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Effectiveness of Trauma-Focused Cognitive Behavioural Therapy in Treating Negative Emotions Among 12-17-Year-Old Female Survivors of Sexual Abuse in Kilifi County, Kenya

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Abstract:
Sexual abuse (SA) constitutes a deeply traumatic experience with enduring consequences for survivors' wellbeing. The resultant negative emotions underscore the necessity for empirically supported therapeutic interventions. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), has demonstrated efficacy in ameliorating trauma-related negative emotions across diverse contexts. Nevertheless, TF-CBT effectiveness in treating negative emotions that were linked to CSA especially in Kilifi County, Kenya was yet to be known. Therefore, the present study sought to evaluate the effectiveness of TF-CBT in mitigating negative emotions among 12 to17 year old female survivors of SA in Kilifi County, Kenya. Employing a quasi-experimental research design, the investigation recruited 40 pairs of 12 to17 year old survivors of CSA and their non-offending caregivers using convenience sampling. The treatment and comparison groups (n=20 each) were drawn from five rescue centres located in Kilifi County. Data collection instruments included self-reports and the Positive and Negative Affect Schedule. Statistical analyses utilized one-way ANOVA. Results indicated that TF-CBT produced a statistically significant reduction in negative emotions (p = 0.00) with a very large effect size (Cohen's d = -2.06). Moreover, the intervention exerted a substantial positive effect on enhancing positive emotions (p = 0.32; Cohen's d = 0.70). These findings affirm the clinical utility of TF-CBT in improving emotional outcomes among sexually abused 12- to 17-year-old female survivors of CSA in the Kenyan context. The study recommends institutionalization of TF-CBT within therapeutic protocols for this population and advocates further research assessing its efficacy among female survivors of sexual abuse in other counties.

Key Words: *Child Sexual Abuse, trauma, negative emotions, TF-CBT, effectiveness, quasi experiment*

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I. Introduction

Child sexual abuse (CSA) is widely recognized as a profound violation of children's rights and an urgent public health challenge with serious developmental, psychological, and social consequences (Bolen, 2001; Olafson, 2011). Additionally, Olafson (2011) characterizes CSA as an exploitative act that undermines a child's physical, mental, and behavioral development, constituting a traumatic experience with long-lasting implications. CSA infringes on internationally recognized rights of children as articulated in the United Nations Convention on the Rights of the Child (UNCRC) and related legal instruments (Hillis et al., 2016). Despite heightened awareness, CSA remains alarmingly prevalent across the globe, with UNICEF estimating that more than one billion children experienced violence, including sexual abuse, in 2015. The ubiquity of CSA underscores the necessity of sustained research, prevention, and evidence-based treatment interventions.

CSA prevalence varies across contexts but consistently affects both boys and girls. Global surveys estimate that between 3–17% of boys and 8–31% of girls experience sexual abuse before age 18 (Barth et al., 2013; National Sexual Violence Resource Center [NSVRC], (2018). Gender disparities remain evident, with adolescent girls disproportionately represented among victims. The higher vulnerability of girls has been further corroborated in retrospective studies (Al-Asadi, 2021). Survivors face elevated risks of depression, post-traumatic stress disorder (PTSD), and substance use disorders, with prevalence rates significantly higher than among non-victims (Auslander, et al.,2016).

CSA prevalence demonstrates significant variation across regions, shaped by cultural, social, and reporting norms. In Asia, prevalence estimates for girls' range between 3.3–42.7% in India, while boys in Sri Lanka report rates of 4.3–58% (Selengial et al., 2020). Notably, some studies document higher reported prevalence among boys, reflecting complex cultural biases. Patriarchal norms often prioritize protecting female

dignity, leading to underreporting of female victimization. Simultaneously, abuse of boys may be trivialized or reframed as normative, particularly in cases involving female perpetrators (Holmes & Slap, 1998; Alshekaili et al., 2024). In Afghanistan, Pakistan, and Sri Lanka, commercial sexual exploitation of boys has been documented, further demonstrating how socio-cultural practices shape abuse dynamics (Human Rights Watch, 2013; Perera et al., 2009). Gendered stereotypes and toxic masculinity exacerbate underreporting and hinder access to support services, particularly for male victims (Jewkes et al., 2015).

