through TF-CBT are also reflected at a neurobiological level, since decreased heart rate, blood pressure, and changes in the activity of frontal brain structures and the amygdala have been observed in children and adolescents after the intervention. These neurobiological changes negatively correlate with symptom severity (Zantvoord et al., 2013). In addition to demonstrating the efficacy of TF-CBT in preschool children, McGuire et al. (2021) highlighted the importance of considering culture during the intervention. This involves making modifications to ensure accessibility and acceptability for the target population, as well as considering intersectionality (such as race, ethnicity, immigration status, and socioeconomic status), since these variables influence interaction with the environment.

The literature reviewed provides limited information on TF-CBT in adults. Only one systematic review was found, conducted by Bisson et al. (2013), analyzing 70 randomized controlled clinical trials using psychological interventions for PTSD. The results indicated that TF-CBT in an individual format proved more effective in decreasing PTSD, depression and anxiety symptoms. However, it is important to note that none of the studies specifically implemented TF-CBT in women. In addition, most of the studies were conducted in high-income countries such as the United States, Canada, Australia and Spain, limiting the generalizability of results to other contexts, especially in middle- and low-income countries. It is also important to note that this review did not provide detailed information on the type of trauma, the study environment, or the specific characteristics of participants.

Based on the above data, the aim of this review was to examine the existing scientific literature on the effects of TF-CBT on PTSD outcomes in women who have been victims of SV. This will enable us to determine the contextual characteristics of women victims of SV to culturally adapt the materials, since in the framework of evidence-based practice, this is essential for designing and implementing effective, validated protocols for PTSD care.

METHOD

This systematic review adhered to the guidelines of the *Preferred Reporting Items for Systematic Reviews* and *Meta-Analyses* (PRISMA; Page et al., 2021) for conducting systematic reviews and meta-analyses.

Information sources and search strategy

The recommendations of the Oxford Centre for Evidence-Based Medicine were followed by conducting an evidence-based review of the research articles. First, we searched for systematic reviews and randomized controlled trials (Level I and Level II Evidence). Cohort studies, case series, correlational studies and analytical observational studies in general were included (Level III and Level IV evidence). Finally, expert opinions, or mechanisms based on reasoning were considered, corresponding to Level V Evidence (OCEBM *Levels of Evidence Working Group,* 2011). The present study did not perform a meta-analysis, despite meeting the minimum number of required clinical trials, due to several limitations, including inconsistencies and heterogeneity in study design, population characteristics, and outcomes. The articles included in our review unfortunately failed to meet the criteria for a robust meta-analysis. Specifically, the studies varied considerably in terms of design, population, and—most notably—outcome measures, with the three clinical trials using different PTSD assessment tools, thereby limiting comparability. Additionally, while many studies reported statistically significant findings for key variables, small sample sizes reduced their statistical power and widened confidence intervals.

Although TF-CBT has been extensively researched, its application in female victims of violence remains underexplored. As this is an emerging area of study, our primary objective was to identify and conceptualize findings based on the existing literature. We believe that a systematic review allows for a more nuanced qualitative synthesis and comparison of available studies.

Table 1
Keywords related to each PIO element

Keywords		
P	*I*	*O*
Women victims of sexual violence	Trauma focused cognitive behavioral therapy	Post traumatic stress disorder
Women who experienced sexual abuse	TF-CBT	PTSD
Women victims of violence		

Note: P = population; *I* = intervention; *O* = outcome; TF-CBT = Trauma-focused cognitive behavioral therapy; PTSD = Post-traumatic stress disorder

Eligibility criteria

Studies were eligible if they (a) implemented TF-CBT, defined as any psychological therapy using predominantly trauma-focused cognitive, behavioral, or cognitive-behavioral techniques, including trauma narrative and gradual exposure; (b) targeted adult female victims of sexual violence diagnosed with PTSD; (c) had been published in peer-reviewed scientific journals from 2010 to 2023; (d) were written in English or Spanish; or (e) were indexed in PubMed, Redalyc, or Cochrane databases (Table 1). Exclusion criteria included non-peer-reviewed articles, studies without a clear PTSD diagnosis, and interventions not primarily focused on TF-CBT (Huang et al., 2006).