In Africa, prevalence patterns are similarly concerning. In South Africa for instance, rates of 14.6% for girls and 9.9% for boys have been documented (Ward-Brown et al., 2018), while community-based studies report even higher figures. In Tanzania and Ethiopia, estimates range between 2.1–68.7% for girls and 4.1–60% for boys (Selengial et al., 2020). Kenyan data further illustrate the gravity of the issue, with cases of defilement and early marriage particularly prevalent in Kilifi County (National Crime Research Centre [NCRC], 2014; Department of Children's Services, Kilifi County, 2015–2019; Otieno, 2023, December 7). These patterns point to systemic failures in protection mechanisms and highlight the underreporting of abuse due to stigma, fear, and distrust of authorities. Studies reveal that many survivors delay disclosure for decades, with one German study showing average disclosure at age 52.2 (ECPAT International, 2020).

The immediate and long-term consequences of CSA are profound. Survivors often exhibit emotional distress, maladaptive beliefs, and behavioral problems, including sexualized behaviors, academic difficulties, and higher likelihood of revictimization or perpetration (Allen et al., 2015; Botsford et al., 2019; Chadwick & Spinney, 2012). CSA has also been linked to intimate partner violence in adulthood (Felitti et al., 1998). Neurological studies suggest that trauma-induced stress disrupts brain development, impairing cognitive functions and increasing vulnerability to psychiatric disorders such as PTSD and depression (Cohen, et al., 2013; Daskalakis et al., 2024). This disruption undermines quality of life, contributing to poor self-perception, weak emotional regulation, and social dysfunction (Berliner & Elliott, 2002; Valiente et al., 2012 & Quidé et al., 2017). Among trauma effects due to sexual abuse are negative emotional responses (Aho et al., 2017). These responses include fear, shame, guilt, helplessness, and anger which according to Wohab & Akhter (2010), affect the survivor's life adversely leading to long-term trauma effects.

Beyond individual suffering, CSA imposes intergenerational costs. Survivors may struggle with parenting, contributing to cycles of violence and trauma (Dunkle et al., 2004). Societal implications include reduced productivity, higher healthcare costs, and enduring social inequalities. These findings underscore the urgent need for early intervention and treatment.

Research highlights the efficacy of trauma-focused interventions in mitigating CSA-related harm. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), developed by Cohen, Mannarino, and Deblinger, integrates cognitive, behavioral, and family therapy principles (Cohen & Mannarino, 2016). TF-CBT emphasizes reshaping maladaptive cognitions, modifying harmful behavioral patterns, and involves supportive family members or a non-offending caregiver to facilitate healing. TF-CBT is one of such interventions that stabilize emotions by modifying the thoughts that contribute to disturbing emotions (Cully &Teten, 2008). This stability is achieved through skill acquisition and homework assignments which are crucial elements of TF-CBT. Additionally, NCTSN (2008) observed that the TF-CBT component of cognitive coping was effective in helping the client connect thoughts and feelings related to Trauma.

Evidence indicates that TF-CBT yields positive outcomes in reducing trauma symptoms across diverse settings, including the U.S., Congo, Ethiopia, Uganda, and Tanzania (Cohen & Mannarino, 2017). The involvement of non-offending caregivers is especially predictive of positive recovery outcomes (Martin et al., 2019). Studies confirm that TF-CBT significantly reduces PTSD symptoms, depression, and behavioral problems among children exposed to trauma (Cohen, Deblinger, & Mannarino, 2016; Allen, Riden, & Shenk, 2020). Nevertheless, the literature identifies critical gaps regarding the model's applicability in specific contexts, such as among adolescent female CSA survivors in Kenya. Despite high prevalence in regions like Kilifi County, there remains limited empirical evidence of TF-CBT's effectiveness in addressing survivors' emotional distress in these settings. This gap justifies focused research to evaluate context-specific applicability and inform evidence-based treatment strategies.

The global burden of CSA, its gendered and regional variations, and it's devastating consequences necessitate comprehensive policy responses. Interventions must prioritize prevention, early detection, and survivor-centered care (Briere & Scott 2015). Community and family engagement are crucial, given that most perpetrators are known to victims. Legal systems must strengthen child protection measures, while mental health systems should expand access to evidence-based therapies such as TF-CBT. In low- and middle-income countries, including Kenya, there is particular need for contextually grounded interventions that address stigma, enhance reporting mechanisms, and provide culturally sensitive therapeutic care.