Study selection

Study selection was conducted in two stages. In the first one, two independent reviewers screened the titles and abstracts to identify studies meeting the inclusion criteria. In the second, the full texts of potentially eligible studies were retrieved and assessed for eligibility by the same reviewers. Any discrepancies between reviewers were resolved through discussion, and a third reviewer was consulted if consensus could not be reached. A PRISMA flow diagram was used to document the selection process.

Data extraction and management

Prior to data collection, the researchers deliberated on which variables would base the primary objective of the study.Data was collected using structured Excel spreadsheets. Two reviewers independently performed data extraction using a standardized form. The extracted data included (a) general study characteristics (author, year of publication, country); (b) participant characteristics (sample size, age, gender, PTSD diagnostic criteria); (c) intervention details (type of TF-CBT, intervention format, number and frequency of sessions, specific techniques used); and (d) outcomes (measures of PTSD symptoms and other psychological outcomes). Any discrepancies were resolved through consensus or by consulting a third reviewer. Data management software was used to ensure accuracy and consistency in managing the extracted data.

RESULTS

Study characteristics

The study selection flow chart is shown in Figure 1. The systematic review identified seven studies, conducted in four countries: Spain (three articles), the United States (two articles), Brazil (one article), and Pakistan (one article).

All articles were written in English and published between 2013 and 2022. Participants were primarily recruited from organizations and institutions, including shelters for female victims of gender-based violence (Jaffe et al., 2021; Latif et al., 2021; Crespo et al., 2021), and public centers for victims of gender-based violence (Matud et al., 2016; Habigzang et al., 2018). One study recruited from the outpatient mental health service at the department of defense veterans' affairs office (Cloitre et al., 2016).

In terms of research design, three studies were clinical trials, two of which had two groups (Crespo et al., 2021; Latif et al., 2021) while the other had three groups (Jaffe et al., 2021). One article included pre- and post-treatment measurements (Latif et al., 2021), one included a two- and six-month follow-up (Jaffe et al., 2021), and another had a three-, six- and twelve-month follow-up (Crespo et al., 2021). Three studies used quasi-experimental designs, of which, one article had pre- and post-treatment measurements (Habigzang et al., 2018), another included three- and six-month follow-up measurements (Matud et al., 2016), and another had one-, three-, six-, and twelve-month follow-up measurements (Sarasua et al., 2013). A final study was conducted with an $N = 1$ design, with pre- and post-treatment assessments (Cloitre et al., 2016).

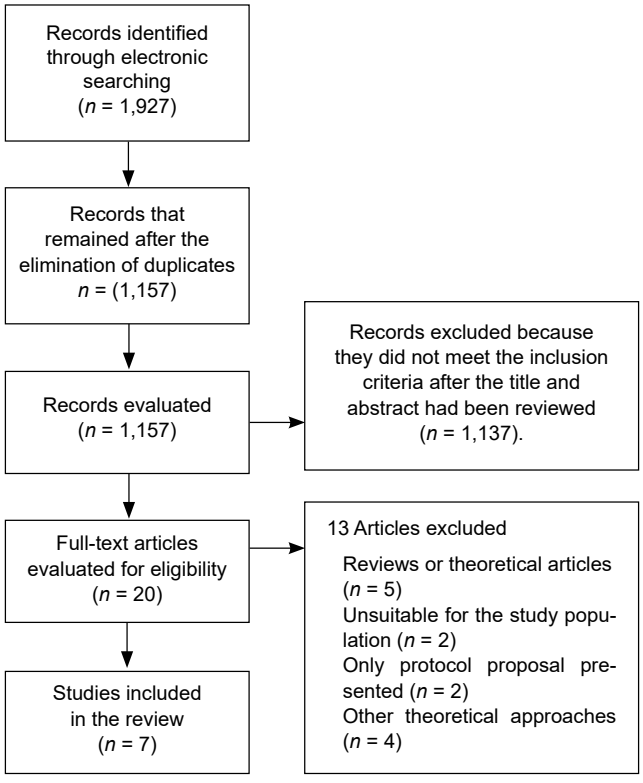

Figure 1. PRISMA Flow diagram showing the search strategy and documents retrieved.