In conclusion, CSA remains a pervasive global problem with severe developmental, psychological, and intergenerational consequences. While global prevalence data highlight widespread victimization, regional variations underscore the influence of cultural norms and reporting practices. Girls are disproportionately

victimized, though in some contexts, boys report higher prevalence due to cultural dynamics of disclosure (Tishelman & Geffner, 2010). Survivors face elevated risks of psychiatric disorders, impaired cognition, and compromised life outcomes. Trauma-Focused Cognitive Behavioral Therapy emerges as one of the most promising interventions, yet significant research gaps persist regarding its application among female adolescent survivors in contexts such as Kilifi County, Kenya. Addressing these gaps through rigorous, context-sensitive research is vital to advancing child protection, informing public policy, and ensuring effective survivor care.
Here is the conceptual framework that served as the foundation for this study.

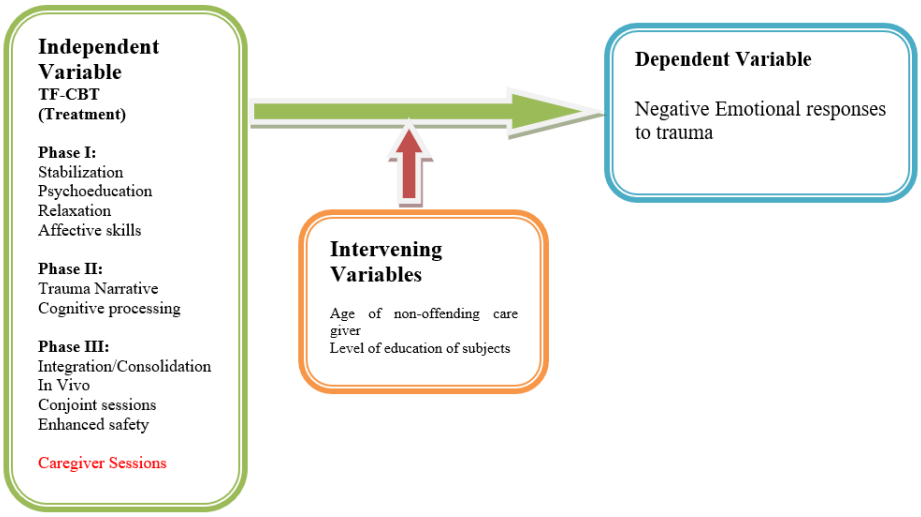

Figure 1.1: Conceptual framework

Figure 1.1 outlines a conceptual framework linking Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as the independent variable to negative emotions as the dependent variable, with the age of non-offending caregivers and adolescents' educational level as intervening variables influencing treatment outcomes. TF-CBT involves three phases: stabilization, trauma narration and processing, and integration/consolidation, aimed at reducing trauma-related symptoms (NCTSN, 2008). Research shows TF-CBT improves survivors' emotional well-being and interpersonal functioning, especially with caregiver involvement (Cohen & Mannarino, 2017). This model emphasizes a holistic, developmentally appropriate approach to treating negative emotions among adolescent female sexual abuse survivors, guiding evaluation of TF-CBT's effectiveness.

II. Research Methodology

This study employed a quasi-experimental research design, specifically utilizing a non-equivalent groups design to assess the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in treating negative emotions among 12–17-year-old female survivors of sexual abuse. The choice of a quasi-experimental design was informed by the ethical and practical constraints inherent in conducting randomized controlled trials (RCTs) with vulnerable populations, such as sexually abused children (Miller et al., 2020). Random assignment in such sensitive contexts is often neither feasible nor ethical, as denying a potentially beneficial treatment to some participants raises significant concerns (Campbell & Stanley, 1963). Hence, the non-equivalent groups design offered a practical and ethically sound alternative by allowing meaningful comparisons between groups while respecting participants' rights and circumstances.

The quasi-experimental design is particularly well-suited to psychological research involving trauma interventions, as it balances the need for methodological rigor with ethical considerations (Siedlecki, 2020). In real-world settings where controlled environments are difficult to replicate, this design facilitates the examination of therapeutic outcomes in naturalistic conditions, providing insights into the intervention's applicability and effectiveness in everyday practice (Shadish & Campbell, 2002). Through the comparison of pretest and posttest measures across groups, the study aimed to detect significant differences in trauma-related outcomes, especially negative emotions, thereby evaluating the therapeutic impact of TF-CBT.