A total of 378 female participants aged 18 to 74 years were included. Study sample size ranged from two to 107 participants. Four articles reported the percentage of participants who dropped out of the intervention, ranging from 16.8% to 54.1%. (Crespo et al., 2021; Habigzang et al., 2018; Matud et al., 2016; Sarasua et al., 2013). Only two studies asked about the socioeconomic status of the sample. Most study subjects were middle class (50.9% and 51.1%; Crespo et al., 2021; Sarasua et al., 2013, respectively). Two articles inquired about educational attainment, with most participants having completed elementary school (35.9% and 27%, Crespo et al., 2021; Habigzang et al., 2018, respectively). Four articles identified the marital status of participants. The results show that 32.1% reported being housewives and 30.2% were living with the aggressor at the time of the sexual violence (Crespo et al., 2021).Habigzang et al., 2018 found that 64% of their sample had separated from their partners, while two articles mentioned that 60.3% and 61.1% of their sample were single (Jaffe et al., 2021; Sarasua et al., 2013). Details of the samples are given in Table 2.

Features of interventions

Five studies used the individual intervention format (Cloitre et al., 2016; Habigzang et al., 2018; Latif et al., 2021; Matud et al., 2016; Sarasua et al., 2013). One study included the intervention in a group format (Jaffe et al., 2021) while another compared both formats (Crespo et al., 2021). The number of sessions comprising the interventions ranged from eight (Crespo et al., 2021) to 20 sessions (Matud et al., 2016). Six articles included psychoeducation on PTSD (Cloitre et al., 2016; Crespo et al., 2021; Habigzang et al., 2018; Latif et al., 2021), and two articles also included psychoeducation on gender, gender-based violence (Matud et al., 2016), and victimization process (Sarasua et al., 2013). Although six studies included cognitive restructuring (Crespo et al., 2021; Habigzang et al., 2018; Jaffe et al., 2021; Latif et al., 2021), two of them used that technique to modify automatic thoughts related to the SV experienced (Matud et al., 2016; Sarasua et al., 2013). Five studies included relaxation training (Cloitre et al., 2016; Crespo et al., 2021; Latif et al., 2021; Matud et al., 2016; Sarasua et al., 2013), four exposure (Crespo et al., 2021; Habigzang et al., 2018; Jaffe et al., 2021; Latif et al., 2021), and four problem-solving techniques (Crespo et al., 2021; Habigzang et al., 2018; Latif et al., 2021; Matud et al., 2016). Three studies included