In this study, together with their non-offending care givers, the participants were divided into two groups based on their availability at the rescue centers rather than random allocation. The treatment group received the TF-CBT, while the comparison group was provided with Treatment As Usual (TAU), which comprised the standard counseling services offered at the respective children's homes and rescue centers. Although randomization was not possible, this design ensured rigorous evaluation of intervention effects by collecting data

at multiple points both before and after the intervention thus enabling the measurement of changes attributable to TF-CBT.

The independent variable in this study was the administration of TF-CBT, an evidence-based therapeutic intervention designed to reduce negative emotions and promote psychological recovery. The primary dependent variable was the level of negative emotions experienced by the 12–17-year-old female survivors, encompassing symptoms such as anxiety, depression, and distress linked to sexual abuse. To enrich the analysis and account for individual differences, the study incorporated two intervening variables: the age of the non-offending caregiver and the educational level of the adolescent participants. These factors were hypothesized to influence therapeutic engagement and outcomes, with caregiver age potentially affecting the support provided during therapy, and educational level shaping adolescents' cognitive readiness and ability to engage with therapeutic content.

The research was conducted in Kilifi County, Kenya, a region marked by a high prevalence of trauma-related issues among children, notably sexual abuse. Kilifi County, located between latitudes 2°20' and 4°00' South and longitudes 39°05' and 40°14' East, was selected for its documented cases of child sexual abuse and related adversities. These cases are often compounded by co-occurring traumas such as neglect, emotional and physical abuse, and exposure to domestic violence, which collectively exacerbate the psychological burden on affected children. The layered nature of trauma in Kilifi County underscores the critical need for structured psychological interventions tailored to this vulnerable population.

The study focused on female survivors aged 12 to 17 years, as this group represents the majority of reported child sexual abuse cases in the county. Kilifi County's annual reports reveal a troubling rise in defilement cases among adolescent girls, with numbers increasing from 189 in 2015/16 to 388 in 2018/19. Adolescence is a developmental period characterized by significant physical, emotional, and social changes, making these girls particularly vulnerable to the long-term effects of trauma. Negative emotions arising from abuse during this stage can lead to behavioral problems and maladaptive beliefs if left untreated, justifying the focus on this demographic.

Participants were recruited using a convenience sampling technique, selecting individuals who were accessible and met the study's inclusion criteria at the time of data collection. Recruitment took place in various rescue centers and children's homes within Kilifi County, where referrals were made by the Department of Children's Services. The treatment group was drawn from Springs of Hope Rescue Centre, Mwangaza Children's Home, and Malezi Children's Home, while the Treatment As Usual group came from Heshima and Bakhita Rescue Centres. To ensure participants' eligibility, the Trauma Screening Questionnaire (TSQ; Brewin et al., 2002) was administered as an initial screening tool. A cutoff score of six or more "yes" responses indicated significant trauma symptoms, qualifying participants for inclusion.

Following screening, all participants completed a pretest assessment to evaluate trauma-related emotional distress. Those assigned to the treatment group then underwent an eight-session TF-CBT program, delivered twice weekly, with each session lasting approximately one hour. The therapy followed a manualized protocol adapted from established TF-CBT manuals and prior research, structured into three core phases: stabilization, trauma narration and processing, and integration/consolidation (Child Welfare Information Gateway [CWIG] (2018); NCTSN, 2008). Importantly, sessions included components designed for non-offending caregivers to enhance support and facilitate family involvement, which is critical for therapeutic success. The comparison group continued to receive Treatment As Usual, consisting of routine counseling provided by in-house professionals at their respective centers.

Sample size determination followed Kirby et al.'s (2002) formula to ensure adequate statistical power, set at 90% with a significance level (α) of 0.05. The initial calculation suggested a minimum of 18 participants. To account for an estimated 10% dropout rate, Sakpal's (2010) attrition adjustment formula was applied, increasing the final sample size to 20 participants. This adjustment was crucial to maintaining the integrity and reliability of the findings despite potential participant attrition.