Table 2
Study characteristics

Author, year	*Country*	*Study design*	*Intervention format*	*Techniques used*	*Sample characteristics*	*Diagnostic criteria for PTSD*	*Results*
Cloitre et al. (2016)	United States	Case studies, with pre- and post-treatment evaluations	Individual, 10 sessions	• Psychoeducation • Relaxation • Mindfulness • Social skills • Narrative therapy (only in case 2)	*N* = 3, only two correspond to women Case 1: 28 years old, Caucasian, war veteran Case 2: 35 years old, Hispanic, war veteran	Score between 10 to 20 points on the Self-Report PTSD Checklist (PCL) based on the DSM-IV	Case 1: Pre-test: 77 points in PCL Post-test: 46 points in PCL Case 2: Pre-test: 76 points in PCL Post-test: 38 points in PCL
Crespo et al. (2021)	Spain	A multi-group (two-group) experimental design was employed with pre and post measures and follow-up measures taken at 1, 3, 6 and 12 months after the end of treatment	Group and Individual 8 weekly sessions 60 minutes for individual sessions 90 minutes in group sessions	Multi-component cognitive behavioral program based on Rincón and Labrador: • Psychoeducation • Diaphragmatic breathing exercises • Behavioral activation • Techniques to increase self-esteem • Cognitive restructuring • Problem solving • Exposure techniques • Relapse prevention	24% dropout from treatment. *N* = 53, individual intervention *N* = 5, group intervention *N* = 28 Average age: 39.17 (*SD* = 10.19) Range: 23-65 50.9% Middle-class 35.8% had completed elementary school 32.1% homemakers 30.2% still lived with their aggressor	Posttraumatic Stress Disorder Symptom Severity Scale (Echeburúa et al., 1997)	50.9% presented with PTSD symptomatology PTSD symptoms showed significant differences over time. *F* (1.51) = .30, *p* < .001 No significant group *x* time interaction effect was found for posttraumatic stress symptoms *F* (1.51) = 65.15, *p* .07)
Habigzang et al. (2018).	Brazil	Quasi-experimental, pre-test/post-test study with a single group	Individual, 13 sessions	Psychoeducation Cognitive restructuring Gradual exposure to traumatic memories Problem solving Relapse prevention	54.1% dropout from treatment. *N* = 11 Average age: 42.7 years (*SD* = 9.5) 64% separated 27% elementary education	Structured interview based on DSM IV/SCID used to assess PTSD	PTSD symptoms remained stable (*p* = .45)
Jaffe et al. (2021)	United States	Randomized controlled clinical trial, with pre/post treatment evaluations and follow-up at 2 and 6 months Participants were randomly assigned to one of the following conditions: a) cognitive therapy only (CPT), CPT with a written account (CPT+WA), or written account only (WA)	Group CPT as CPT+A included 12 60-minute sessions twice a week The WA condition involved two 60-minute sessions in the first week followed by five 120-minute sessions per week	CPT intervention involves addressing beliefs about the meaning and implications of the traumatic event through cognitive restructuring The storytelling component of the CPT+A and WA interventions involves writing and reading a detailed recollection of the trauma memory, followed by a Socratic dialogue with the therapist	*N* = 58 participants 32% were under the influence of alcohol or drugs at the time of the sexual abuse. Age: 33.52 years (*SD* = 13.52, range: 18-74 years), 69% White 60.3% single 66.1% reported an annual income less than $30,000 USD	a) Post-traumatic stress symptoms *Clinician Administered PTSD Scale* (CAPS, administered by a physician, Blake et al., 1995) was used b) Standardized trauma interview, adapted from Resick et al. It included additional questions to preponderate the AS index	PTSD severity at 6-month follow-up was higher for individuals who experienced substance-related sexual abuse compared with nonsubstance-related sexual abuse among individuals in the reference group (i.e., CPT+ A; *p* = .047) A large effect size is reported for the CPT group relative to both CPT+WA (*d* = -1.10); and WA (*d* = -.79), among women who experienced substance-related sexual abuse

Table 2
Study characteristics (continued)

Author, year	*Country*	*Study design*	*Intervention format*	*Techniques used*	*Sample characteristics*	*Diagnostic criteria for PTSD*	*Results*
Latif et al. (2021)	Pakistan	Randomized clinical trial with pre-post treatment measurement	Individual Nine sessions distributed over 12 weeks	• Psychoeducation • Symptom management • Graded exposure • Cognitive restructuring • Behavioral activation • Problem solving • Improving relationships and communication skills	*N* = 60, 50 finished (25 in each group)	a) Clinical psychologist assessed PTSD symptoms during a clinical evaluation based on DSM-5 criteria b) The IES-R (Weiss & Marmar, 1996) is a 22-item self-report measure (for PTSD according to DSM-IV criteria) that assesses subjective distress caused by traumatic events	The effects of treatment differences were small, (*d* = .01 - .18), among women who experienced non-substance-related sexual abuse There were significant differences in the IES-R between intervention and treatment groups at the end of the intervention (*F* (1.41) = .48, *d* = .48; *p* < .000)
Matud et al. (2016)	Spain	Quasi-experimental design with two independent groups (intervention and control) and repeated measures (pre-treatment, post-treatment, and follow-ups at 3 and 6 months)	Individual Between 15 and 20 sessions	• Psychoeducation in gender and gender violence • Cognitive restructuring • Problem solving • Relaxation • Techniques to increase self-esteem • Social skills training	16.8 % dropout rate from treatment *N* = 107 Mean age = 39.64 years (*SD* = 9.87), range 23 to 64 years	Symptom Severity Scale for Post-traumatic Stress Disorder (PTSD; Echeburúa et al., 1997) based on DSM-IV criteria	Statistically significant decrease in re-experiencing symptomatology, *F* (1.96) = 104.57, *p* < .001; avoidance *F* (1.96) = 104.57, *p* < .001; and arousal, *F* (1.96) = 104.57, *p* < .001
Sarasua et al. (2013)	Spain	A single-center study using a single-group design with pre-post repeated measures and follow-ups of 1, 3, 6 and 12 months	Individual, 12 weekly 60-minute sessions	• First level of intervention: Motivation and emotional catharsis • Second level of intervention: Psychoeducation: victimization processes and psychological consequences. Cognitive restructuring: cognitive distortions, rationalization of the situation experienced • Third level of care: Coping skills training: cognitive distraction, progressive muscle relaxation, behavioral activation, normalization of sexual behavior	28.1 % dropout from treatment *N* = 87 Average age: 27.8 years (*SD* = 9.2; range: 18-54), 61.1% did not have a partner 90.1% Spanish nationality 51.1% socioeconomic level medium 42.7% low socioeconomic level	Symptom Severity Scale for Post-traumatic Stress Disorder (PTSD; Echeburúa et al., 1997) based on DSM-IV criteria	The success rate in the post-treatment evaluation in relation to PTSD is 90.7%, in other words, of the 43 victims who suffered from PTSD at the beginning of therapy, 39 overcame it