Data collection employed two key instruments to measure trauma effects and emotional states. The Trauma Screening Questionnaire (TSQ), developed by Brewin et al. (2002), served as the primary screening tool. It is a 10-item self-report measure designed to detect trauma symptoms with established sensitivity (78.8%) and specificity (75.6%) as reported by de Bont et al. (2015). Emotional responses were assessed using the Positive and Negative Affect Schedule (PANAS; Watson et al., 1998), a widely validated 20-item Likert scale questionnaire that quantifies both positive and negative affective states. PANAS has demonstrated high internal consistency and construct validity, making it suitable for capturing changes in emotional distress related to trauma.

To ensure the appropriateness of the research instruments for the target population, a pilot study was conducted involving three female survivors aged 12–17 years and their non-offending caregivers from Good Hope Children's Home in Mombasa County. This preliminary phase evaluated the content validity, clarity, and cultural relevance of the tools, as well as the time required for administration. Feedback from the pilot informed necessary modifications, enhancing the reliability and feasibility of the instruments for the main study. Ethical

considerations were paramount; all pilot participants received supportive therapy referrals to safeguard their well-being.

Pretest assessments were conducted before the intervention to establish baseline trauma symptomatology and emotional states. Post-intervention, both treatment and comparison groups were reassessed to detect changes in level of negative emotions. The comparison of pretest and posttest scores facilitated evaluation of the intervention's impact. The data were analyzed using One-way Analysis of Variance (ANOVA) to compare group means on the dependent variables, with significance set at $p \leq 0.05$. Effect sizes were calculated using Cohen's d, which quantifies the standardized difference between means (Fritz et al., 2012). Following conventional benchmarks (Cohen, 1988), d values of 0.2, 0.5, and 0.8 indicate small, medium, and large effects respectively. The directionality of effects was also interpreted, with negative d values reflecting the relative positioning of group means.

Ethical approval for the study was obtained from the National Council for Science, Technology and Innovation (NACOSTI). Additional permissions were secured from local authorities, including the Kilifi County Commissioner, Ministry of Education, and the County Children's Services Department. Informed consent was sought and obtained from non-offending caregivers and their children, with clear communication provided about study procedures, confidentiality, and voluntary participation. The research maintained strict confidentiality standards, with safeguards in place for potential breaches mandated by law or ethics.

In preparation for conducting this sensitive research, the investigator engaged in personal therapy to enhance self-awareness, emotional resilience, and reflexivity. This preparatory step was crucial for maintaining professional boundaries and empathetic engagement when working with traumatized adolescents.

In summary, this methodology was carefully crafted to balance scientific rigor with ethical responsibility. The quasi-experimental design, combined with validated instruments and rigorous sampling and analysis procedures, aimed to provide robust evidence on the effectiveness of TF-CBT in addressing trauma-related negative emotions among adolescent female survivors of sexual abuse in Kilifi County, Kenya.

III. Results And Discussion

The study employed a one-way Analysis of Variance (ANOVA) to compare pre- and post-test outcomes for negative and positive emotional responses in two groups of female sexual abuse survivors aged 12–17 in Kilifi County: an experimental group (TF-CBT, n = 20) and a comparison group receiving Treatment as Usual (TAU, n = 20).

At pre-test, there were no statistically significant differences between groups. For negative emotional responses, the p-value was 0.96 with Cohen's d = –0.02; for positive emotional responses, p = 0.92 with Cohen's d = 0.03. These high p-values and negligible effect sizes indicate that both groups were equivalent at baseline.

Following the eight-session TF-CBT intervention, the post-test results showed strong evidence of TF-CBT's efficacy. Negative emotional responses were reduced significantly in the TF-CBT group when compared to TAU (p = 0.00), with a very large effect size (Cohen's d = –2.06), signifying a robust decline in negative emotions. Positive emotional responses were also significantly improved in the TF-CBT group relative to control (p = 0.032), with a moderately large effect size (d = 0.70). This suggests TF-CBT not only alleviates distress but also fosters emotional well-being in the positive affect domain (Canale et al., 2022).

These results align with established literature. For example, de Arellano et al. (2014) found large effect sizes for trauma symptoms ($d \approx 2.04$), anxiety ($d \approx 1.67$), and depression ($d \approx 1.68$) in children receiving TF-CBT. The current study's effect sizes, particularly for negative affect, are similar or even more pronounced. The discussion also notes the relevance of sample size: as Bhandari (2023) argues, studies with small samples may fail to detect true effects even when effect sizes are large; in this study, large effect sizes accompanied significant p-values posttest, strengthening confidence in the results.

In summary, the findings support the primary objective: TF-CBT is effective in reducing negative emotional responses and enhancing positive affect among adolescent female survivors of sexual abuse. The baseline comparability confirms that the observed improvements can be attributed to the intervention rather than preexisting differences. Analysis and presentation of the data was done as shown below in **table 1.2**

Table 1. 2: ANOVA Results for emotional Responses to trauma at Pre-test and Post-Test

			Sum of Squares	df	Mean Square	F	Sig.
Negative emotional responses (Positive Affect) Pre-test 1 * Treatment	Between Groups	(Combined)	.225	1	.225	.010	.921
	Within Groups		867.550	38	22.830		
	Total		867.775	39			
Negative emotional response (Negative Affect) Pre-test 2 * Treatment	Between Groups	(Combined)	.100	1	.100	.002	.962
	Within Groups		1679.900	38	44.208		
	Total		1680.000	39			
Negative emotional response (Positive Affect) Post-test 1 * Treatment	Between Groups	(Combined)	403.225	1	403.225	4.926	.032
	Within Groups		3110.550	38	81.857		
	Total		3513.775	39			

Negative emotional response (Negative Affect) Post-test 2 * Treatment	Between Groups	(Combined)	2755.600	1	2755.600	42.483	.000
	Within Groups		2464.800	38	64.863		
	Total		5220.400	39			

In this study, pre-test comparisons of two groups (TF-CBT vs. TAU) showed no significant differences: positive emotional responses, p = 0.92, and negative responses, p = 0.96, indicating comparable baseline means. After the TF-CBT intervention, post-test results revealed significant group differences: positive emotional responses improved (p = 0.03) and negative emotional responses decreased substantially (p = 0.00). With $p \leq 0.05$ as the threshold, the null hypothesis was rejected in favor of the alternative. Cohen's d effect sizes were computed based on group means, standard deviations, and pooled standard deviations (via the formula (M1 - M2)/ SDpooled), to quantify the magnitude of these differences.

Table 1. 3: Comparison of means for emotional responses to trauma at pre-test and post-test

Treatment		Negative emotional responses (Positive Affect) Pre-test 1	Negative emotional response (Negative Affect) Pre-test 2	Negative emotional response (Positive Affect) Post-test 1	Negative emotional response (Negative Affect) Post-test 2
TF-CBT	Mean	**18.90**	**41.45**	**30.75**	**19.50**
	N	20	20	20	20
	Std. Deviation	4.424	5.491	7.538	6.902
TAU	Mean	**18.75**	**41.55**	**24.40**	**36.10**
	N	20	20	20	20
	Std. Deviation	5.108	7.633	10.338	9.061
Total	Mean	**18.82**	**41.50**	**27.58**	**27.80**
	N	40	40	40	40
	Std. Deviation	**4.717**	**6.563**	**9.492**	**11.570**

This study aimed to assess the effectiveness of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in treating negative emotional responses to trauma among 12–17-year-old female survivors of sexual abuse in Kilifi County, Kenya. The quantitative analysis utilized a One-Way Analysis of Variance (ANOVA) to compare pre-test and post-test scores between the experimental group (n=20) and the control group (n=20), employing the Positive and Negative Affect Schedule (PANAS) as the assessment tool.

At the pre-test stage, the p-values for positive and negative emotional responses to trauma were 0.92 and 0.96, respectively, with Cohen's d values of 0.03 and -0.02. These high p-values and negligible effect sizes indicate no significant differences between the treatment and comparison groups at baseline. This suggests that both groups were comparable in their emotional responses to trauma prior to the intervention.

Following the eight-session TF-CBT intervention, significant changes were observed in both positive and negative emotional responses. The post-test results revealed a p-value of 0.032 for positive emotional responses and 0.00 for negative emotional responses, with Cohen's d values of 0.70 and -2.06, respectively. The positive emotional response Cohen's d of 0.70 indicates a moderate effect size, suggesting a meaningful improvement in positive emotions among the treatment group. The negative emotional response Cohen's d of -2.06 represents a very large effect size, indicating a substantial reduction in negative emotions among participants who underwent TF-CBT compared to the control group.