Note: PCL = PTSD Checklist for DSM–5 ;TF-CBT = Trauma-focused cognitive behavioral therapy; PTSD = Post-traumatic Stress Disorder; DSM = diagnostic and statistical manual of mental disorders; *SD* = Standard deviation; IV/SCID = Structured Clinical Interview for DSM-IV Axis I Disorders; CPT = Cognitive Processing Therapy; WA = written account only; CPT + A = cognitive processing therapy and written account; IES-R = Impact of Event Scale-Revised

social skills (Cloitre et al., 2016; Latif et al., 2021; Matud et al., 2016), and three behavioral activation (Crespo et al., 2021; Latif et al., 2021; Sarasua et al., 2013), while two included techniques for boosting self-esteem (Crespo et al., 2021; Matud et al., 2016). Mindfulness (Cloitre et al., 2016); relapse prevention (Habigzang et al., 2018), and cognitive distraction and normalization of sexual behavior (Sarasua et al., 2013) were included in one study each.

PTSD Measurement

Five studies used scales based on DSM-IV diagnostic criteria (Cloitre et al., 2016; Crespo et al., 2021; Habigzang et al., 2018; Matud et al., 2016; Sarasua et al., 2013). Another two used clinical interviews based on DSM-V criteria were conducted by mental health specialists (Latif et al., 2021; Jaffe et al., 2021).

Differences in PTSD symptoms before and after the intervention

Six of seven studies showed a reduction in PTSD after the intervention. Four of them reported significant differences ($p < .001$), showing decreased PTSD (Crespo et al., 2021; Latif et al., 2021; Matud et al., 2016). One study also identified statistically significant decreases ($p = .001$) in each of the symptoms constituting PTSD: re-experiencing, avoidance, and arousal (Matud et al., 2016). Another used a multiple indicator of therapeutic success, evaluating the reduction of PTSD (score < 15 on the EGS), finding that the intervention had been successful with 90.7% of the sample. It obtained an improvement between pre- and post-treatment assessments, which remained constant and actually increased until 12-month follow-up ($p = .001$; Sarasua et al., 2013).

Two articles reported decreases in PTSD, although they did not mention statistical significance. One article concluded that in one case, an intervention including trauma narrative showed the greatest reduction in PTSD compared to one that only included cognitive behavioral techniques (Cloitre et al., 2016). Another study showed a greater effect in reducing the severity of PTSD symptoms from pretreatment to follow-up in an intervention that only included cognitive behavioral techniques, $d = 2.02$.