These findings align with existing research on the efficacy of TF-CBT. For instance, a meta-analysis by Wang et al. (2023) reported large effect sizes for posttraumatic growth and emotional management among maltreated children receiving TF-CBT. Additionally, a study by Kaminer et al. (2023) demonstrated significant reductions in PTSD and depression symptoms among adolescents following TF-CBT treatment. Moreover, Allen and Hoskowitz (2017), Racco and Vis (2015), and Cully and Teten (2008) have all demonstrated the effectiveness of TF-CBT in alleviating negative emotions.

Kaminer et al. (2023) conducted randomized controlled trials in South Africa involving 75 adolescents (54 girls and 21 boys aged 11–19). The results showed a significant reduction in PTSD symptom severity following TF-CBT treatment, with a Cohen's *d* of 0.60 ($p < .01$) at post-treatment and 0.62 ($p < .01$) at a three-month follow-up. Similarly, symptoms of depression were significantly reduced, with a Cohen's *d* of 0.51 ($p = .03$) at post-treatment and 0.41 ($p = .05$) at follow-up. These results reinforce the assertion that TF-CBT is an effective intervention for trauma and depression symptoms in adolescents.

Further evidence supporting the findings comes from a meta-analysis by Thielemann et al. (2022)**,** which examined 28 randomized controlled trials and 33 uncontrolled studies with a total of 4,523 participants. The analysis reported substantial symptom reductions for PTSD symptoms (PTSS), anxiety, grief, and depression. Specifically, post-treatment symptom improvement in the treatment group showed a large effect size (PTSS: $g = 1.14$, CI 0.97–1.30). When compared to control groups receiving either standard or alternative treatments, the effect size remained moderate to large (PTSS: $g = 0.52$, CI 0.31–0.73), especially in group therapy settings. These findings further highlight the efficacy of TF-CBT in reducing negative emotions.

In a quasi-experimental study by Muderhwa et al. (2022), involving 488 university students aged 18–25 in Goma, DR Congo, TF-CBT was compared with alternative treatments for PTSD and depression. The results revealed superior efficacy of TF-CBT (p = .000 for both PTSD and depression outcomes), indicating its broader applicability even beyond the specific age group of the current study.

Jensen et al. (2022) conducted a European study on TF-CBT effectiveness in reducing PTSD and Complex PTSD (CPTSD) symptoms among 73 youths. The study demonstrated that participants diagnosed with CPTSD experienced more significant reductions in PTSD and CPTSD symptoms than those diagnosed with PTSD alone. Importantly, the post-treatment levels of PTSD and CPTSD symptoms were comparable across treatment and control groups**,** reinforcing the positive therapeutic outcomes of TF-CBT, especially in treating affect dysregulation—an important dimension of negative emotional responses to trauma.

Additionally, Chipalo (2021) synthesized findings from 1,650 articles and four peer-reviewed studies involving 64 refugee children from 21 countries. All four studies confirmed the positive impact of TF-CBT in reducing trauma-related symptoms, including negative emotions, with improvements sustained during follow-up assessments.

Márquez et al. (2020) also provided relevant insight through a case study of an adolescent in the U.S. who had survived domestic sex trafficking. Following 20 sessions of TF-CBT, the adolescent exhibited significant reductions in post-traumatic stress and depressive symptoms, further confirming the robust effectiveness of the treatment, despite the gender of the participant not being disclosed. This case aligns closely with the current study's findings and contributes additional support for the use of TF-CBT in trauma recovery. Moreover, in a multisite, randomized controlled trial for sexually abused children Cohen et al. (2004) found that TF-CBT was an effective treatment for PTSD symptoms that were linked to the trauma.

These studies provide supporting evidence for the outcomes observed in the current study. Likewise, findings from the National Child Traumatic Stress Network (NCTSN, 2008) emphasize the role of cognitive coping, a core component of TF-CBT, in assisting individuals to connect their thoughts and emotions related to trauma, thereby mitigating negative emotional reactions. It is evident that the growing body of research has consistently demonstrated that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a highly effective, evidence-based treatment for managing negative emotional outcomes in female survivors of sexual abuse (Dalgleish et al.,2015). This therapeutic model blends core elements of cognitive-behavioral therapy with trauma-informed strategies to specifically address the psychological impact of sexual trauma. It is designed to target dysfunctional thinking patterns, emotional instability, and avoidance behaviors that are commonly observed in individuals who have endured such experiences.

TF-CBT significantly reduces symptoms associated with post-traumatic stress disorder (PTSD), depression, anxiety, guilt, and shame in this population (Odero et al., 2023). By combining therapeutic techniques such as psychoeducation, emotional regulation skills, trauma processing, and cognitive restructuring, TF-CBT provides a comprehensive and structured pathway for recovery (Alpert et al.,2021; Deblinger, et al., 2012; Thornback & Muller, 2015). The approach also often includes involvement of non-offending caregivers, which enhances support systems and promotes emotional healing, especially in younger survivors of sexual abuse (Nurhalimah, et al., 2024; Rohde & Masten, 2006).

The cumulative evidence strongly supports the effectiveness of TF-CBT in promoting psychological recovery and emotional resilience among female survivors of sexual violence. Its trauma-sensitive design helps individuals make sense of their experiences, challenge unhelpful beliefs, and gradually restore a sense of personal safety and empowerment. Rather than simply alleviating symptoms, TF-CBT fosters deeper psychological growth and coping capacity, making it an indispensable part of trauma care (Sánchez-Meca et al., 2011; Wildfeuer, 2024). Additionally, Mannarino, et al. (2012) found that these positive effects were maintained post treatment.

In conclusion, the study provides compelling evidence supporting the efficacy of TF-CBT in treating emotional responses to trauma among female adolescents in Kilifi County. The significant effect sizes observed in both positive and negative emotional responses attest to the intervention's effectiveness. Given these findings, it is recommended that TF-CBT be considered a standard therapeutic approach for addressing trauma-related emotional disturbances in this population. Further research with larger sample sizes and diverse populations is warranted to generalize these findings and explore the long-term benefits of TF-CBT.

IV. Conclusions And Recommendations

This study provides compelling evidence supporting the efficacy of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in addressing trauma-related emotional distress among adolescent survivors of sexual abuse in Kilifi County. The intervention led to significant reductions in negative emotional responses, with a Cohen's d of -2.06, indicating a very large effect size. Additionally, improvements in positive emotional responses were observed, further underscoring TF-CBT's effectiveness in promoting emotional well-being (Schmidt & Oliver, 2022; Webb et al., 2014).

These findings align with existing literature, reinforcing TF-CBT's status as a gold-standard treatment for trauma-exposed children and adolescents. Studies have consistently demonstrated TF-CBT's ability to alleviate symptoms of PTSD, depression, anxiety, and other trauma-related disorders. The current study contributes to this body of evidence, particularly within the context of Kilifi County, a region with unique socio-cultural dynamics and resource limitations.

Given TF-CBT's demonstrated effectiveness, it is recommended that the Kenyan government and relevant stakeholders incorporate TF-CBT into national and county-level mental health policies. This integration would standardize trauma care protocols and ensure that adolescent survivors of sexual abuse receive evidence-based interventions. Policy adoption should include provisions for training mental health professionals, allocating resources, and monitoring implementation to maintain fidelity to the TF-CBT model.

To facilitate the widespread adoption of TF-CBT, it is essential to train counseling psychologists, social workers, children's officers, and other child welfare practitioners in the TF-CBT model. Training programs should be culturally tailored to the Kenyan context and include components on trauma-informed care, emotional regulation, and cognitive restructuring. Ongoing supervision and support should be provided to ensure the quality and consistency of TF-CBT delivery.

Raising community awareness about the availability and benefits of TF-CBT is crucial for encouraging help-seeking behaviors among survivors and their families. Community-based organizations, schools, and religious institutions can play a pivotal role in disseminating information and reducing stigma associated with mental health services. Additionally, engaging community leaders in advocacy efforts can foster a supportive environment for survivors.

The current study focused exclusively on female adolescents. Future research should investigate the applicability and effectiveness of TF-CBT for male survivors of sexual abuse in Kilifi County. This would provide a comprehensive understanding of TF-CBT's impact across genders and inform gender-sensitive adaptations of the intervention.

Conducting longitudinal studies to assess the sustainability of TF-CBT's effects over time is essential. Such research would provide insights into the durability of treatment gains and the need for booster sessions or ongoing support for survivors.

In conclusion, this study affirms the efficacy of TF-CBT in treating trauma-related emotional distress among adolescent survivors of sexual abuse in Kilifi County. The intervention's success highlights the importance of integrating evidence-based therapies into local mental health frameworks. By implementing the recommended policies and practices, and pursuing further research, stakeholders can enhance the psychological well-being of survivors and contribute to the broader goal of trauma-informed care in Kenya.

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