However, it also observed reductions in the group where techniques included CBT in addition to trauma narrative, $d = .92$. The group with which only the trauma narrative was used obtained $d = 1.23$. This occurred with women victims of sexual abuse, who had been under the influence of alcohol and other substances at the time of the trauma. Conversely, for women who had not consumed alcohol or other substances at the time of the sexual assault, the intervention modality that achieved the greatest reduction in PTSD was CBT + NT, $d = 2.22$, followed by the trauma narrative modality, $d = 2.05$, and then CBT alone, $d = 2.04$ (Jaffe et al., 2021). The last study concluded that PTSD symptoms remained stable after the intervention, meaning that there was no improvement (decrease) in PTSD ($p = .45$; Habigzang et al., 2018).

Main elements to be considered in the implementation of TF-CBT

After the analysis of the articles and as part of the main objective of the present review, it is important to mention the elements that should be considered for the implementation of TF-CBT. For explanatory purposes, they were divided into two parts. On the one hand, there were some elements that should always be considered, regardless of the sociocultural context, while on the other, there some that are important in certain contexts (Table 3).

Table 3
Elements to be considered for the implementation of TF-CBT

General factors in the implementation of TF-CBT
Elements related to the format of the intervention
Therapist profile The therapist profile for the administration of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) should be that of a clinical psychologist with specific training in CBT and adequate training in TF-CBT, as noted by Cloitre et al. (2016). It is essential for the therapist to be sensitive to the dynamics of gender-based violence to ensure that the therapeutic space is completely free of comments or attitudes that could re-victimize the person being treated.
Intervention protocol It is essential to have an intervention manual that ensures treatment integrity and consistency (Cloitre et al., 2016; Habigzang et al., 2018; Latif et al., 2021).
First part of intervention implementation The initial modules of the intervention should focus on the development and strengthening of coping skills. To this end, it is essential to implement techniques that include psychoeducation, emotional regulation, mindfulness, problem solving, and cognitive flexibility. These strategies are critical to provide a solid foundation to base the subsequent therapeutic process (Bailey et al., 2019; Cloitre et al., 2016; Habigzang et al., 2018; Latif et al., 2021; Matud et al., 2016).

Table 3
Elements to be considered for the implementation of TF-CBT (continued)

General factors in the implementation of TF-CBT
In the field of psychoeducation, it is essential to incorporate detailed information on the intergenerational cycle of domestic violence and its different manifestations (Habigzang et al., 2018; Matud et al., 2016).
Second part of the implementation of the intervention After the strengthening of coping skills, it is necessary to proceed with the implementation of specific techniques for trauma processing. These techniques comprise the construction of the narrative of the traumatic event and gradual exposure (Bailey et al., 2019; Cloitre et al., 2016; Habigzang et al., 2018; Latif et al., 2021).
Third part of the implementation of the intervention The final module of the intervention should focus on relapse prevention, consolidating the skills acquired and ensuring the sustainability of the therapeutic progress achieved (Bailey et al., 2019; Cloitre et al., 2016; Habigzang et al., 2018; Latif et al., 2021).
Activities in the intervention modules Throughout all intervention modules, it is essential to incorporate activities that facilitate the consolidation of acquired knowledge and strengthen coping skills. These activities have proven effective in ensuring a deeper integration of the skills acquired during the therapeutic process. (Latif et al., 2021; Cloitre et al., 2016).
Individual and group therapy Both therapeutic formats have proved effective in reducing post-traumatic symptomatology. However, it is recommended to prioritize group therapy in cases where women lack a support network, as this format can offer a space for containment and connection with peers that is fundamental to their recovery process (Cloitre et al., 2016).
Trauma-related elements
Differentiate between a traumatic event and a history of sexual violence For processing a traumatic event, the task will be to include the traumatic event in the narrative. Conversely, for a history of sexual violence, since it is essential for the user to prioritize the memories of these traumatic events, only one to three events will be included in the narrative, namely those that cause the most emotional discomfort. It is important not to include more events, as this can be emotionally draining for the patient (Habigzang et al., 2018; Latif et al., 2021; Cloitre et al., 2016).
Identify whether substance use and abuse is related to the trauma If substance abuse limits the memory of the traumatic event to be narrated, it will be better not to use the narrative or gradual exposure techniques and spend more sessions strengthening coping skills. It is also recommended to pay special attention to the identification of guilt in women, since this emotion is usually associated with substance abuse, and if guilt is manifested, it will be advisable to implement emotional regulation (Jaffe et al., 2021).
Elements related to the user Women who cohabit with the aggressor cannot be part of the protocol because, as already mentioned, a fundamental part of the intervention is to expose themselves to certain events and situations that generate stress, such as the sexual aggressor. However, exposing themselves to him would only put them at risk (Bailey et al., 2019; Jaffe et al., 2021).
Specific factors to be considered in specific contexts for the implementation of TF-CBT
Elements related to the intervention format
Online intervention In low-income countries, it is important to use tools that foster the availability of access, such as online interventions, which have been shown to reduce time and monetary costs and consequently, foster therapeutic adherence (Latif et al., 2021; Matud et al., 2016).
Teaching resources in the intervention Teaching resources should be based on the sociocultural context, and easy to understand in countries with low educational levels (Latif et al., 2021; Cloitre et al., 2016).

DISCUSSION AND CONCLUSION

The overall results indicate that TF-CBT is effective in reducing PTSD in adult female victims of SV. However, this evidence must be expanded, mainly with randomized controlled studies in low-income countries, as only three of the seven studies included in this review incorporated comparison and randomization in their design. Most of the studies analyzed (five out of seven) were conducted in high-income countries such as Spain and the United States, with mostly white participants (Cloitre et al., 2016; Crespo et al., 2021; Jaffe et al., 2021; Matud et al., 2016; Sarasua et al., 2013).

This highlights the need to develop studies on the efficacy of TF-CBT in low- and middle-income countries, because of the stark difference between the violence suffered by women in predominantly white countries and in racialized countries. This can be explained by several factors. These include sociocultural factors, specifically regarding gender norms and social roles, which differ significantly from one culture to another. In some countries, such as those in Latin America, traditional norms may justify or normalize violence against women. In this same context, the stigma attached to being a victim of sexual violence may be more pronounced, deterring women from seeking help

(Contreras et al., 2010; González, 2019; Ferrer & Bosch, 2004), whereas in others there may be greater awareness and rejection of these behaviors. Regarding economic factors, women in high-income countries may have better access to resources such as shelters, mental health services and legal support (Contreras et al., 2010; Londoño et al., 2017). By contrast, in many low- and middle-income countries, these resources may be limited or non-existent. Moreover, financial dependence on a violent partner may be more prevalent in countries with fewer job opportunities for women, making it more difficult to leave violent situations (Londoño et al., 2017; Scott et al., 2018). Finally, political and structural factors determine the effectiveness and fairness of the legal system. In some countries, gender-based violence may not be taken seriously, while laws to protect women may not be fully implemented. Law enforcement response may be ineffective or even counterproductive in certain countries, where corruption or lack of gender training is common (Contreras et al., 2010; Londoño et al., 2017). In short, although sexual violence is a global problem, women's experiences may differ significantly depending on the cultural, economic, political, and structural context of their respective countries. These differences underscore the importance of tailoring interventions and policies to specific contexts to effectively address the needs of women in different parts of the world. In this respect, the present literature review allowed us to identify the elements that contribute to the effectiveness of TF-CBT, regardless of the context in which it is implemented. In other words, it enabled us to determine the components that should be present in its implementation because they are related to the psychological processes that allow for the reduction of post-traumatic symptoms. These elements will be mentioned below, together with other elements that should be considered based on the sociocultural context in which the TF-CBT is implemented.

Regarding the techniques used to implement the intervention, all the articles included cognitive and behavioral elements (Part One of the intervention) allowing the development of adaptive coping strategies for dealing with life stressors and preparing patients for Part Two of the intervention involving trauma narrative and graded exposure. These approaches proved effective in reducing PTSD, which is in line with the findings of a narrative review analyzing the effectiveness of 20 psychological interventions for reducing PTSD in women victims of intrapersonal violence. This review concluded that psychoeducation, mindfulness, cognitive restructuring, relaxation, social skills training, safety planning, and gradual exposure were helpful in reducing PTSD (Bailey et al., 2019; Matud et al., 2016; Sarasua et al., 2013). These features should therefore always be considered in the administration of TF-CBT.

Gradual exposure is a key element of TF-CBT for achieving trauma processing, since it allows the extinction of anxious responses through the repeated presentation of the feared stimuli. It also promotes the habituation of unpleasant emotional and physiological responses, thereby achieving an increase in the perception of self-efficacy (Fernandez et al., 2012). Although it is an element that should also be considered a core element in the implementation of TF-CBT, this technique is contraindicated for women still living with the batterer, since exposing themselves to him would increase the risk of experiencing more severe violence (Bailey et al., 2019), Cohabitation with one`s sexual aggressor should be carefully evaluated, especially in women whose contexts limit their financial resources and access to work and encourage economic dependence on the violent partner. In these cases, efforts should focus on providing adaptive coping strategies and ancillary services to guarantee security, both individual and organizational (Bailey et al., 2019).

Most of the articles reviewed included psychoeducation about trauma, posttraumatic symptoms, and elements of TF-CBT in their intervention protocol. However, only two of the seven studies reviewed included psychoeducation about gender-based violence and victimization processes. (Matud et al., 2016; Sarasua et al., 2013). This aspect is particularly relevant in sociocultural contexts where gender norms are deeply entrenched and lead to violence against women. For example, in sexual violence, women victims are often held responsible for the violence suffered (revictimization), which can create feelings of guilt and shame. Providing information about the context of violence in a cultural system is therefore crucial to restructuring negative automatic thoughts and emotions such as guilt. Some studies have shown that this technique is most successful when applied to women victims of violence and PTSD (Gil-Iñiguez, 2016; Matud et al., 2016).

Another aspect to be considered is the high dropout rate of women participating in the interventions, especially when these were not mandatory in the shelters where they were living (Crespo et al., 2021; Habigzang et al., 2018; Matud et al., 2016). It was observed that the group format had a higher dropout rate than the individual format. Perhaps this is due to the fact that individual therapy is better adjusted to the time available to the women, although there were still cases of dropouts in this modality. These findings are consistent with previous research indicating that women attended the first sessions, but most failed to complete the treatment. Perceived barriers and social determinants, such as responsibility to family, may influence this trend. For example, it has been found that women with HIV consider that health care can wait, as they prioritize attention and care for their families (Díaz-Sosa et al., 2021). It is therefore suggested that future interventions consider strategies tailored to women's needs. In this sense, psychological interventions through information and communication technologies (ICTs), in other words telepsychology, has shown that it can reach a greater number of people who could

benefit from psychological treatment, therefore reducing the financial and time expenditure required for face-to-face therapy. There is also evidence that TF-CBT in an online format has the same effectiveness as the in-person format, but with the added bonus that it decreases the stigma associated with mental health care-seeking (Lewis et al., 2018). However, the evidence does not include specific cases of sexual violence, meaning that future research is required to test it in this vulnerable population. There is a significant lack of evidence based on randomized clinical studies evaluating the efficacy of TF-CBT in adult female victims of sexual violence. This absence of evidence makes possible to draw definitive conclusions about the efficacy of these interventions. Nonetheless, the results appear promising for decreasing post-traumatic symptoms in adult female victims of SV. However, it is essential to gather more evidence, especially through randomized controlled studies in low-income countries, with intervention protocols adapted to the specific needs and characteristics of the of the population, including components. This involves including components of psychoeducation on gender-based violence, to gradually increase exposure in the case of complex trauma referrals, not subject women still living with the aggressor to the gradual exposure technique, and develop strategies to improve women's access to TF-CBT, such as technology-mediated interventions.

Limitations

Data in the present review should be analyzed with caution in view of certain limitations. First, the number of randomized controlled trials was limited, which led to include randomized and observational studies data, which in turn yielded lower quality evidence. In addition, more than a half of the studies included had a high risk of bias, as they lacked randomization and control groups, besides a high dropout rate and small sample size.

Finally, it is important to consider that many of the studies relied on self-report measures, may be mediated by social desirability. In future studies, it is suggested that researchers establish a good rapport with participants, especially because of the emotions present in female victims of SV, such as guilt or shame. This would help to improve the reliability and validity of the measurements used.

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Conflict of interest

The authors have no competing interests to declare.

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